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Aborting America

A well-known obstetrician and gynecologist, at one time the most prominent doctor in the fight to repeal abortion laws, now, after years of philosophical and moral struggle, believes that abortion on request is wrong. **ABORTING AMERICA** is about the evolution of Dr. Bernard N. Nathanson's beliefs as well as the changes that went on in medicine and in the country during those years.

In his medical school days Dr. Nathanson underwent the harrowing experience of procuring an abortion for his girlfriend. That experience began his questioning of the existing prohibitions. Over the early years of his practice those questions grew, he came to favor legalization of abortion and became a co-founder of the National Association for Repeal of Abortion Laws (now the National Abortion Rights Action League). From February 1971 to September 1972, he was director of the Center for Reproductive and Sexual Health, the largest and busiest abortion clinic in the world. By 1973, when the Supreme Court handed down its revolutionary decision on the right to

abortion, Dr. Nathanson was Chief of Obstetrical Services at St. Luke's Hospital in New York City. In this position he dealt with the fetus as an intrauterine patient, actually "seen" by fetoscopy and monitored by various pieces of very sophisticated equipment. The blips and beeps that appeared on the monitors were the same for the fetus as for the infant. Consequently, new reflection provoked Dr. Nathanson to a now famous 1974 statement that he had "in fact presided over 60,000 deaths."

ABORTING AMERICA is a controversial book about one of the most volatile subjects in America today. Dr. Nathanson takes the reader inside the pro-abortion movement and its political maneuverings from its beginning to the time of New York State's liberalized abortion law. As director of the clinic, he presents a detailed account of the machinery of the massive abortion industry. He confronts the arguments for and against abortion straightforwardly and without sentiment. Most people thought the Supreme Court settled the abortion issue for all time. Dr. Nathanson shows that the real thinking on the issue has just begun.

Aborting America

Bernard N. Nathanson, M.D.
with Richard N. Ostling

1979
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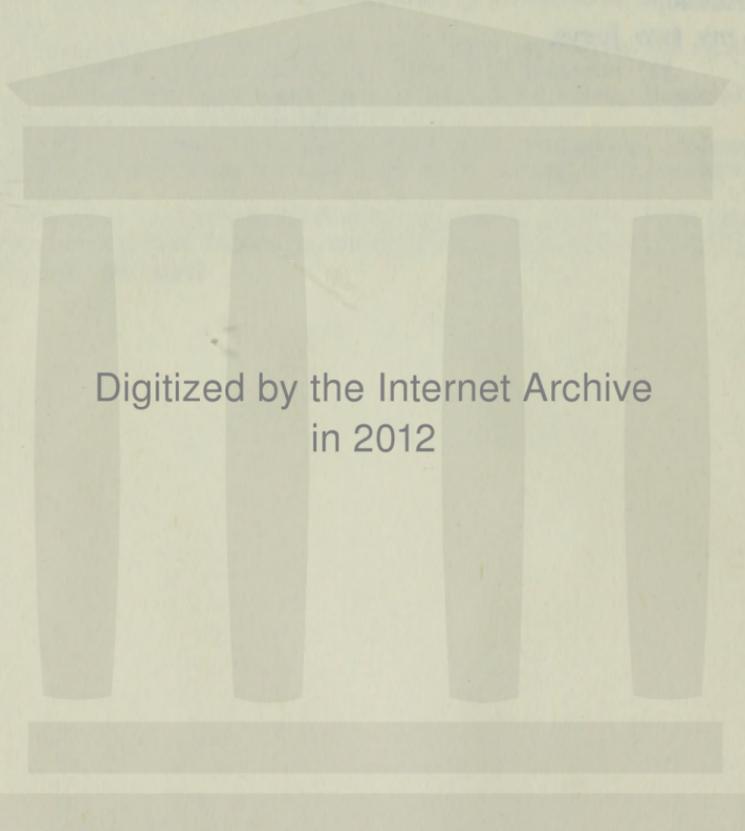
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First Edition

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Acknowledgments

To Adelle,
and my two Joeys.

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Acknowledgments

The author would like to thank his father, Joseph N. Nathanson, for his help in developing the material in the early chapters, Beth Chadwick for her assistance in research and documentation on the abortion movement, and, finally, Hunter Frost, a rare and delightful man and deeply valued friend. He was the true *accoucheur* of this book, and the author unreservedly melds his debt.

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Preface

The present work is a unique document of American social history, not only because few physicians have written about abortion for the general public, but because no physician in the nation has had more clinical experience with abortion than Bernard N. Nathanson. A prominent obstetrician-gynecologist in New York City, he was as well the only doctor among the handful of activists who founded and ran the National Association for Repeal of Abortion Laws (N.A.R.A.L.), which lobbied successfully for the removal of abortion restrictions in New York and elsewhere.

In November of 1974, Nathanson published a piece entitled "Deeper into Abortion" in the nation's leading medical periodical, the *New England Journal of Medicine*. It created something of a sensation, for besides his N.A.R.A.L. activities, Nathanson had been the director of the largest abortion clinic in the world. In reflecting upon his work there, he wrote: "I am deeply troubled by my own increasing certainty that I had in fact presided over 60,000 deaths. . . . We are taking life, and the deliberate taking of life, even of a special order and under special circumstances, is an inexpressibly serious matter."

After several years of further reflection, Nathanson has decided to explain in detail for the first time what formative experiences caused him to join the abortion liberalization movement, how it functioned, why (wholly apart from religious considerations) he eventually developed doubts about abortion, his disagreements with both sides in the controversy, his analysis of the arguments they use, and what he has finally concluded about this agonizing personal and public question.

1

BEGINNINGS

I come by my rebelliousness honestly. As a physician, I doubt that it is a quality passed on by any recognized Mendelian mechanism. But my father had it in abundance, except that in his generation and in the community in which he was brought up they often called it *chutzpah*. Not that abrasively intellectualized *chutzpah* one finds in the terminal angst of (prospering) Jewish writers, but the obsessive drive and irrepressible courage of young Jewish males born into overweening poverty within a Gentile world in the last century, pushing and shoving their way into the pecking lines.

Ottawa was, in Wilde's yellow '90s, a stiff-backed little city whose chief source of pride was that it was the seat of Canada's government. From several childhood visits there, my residual impression of the place is Seriousness. Leveled eyes, sincere voices, and tumescent integrity. My father had been born in New York City in 1895, but his father died when little Joey was only two, and his mother married Jacob Mirsky, the *shochet* (ritual slaughterer) of Ottawa. She took Joey, her youngest, with her and left the three older children with various relatives in New York. The *shochet* (never referred to as anything but Old Man Mirsky) had himself been widowed with five small children, and money was

tight. It was earned killing animals in the prescribed kosher manner at \$.25 apiece; the family continually looked forward to those wonderful but rare occasions when there was a cow and a big fee: \$.50. That meant a new pair of shoes for one of the children whose worn-out pair had been lined with newspaper for the past month.

There was no rabbi in those years for the tiny Orthodox community of Ottawa, so Old Man Mirsky was as well its spiritual leader, the Just Man. He adjudicated marriage contracts and matrimonial disagreements and presided over the High Holy Days. The bearded stepfather was kind but stern, insisting that religious training take precedence over all else. Shabbas was the apogee of the week. The family survived in Dickensian, genteel poverty, yet my father pridefully tells me that the home was always open those Friday nights to indigent Jews or itinerant peddlers ("I cash clothes") for a ritual meal, a glass of the dark, cloying wine, and *pilpul* (Talmudic disputation).

Like the other little Orthodox boys, Joseph Nathanson attended both *cheder* (Hebrew school) and English (secular) grammar school. He expressed a desire to move on to academic high school, but the annual ten-dollar registration fee was out of the question. So he spent a year of frustration, learning the rudiments of bookkeeping at the tuition-free vocational school, his dream of being a doctor seemingly unreachable. A kindly relative heard of his misfortune, took "pity" (my father's word) on him, and sent ten dollars so he could go to "Collegiate." In the autumn of 1914 he entered the McGill University Medical College in Montreal.

He was a marasmically thin young man with a nose squashed inartistically into his triangular face and a stride much too long for his modest height. He was (and is) very intense, enthusiastic, a compulsive collector of facts—and incapable of understanding anyone who was not. The 1919 yearbook includes the obligatory gallery of graduates' photographs with biography and a descriptive quote selected by the subject. Joseph N. Nathanson's choice: "An insatiable thirst for knowledge." He worked his way through medical school by holding a variety of summer jobs: government clerking, selling flypaper and newspapers, teaching English to immigrant Jews . . . a list suitable for the inside dustjacket of a first novel. He graduated second in the class. The man who beat him

out was a penniless West Indian black who worked as a redcap each night at the railroad station. Philip Savory subsequently amassed a fortune and broad political influence as a doctor in New York City's Harlem and publisher of the *Amsterdam News*.

There was a Mirsky family crisis after my father's first year of medical studies. He returned to Ottawa, called the family together, and announced his renunciation of Orthodox Judaism. Had Torquemada himself materialized in the living room, that innocent household would not have been more astonished. That summer was a touchy time of innumerable sharp contests with his mother and long inquisitorial sessions with his stepfather. Though he never backed down, his apostasy was Joycean; the flight past the nets of blind, ritualized faith was accomplished, but the immense gravitational force of his Jewishness was omnipresent. He has remained throughout his life one who demanded God's credentials, denied the Torah, but maintained his commerce with the world in terms of ". . . but is it good for the Jews?" Many years later my father would explain to me that his biological training no longer permitted him to accept on faith the anachronistic dietary laws or the mulish self-denial of the Shabbas rules. I strongly doubt that science alone prompted the break. Adolescence, the abrupt entry into the secular world of the urban goyim, and that indefinable quality of rebelliousness all conspired to move him away from Orthodoxy.

He married Harriet Dover of Ottawa in 1920, and with the small dowry which she brought to the union he opened a modest office for the general practice of medicine there in the summer of 1921. Industrious, compassionate, well-trained, he was an immediate success. In that era, prenatal care of the pregnant woman was a development only in places like New York and Chicago. When he proposed a prenatal clinic for the Ottawa Maternity Hospital to the administrative director, sixty-year-old Agnes McCall, he met stony resistance. She was particularly outraged when he indicated that part of the routine clinic protocol would be blood Wassermann tests for syphilis on all pregnant women. The women of Ottawa were inviolably decent, she declared, and there was no need for any such insult. The battle lines were thus drawn, and the fight was carried to the highest echelons of medical power in the city. He prevailed, and in its first year (1921) the prenatal

clinic cared for 413 pregnant women. Thirteen of them turned up with syphilis. They were treated with the appropriate drugs of that era, sparing the infants the devastating stigmata of congenital syphilis; Miss McCall became one of my father's most convinced admirers.

Pursuing his intense interest in obstetrics, the young general practitioner carried out a brilliant piece of original research in his own kitchen. To study the vascular structure of the placenta affected by syphilis, he boiled colored gelatin and injected it into the vessels. The scientific paper he published describing the experiment was enthusiastically received. He decided to move to New York City in 1925 in order to establish a practice in obstetrics and gynecology. It was there that I was born the following year at Woman's Hospital on a muggy July 31, the obstetrical product of a rather lengthy labor and a forceps rotation of the head from the posterior position. The bill for my mother's ten days in a private room: \$43. Today it would be sixty-six times that amount.

Right to the very borders of my memory, there was relentless pressure to become a physician. When I came to the dining table with sticky hands or dirty fingers at age eight or nine I would be reminded that surgeons keep their hands clean at all times. When I broke a finger at age twelve playing baseball, I can recall my father's excited queries to the man who set the finger about whether the injury would affect my ability to perform surgery. Always there were the promises and the plans: how we would become partners in practice, how we would discuss our cases together. (Ironically, when I entered practice in 1957 I shared an office—but not a practice—with him for three years, then had a violent schism over the question of my impending marriage to a non-Jewish woman. We did not speak to each other for several years thereafter.)

Even as a child I would accompany him to the hospitals, where he would place me in the attending physicians' lounge while he made rounds. He would introduce me to his colleagues as his "future partner." Once, when I was eleven, he actually took me along to the patients' rooms. In one, I watched a blood transfusion running into the arm of one ashen-faced woman, and ran from the room into the corridor, gagging violently. He expressed puzzlement, tinged with a bit of disappointment, at this display. I never

again accompanied him on rounds until I was a medical student—and I never got sick again in the course of my professional career.

My family was beyond question a patriarchy. The tempo of our West Eighty-sixth Street apartment was organized around the unpredictable hours and physically draining demands of his work as an obstetrician. We arose at six because he did, had dinner at 5:30 because that was when he got hungry. Homework had to be inspected and approved before bedtime. My mother, a large, raw-boned woman with an uncommonly well-developed small-town rectitude, was completely under his dominion, save for an occasional minor rebellion over his dole of household funds. She shamelessly padded the bills to exact trifling amounts in graft. She was undeniably an uneducated woman who had been forced to leave school because she was the oldest of five children and her mother died when she was only thirteen. As she would recount to my father the somewhat less than pulse-pounding events of her day, he would affect a majestic disdain. In particular, she loved to harass the local butcher, so much so that she eventually was banned from all butcher shops in that part of Manhattan like a hostile critic banned from certain Broadway openings.

Any author on abortion must submit to religious dissection. I went to Columbia Grammar School, a fine private school with virtually 100 per cent Jewish students at that time, and three times weekly attended Hebrew school at B'nai Jeshurun, which is considered one of *the* Conservative synagogues. Religious instruction in that era meant endless slogging through turgid passages of Hebrew Scripture, mindless memorization of Hebrew prayers for numerous occasions, and sanctimonious lectures about the chosenness of the Jewish race. Preoccupation with Zionism and fund-raising left little energy for instruction in conversational Hebrew or any demeaning excursions into the arcane regions of faith.

In religion, as in everything, my father was the central influence on my life. I would return home from these classes and, at my father's prompting, dutifully recite what I had learned. He would respond by scornfully pointing out the logical inconsistencies, and retire to his study muttering imprecations about organized religion and the "goddamn Zionists." Anytime religion came up in conversation he would scoff or undermine belief with a sharp, perceptive remark. On the other hand, my father tried to instill pride in me

about being Jewish and never got away from attending the High Holy Day services, where he would sit in grudging protest. At my Bar Mitzvah in July of 1939, he expressed considerable dissatisfaction with what he maintained was a dispirited reading of my assigned passage in the Torah.

Caught in such a whipsaw of contradictions, it is no wonder that I have never entered a synagogue again since that July day, nor, may I add, any other house of worship. My father undermined religiosity in me so continually and so artfully that I was left with nothing to believe in. Consequently, I am not only a convinced atheist but have never been particularly *interested* in organized religion. It is fair to say that my opinions about abortion—or anything else—have never been influenced in the slightest by the empires of faith.

My sexual instruction was both more and less complicated than my religious instruction. Sex was referred to only elliptically in my home and then largely with snickers. If it had to be discussed in front of the children (I had a sister three years my junior) it was in Yiddish, with sly, knowing smiles. I never heard the word “abortion” mentioned, nor of course was I ever told the rudiments of contraception. When I was thirteen my father summoned me to his study, wearing his most serious face. (Even in repose his face resembled that of a particularly pugnacious bulldog, so much so that colleagues and students at Woman’s Hospital often referred to him privately as “even-tempered Joey. Always mad.”) He announced that he wished to discuss the matter of sex. By that age I of course was conversant with the usual four-letter words, had looked them up in the dictionary, had examined an ancient copy of the old *Police Gazette* with what can only be described as an unusually prurient interest, and had progressed to holding the underwear advertisements in the *New York Times Magazine* section up to the light for possible unchaste perceptions.

I suppose that I was anticipating with some relish at least a slide-illustrated lecture on sex—what goes where and who does what to whom—and was keenly disappointed when, without comment, he handed me a thin booklet with a glossy cover, upon which a boy and his dog were cavorting. The editorial content consisted of a prim, exceedingly orderly exegesis on the matter of male semen and nocturnal emissions, capped by dark, veiled warn-

ings about the noxious effects of masturbation on the pubescent body and mind. There were a few arcane references to fertilization and implantation, accompanied by two line drawings of the male and female genitalia so businesslike that I hastily retreated to the current copy of *Look*, which had, a friend had informed me, a photo that revealed the inside of Paulette Goddard's inner thigh—above the stocking line!

When I entered Cornell it had been largely appropriated by the armed forces, like most universities in 1943. Glamorous Navy and Marine uniforms were everywhere, and we poor civilian freshmen were casually despised. I found myself a little room in "College Town," a small off-campus community, in the home of George Smiley and his wife. Mr. Smiley was a figure of vast bulk topped by a crew cut. He walked with a pronounced limp, which he attributed to the gout, and ate with a mammoth appetite. Mr. Smiley was inordinately fond of waving a turkey leg at me as I would pass him by on my way to my room, smiling and growling, "Go slow." What exactly he meant by that cautionary I never knew, but his wife, her iron-gray hair drawn back in a bun, seemed to understand, for she always nodded assent. As events were to develop in subsequent years, it might have been good advice.

The premedical curriculum at Cornell was a dreary succession of science courses, interspersed with the rare excursion into the humanities. My closest friend was Peter who also stayed at the Smiley domicile. Peter was the first Roman Catholic, indeed, the first Gentile, I ever got to know, and for the first few weeks of our acquaintance I observed him with the careful scrutiny and respectful distance one would afford a visitor from another galaxy. Weekly confession, Mass, and the preputia intacta. What exotical! My father had been scornful of Catholics as dupes and ignoramuses for their "blind adherence" to dogma, but then, he lashed out at Orthodox Jews the same way.

Peter was to provide me with my first experience, however secondhand, with abortion. He had visited his fiancée in New York in early November of our freshman year, and as Christmas neared she missed her menstrual period. He had used condoms (what Cornell man of the '40s was to be caught without a "rubber" concealed in his wallet?) and could not understand how, after such a prophylactic encounter, a contretemps such as pregnancy

could have occurred. As the son of a gynecologist as well as his best friend, I was pressed into service as a consultant, but my suggestions were at least as fatuous and naïve as his. We had more or less decided upon marriage as the only feasible route when a waitress at the local greasy spoon pulled me aside after I had explained the situation (naturally she thought *my* girl was "in trouble") and informed me grandly about Humphries No. 11. This was a byzantine compound of recondite draughts, herbs, purgatives, and emmenagogues which was the pharmacological equivalent of leeching for pneumonia. Peter and I immediately hitched a ride to nearby Cortland where we sought out a drugstore and, with much conspiratorial hissing and cajoling, managed to purchase a vial of the potion. Peter caught the next train to New York, the vial secreted in his valise. He returned forty-eight hours later looking considerably relieved. When I asked what had happened he only favored me with an inscrutable smile and a broad wink. It was the last I ever heard of it.

ANOTHER “UNWANTED PREGNANCY”

I labored through summers and holidays at Cornell in order to complete the four academic years in two calendar years and enter my father's alma mater, McGill University Medical College, in the Indian summer of 1945. I was nineteen, and approached McGill with the same attitude as Cornell, purposeful toward the work in order to get good grades, but curiously disengaged. I doubt that in four years of med school I ever really thought of the curriculum as preparing me for a life's work. The understanding that I was actually a doctor, a physician, did not come to life when I received my diploma in June of 1949, but only when my father introduced me as "my son, Doctor Nathanson" on the train back to New York following graduation.

I was predestined not just for medicine, but for his field of obstetrics and gynecology. Instruction in those fields began in the latter part of my second year at McGill with a series of didactic lectures on the basic anatomy and physiology of the reproductive systems. The lectures were given in the drafty main lecture room of the great old Royal Victoria Hospital, a magnificent edifice resembling an immense gray French château poised at the very foot of Mount Royal, which dominated the city. Several of the

weekly lectures were delivered by a Dr. Newell Philpott—chairman of the department—a reedy gravel-voiced Canadian of glabrous skull. He was fond of reminiscing about his postgraduate year in Kiel, Germany, carrying out some obscure bit of research in the innervation of the rabbit uterus, a topic which he found to be endlessly fascinating and the students, cosmically boring. But he did have a mischievous sense of humor. Word got out of his scheduled lecture on contraception, and on the awaited day the baronial lecture hall was in standing-room-only state, with students both medical and non-medical. Philpott strode to the lectern, gazed out at the expectant audience, pulled a rubber condom from his pocket, blew it up till it burst, then turned his crooked smile on us and walked off stage as if to say, so much for your prurience. Later, without preliminary hype, he did lecture on contraception, and it was not much more informative than the earlier session, though less histrionic.

In the third-year lectures we got down to business: mechanism of labor, architecture of the pelvis, Caesarean section. And even a few words on abortion. The lecturer on the latter subject was a peppy little French Canadian named Latour, who had given other lectures which were models of objectivity and informational value. But this was Montreal of 1947, and when he lectured on therapeutic and “criminal” abortion, his voice became steely and strident and his eyes narrowed like Saint-Just at the bar of justice of the Terror. The tone of the address was prosecutorial, revanchist. Listen to what our textbook (*Essentials of Obstetrics and Gynecology* by Scott and Van Wyck, 1946) stated:

“A patient who has a high fever should be considered a case of induced abortion, irrespective of the history as, in most cases of criminal abortion, it is difficult to obtain a true story. If the patient *confesses* to having adopted simple measures to bring about abortion such as taking castor oil or a hot bath, one can often be reasonably sure that this may be only part of the truth and that mechanical means have also probably been employed.” (Italics mine.) Again: “All cases of septic abortion in which criminal interference is suspected should be reported to the coroner . . .”

We were abundantly forewarned, though no source offered us firm clinical guidance on which abortions were truly “therapeutic.” As an impressionable student clerking in the gynecologic

wards at Royal Victoria, I recall watching detectives from the Montreal police closely questioning gravely ill young women lying in their hospital beds with infected induced abortions. I was dismayed by the intrusion of the law into what I had heretofore considered the inviolable sanctum of healing. They were not gentle, those French detectives, and they were not above pushing a priest in ahead of them to administer the last rites before interrogation, to set the stage.

At a student dance in 1945 I had met Ruth Potemkin, a lively freshman at Royal Victoria College with black eyes, a lush adolescent body, and an artless warmth that immediately attracted me. We began a love affair (not a "relationship" or an "encounter") that lasted three years and broke apart in the wake of an abortion. Her parents were immigrants with the characteristic Russian ebullience and Jewish hospitality. By March 1946 they prevailed upon me to stay the night in the guest room when we returned to the Potemkin home late on Saturday night. It was only a matter of weeks before we were sleeping with each other. Our method of birth control became something of a matter of public record one evening in the living room when I pulled out my wallet to extract a picture and a condom fell to the floor and wheeled away, coming to rest directly opposite Papa Potemkin's foot. I swooped down upon it like an eagle after an errant lamb, stuffed it into my pocket, and met the questioning looks with a flustered explanation that it was a finger cot with which we do rectal examinations on pregnant women. (My father had once shown me a *real* finger cot in his office.) The fact that I was a first-year student still to have my first professional encounter with a pregnant woman may have robbed the explanation of a certain degree of conviction. If the story did not fully satisfy the Potemkins, it at least palliated the tension, and neither Ruth nor I heard anything more about it. By my third year at McGill I rented a room with Ruth's brother and his wife. Their large apartment was in the heart of the unfashionable Jewish ghetto (the fashionable Jews lived in Westmount among the Protestants). Naturally, Ruth and I spent increasingly lengthy intervals together, actively making plans to marry upon my graduation the following year.

And then Ruth became pregnant.

It is extraordinary how unfocused a medical student can be on

matters of biological interest to himself. On the one hand, during my second and third years—like most of my classmates—I imagined that I was suffering from a richly varied succession of illnesses, ranging from Brown-Sequard's Paralysis to the Granville Wilt. A particularly severe headache augured a tragic end from a brain tumor, though it was quickly abolished with two aspirins. But when Ruth missed her period in February of 1948, we quite simply ignored it. When she missed her second period and complained in classical pattern of nausea, breast swelling, and urinary frequency, I was fully prepared to launch a comprehensive endocrine work-up to uncover the source of this mystery. Only after she missed her third period and her abdomen appeared unusually distended did the profoundly disturbing reality seize center stage.

We told no one of this turn of events save for my father, who was not only my confidant but by this time one of New York City's busiest and most competent obstetricians. I phoned him and he was soothing but pragmatic, instructing me to send her urine specimen to him for testing without delay. When the test came out positive he wrote me a long letter telling me somehow to make contact with an abortionist—*any* abortionist—but he knew no names. He enclosed \$500 in Canadian bills. Before the incident, my father had continually cautioned me against marrying during my schooling. He felt (correctly) that a wife would be a serious financial burden during the many years of postgraduate training ahead. In the '40s, income for interns and residents was about on a par with that of southern sharecroppers. (My net pay as an intern began at \$12.50 a month.) In this interchange, the first I ever had with my father about abortion, he expressed no opinions against it, though he later told me that he had never performed one except for medical reasons. I am certain that this is true, for he has always been obsessed with legality.

Two babes in the woods. With what I imagined was great tact we asked friends about contacting an abortionist. As I look back on it I realize that we were so elliptical in our quest that no one took us seriously. ("Hey, um, Art, um, who do you think is doing all these cases that we see as 'incompletes' on the ward service?") After a week of such precious investigation I phoned my father to report, in a devious manner that would have done credit to a C.I.A. operative, that we had struck out. He advised me in crisp

though sorrowful terms to proceed across the border to Plattsburgh and marry Ruth. Since he opposed marriage, why this advice? Surely he must have known of abortionists in New York or one of his physician friends could have arranged a trumped-up "therapeutic" abortion. Why did he not invent such indications and do it himself? And why did I not ask him these questions at the time? There was—and is—something awesome about abortion.

I didn't tell Ruth about his advice, but resolved to launch a more serious search and this time to hell with discretion. When I cornered a close friend and classmate who had been raised in Montreal, he smiled, wrote down the name and address of a Dr. M——, and slapped me on the back. Ruth made the appointment with M—— but would not permit me to accompany her for fear that if the police burst in, my career would be ruined. I put the \$500 in her pocketbook, arranged to meet her three hours later on the steps of Redpath Library on campus, and kissed her good-bye.

When seven o'clock struck on the library bell and she was four hours late, I was convinced that a catastrophe had occurred. Death from hemorrhage, irreversible damage to the female organs with permanent sterility, massive infection, a terrible demise. I didn't know where she was, how to get in touch with her, anything. *Did the money have my fingerprints on it?*

She drove up in a cab about eight o'clock, and I drew her tenderly out onto the sidewalk. There was a pool of clotting blood on the floor of the cab. She was ashen and trembling violently. I thrust some bills into the driver's hand and led her to the library steps. We sat for a moment on that orange May evening, and I held her while she wept, softly and piteously. She said that there had been more bleeding than M—— had expected, that he seemed to become somewhat panicky in the course of the operation, that it took ninety minutes, and at the end, while she was still bleeding heavily, he had insisted that she leave. But, she said proudly, she had haggled down his price to \$350 before the procedure. She handed me the remaining \$150. "I did all right, didn't I, doll?" I hadn't told her that the money had come from my father; I had led her to believe that I had borrowed it from a friend.

I took Ruth home and remained with her that weekend, bringing her meals in bed (we told her parents that she was having a

particularly difficult period), taking her temperature every four hours, and remaining alert for the smallest sign of some catastrophic complication of the apparently bungled operation. Miraculously, inexplicably, she remained without fever, the bleeding stopped, and against my strenuous objections she returned to her Monday classes looking wan and a little saintly.

For a brief period that devastating experience brought us closer together, like soldiers who huddle under cover during a bombardment and, when it is over, separate, promising to get together sometime. We spent an inordinate amount of time in the next month clinging wordlessly to each other, avoiding the usual double dates and family dinners. But there was an uneasiness in the air. If I had not married her under those most compelling circumstances, then when would I? Why had I resorted to such a dreadful remedy to our "problem" if I loved her as much as I claimed to? Would she ever be able to bear children, and if not, what empyreal judgment would be visited upon us—upon me? The questions hung between us, unarticulated, unanswered, and unanswerable. The long silences, which at earlier times were comfortable lacunae into which a squeezing of the hand or a loving look had fitted perfectly, were now arid stretches to be negotiated with caution.

Her menstrual periods returned. We decided to double, triple, the birth control, and approached the bed, two parties about to arbitrate a disarmament agreement. Looking into her eyes I would see fear and—even now I recoil a little as I recall it—mistrust. If only she hadn't saved me that \$150. I keep returning to that, saving me the money. How many women, with their life on the line, will put their lover's financial obligations first in the order of things? What an unpayable mortgage this laid on me. At first I was in thrall to her demonstrated love, but insidiously the dacoits of pragmatism began to infiltrate my consciousness. Marriage seemed ludicrous now, untimely (from *my* standpoint). I returned to New York that summer with a great sense of reprieve. The conviction was growing that it was time, as a friend put it when I confided to him my dilemma, to "taper off with Ruth."

We met one more time, in the old McAlpin Hotel on Broadway, not far from where I now live. I had taken a shabby single room for the night's rendezvous after she had written me a tepid

letter explaining that she would be in town only one night. It was a searing day. When I opened the door of the room in response to her knock, I immediately noticed that her usual warm, diffident smile had been replaced by something tighter. Between us we managed to generate enough ersatz passion to go to bed, but though we moved in the same well-remembered rhythms, it was forced, even mechanical. We dressed in respectful silence. She said good-bye to me brightly and disappeared from my life. To my relief.

I retained a residual, deep concern about her ability to bear children. In 1954 I passed through Montreal and phoned her parents from the airport on an irresistible impulse. I was informed rather coolly by Mrs. Potemkin that Ruth had married several years ago and that she had three children. I wondered whether she had told her husband of the abortion. When our relationship had begun to founder she had indicated that she intended to tell whomever she ultimately married, before they were married. I had disagreed, feeling then that the mistakes of the past were intensely private and would only muddy her image in his eyes. Unaccountably, I was not only relieved at the news of her children, but saddened at the awakened memories of our loss of innocence that spring.

3

EAST SIDE, WEST SIDE

After McGill I spent a happy year at Michael Reese Hospital in Chicago. The intern group was cheerful and close-knit, and the classical stories came to life: the intoxicating fatigue and madness of the Emergency Room on Saturday nights, the sneaking of nurses in and out of the interns' quarters, the parties and the skits lampooning members of the "attending" staff. ("Always knock loudly before entering the men's room. You might surprise two 'attendings' splitting fees.") In a South Side dive across from the hospital, we would order up fifteen-cent draft beers and join in the drinking song of the gynecologic intern, set to a martial ditty:

*There's a fortune . . . in abortion
Just a twist of the wrist and you're through.
The population . . . of the nation
Won't grow if it's left up to you.
In the daytime . . . in the nighttime
There is always some work to undo.
Oh, there's a fortune . . . in abortion
But you'll wind up in the pen before you're through.

Now there's a gold mine . . . in the sex line
And it's so easy to do.*

*Not only rabbits . . . have those habits
So why worry 'bout typhoid and flu?
You never bother . . . the future father
And there are so many of them, too.
Oh, there's a fortune . . . in abortion
But you'll wind up in the pen before you're through.*

My years of internship and residency back in New York City were interrupted in 1953, when I enlisted in the U. S. Air Force. It seemed an act of unexpected decency on the part of the military to ask where I would prefer to be stationed after basic training. I selected the "Northeast Air Command," the Northeast to me encompassing that area bounded on the north by Central Park and on the west by the Hudson River. I did not realize that in Air Force parlance it was an area that included Greenland, Iceland, Labrador, and Newfoundland, perhaps the most inhospitable tundra on this planet. *Mirabile dictu*, there was a general hospital in St. John's, Newfoundland, where I tended to the obstetrical and gynecological needs at the command's headquarters, Pepperrell Air Force Base. At the doctors' table in the hospital dining room, at least once a week someone dredged up the old line that if the world ever needed an enema, this was where they would put the nozzle.

In April 1955, I resumed my interrupted residency in obstetrics and gynecology at Woman's Hospital, where I have worked ever since, and where I have performed 1,500 or more abortions. This institution, the first in the United States devoted solely to the care of women's diseases, was organized in 1855 by James Marion Sims, who virtually single-handedly established gynecology as a recognized specialty in this country. Such was his international reputation that he was summoned into consultation by the Empress Eugenie in France in 1864. To mark the occasion, he fashioned a special gold-plated vaginal speculum with which he examined her. Whatever her condition, Sims brought the speculum home, and it was still on exhibit under glass in the library when I began my residency. Even to a gynecologist, there always seemed something a trifle strange about such an exhibition. What would the Empress (or the Emperor) have said?

The hospital outgrew its quarters and by 1900 had moved uptown to 110th Street at Amsterdam Avenue, on the West Side

next to Harlem. The new building was a baroque behemoth with a copper mansard roof, long since greened, and a complex of loggias, dark corridors, unexpected crypts and cubicles that might have baffled a mole. The main sixth-floor operating room, named for Sims, was a vast amphitheater accommodating no less than one hundred spectators, not one of whom could have the slightest idea of what was going on down at the operating table. My father, a staff surgeon there from 1926 on, assured me that until World War II a bed check was made nightly in the residents' quarters to make certain that each was in bed—alone—by eleven, on the theory that a tired or hung-over resident was a menace in the operating room. No resident in that era was permitted to be married, though a few were, secretly.

The new resident began his assignment with a six-month tour in the pathology laboratory. Here all tissues which were removed during operations were examined with the naked eye, described, cut into suitable bits for processing through various fixatives and stains, finally to be scrutinized under the microscope. It was pretty dull stuff, especially for an ambitious young physician chafing to get into the operating room, but it was enlivened by the presence of the lab's director, Leon Motyloff. Motyloff was a corpulent Russian, so perpetually rumped that he resembled an exploding laundry bag. He accepted a position at Woman's under a Faustian pact: He was allowed to use the lab to conduct a private practice in addition to doing the hospital's work. He had thus made—and kept—a fortune, but lived in a mean little room in the Hotel Harmony and ate his meals in the hospital dining room. His married life was something of a mystery in that he was reputed to have once had a wife back in Russia but had later married the nurses' supervisor some years before I arrived at Woman's, though they appeared to live apart. Russian to the marrow, Motyloff was given to extravagant fits of melancholy which were relieved by heavy-handed baiting of one or another of his worshipful secretaries and technicians. He had an inexhaustible eye for attractive women, the younger the better, and when conquest was in mind he could be formidably charming.

At 10:30 each morning this Nabokovian character would hove into view with a retinue of aides in his wake. Invariably, the first stop would be the banks of mouse cages used for pregnancy tests,

where he would pluck one of the animals from its abode to smooth its fur and croon Slavic endearments to it. He would then gas it, slit open its belly, read its ovaries, then flip it to the side and proceed to do the same with a dozen others. Next, Motyloff would proceed into his office, which was littered with disorderly heaps of unanswered correspondence, pathology reports, back copies of the *Wall Street Journal*, and microscopes looking like miniature hunched disciples at the Stations of the Cross. The high point of the day was 11:30 when the professor would break for tea. A sixteen-year-old secretary would bring a pot and summon the resident on her way out. I would join him as he sipped his cup, held with one hand while he licked a spoonful of jam held in the other. Motyloff would reminisce about life under the Tsar, the tyranny of his training in Berlin, his latest after-hours diversion or stock-market coup, and also offer his trenchant critique of various members of the attending staff. The tea finished, I would be abruptly dismissed as he turned back to his microscope.

What I most remember Leon Motyloff for, apart from his skill as perhaps the greatest gynecologic pathologist this country has ever known, was his pervasive cynicism and my medical defloration. More than most, he knew that there were numerous marginally indicated operations being done at Woman's, and this hospital was by no means unique in that regard. But when he examined the specimens he would manage to find something, anything, abnormal to justify the operation. He would rather have suffered death by lapidation than to report a tissue as "normal." When I first protested the practice, he looked at me scornfully and said, "Now look at dot, dolling, you're just a baby and you don't understand dese tings." In this manner he made himself indispensable to the surgical staff, and his reports always appeared exemplary when various accrediting agencies inspected them.

After pathology I began learning all the arts and crafts of this marvelous discipline and, following the Air Force interruption, to begin moving into the senior levels of residency. As I assumed larger responsibility for the care of clinic patients I was confronted for the first time with what seemed to me to be the tragic wastefulness, infuriating injustice, and medical hypocrisy surrounding the abortion problem.

During a typical thirty-six-hour "on call" shift I would be in-

formed at 2 A.M. or thereabouts that a clinic patient was bleeding in the Emergency Room. I would haul myself out of bed, struggle into my whites and trudge down to the E.R. There a petrified, shivering creature would be lying on the examining table, bleeding profusely from the vagina, and moaning softly to herself. Invariably, the patient would be black or Puerto Rican. A thermometer registering 103° or 104° would be taken from her mouth and with this, the moaning would give way to loud cries or praying in tongues. Skipping introductions or interrogations, I would proceed immediately to the ordeal of vaginal examination, often fishing out sizable chunks of pregnancy tissue lying free among the huge clots. Another victim of a hack abortionist or of self-abortion. I would sign the admission slip, ordering intravenous antibiotics, blood tests, and preparations for a dilation and curettage (D and C). I would pass an hour or two mindlessly watching the "Late Late Show" on the dilapidated TV set in the residents' quarters until it was time to carry out the D and C, removing the rest of the tissue. If she were lucky, she would be returned to her room, be discharged forty-eight hours later, and instructed to return to the gynecology clinic for a checkup one month hence.

If she were *not* lucky, she might:

—Vomit under anesthesia, aspirate her vomitus, and die of respiratory obstruction and cardiac arrest.

—Continue to bleed from a perforation of the uterus that had been inflicted by the abortionist. Hysterectomy (removal of the uterus, causing lifelong sterility) would be carried out without delay.

—Continue to spike high fevers for days or weeks. In that era we had only a few antibiotics available, and most had serious side effects. This might culminate in the formation of multiple pelvic abscesses, requiring periodic drainage of the pus which would collect. The pus was usually fulvous, wrenchingly foul-smelling, and so astonishing in quantity that even those hardened to it had to marvel at the body's ability to tolerate such pervasive corruption. In many cases the infection would be uncontrollable by means short of hysterectomy.

—Occasionally, even a hysterectomy would not slow the steady march of internal gangrene, and the woman would die painfully, her vital organs filthy with the satellite abscesses of her disease.

And what of those who survived with their organs still in place?

The gynecology clinic convened each afternoon at 1:30. Many of the same impassive faces would populate the merciless wooden benches, month after month, year after year. None of the residents ever remembered their names. Like well-drilled soldiers these women would hobble into the examining room, doff their underwear, climb onto the table, allow themselves to be racked into the stirrups by a bored nurse's aide, and then point mutely to the lower abdomen. Occasionally they would mutter "hurts here" or "*dolor aqui*." But they (and we) knew that there was nothing to be done short of removal of the female organs. There was a street fear that a hysterectomy would harm the woman's sex life, but eventually the patient's resolve would break down and the resident would have himself a good "case" to do the next week. (The number of major operations performed was and still is the yardstick of accomplishment among gynecologic residents.) Those patients who stood fast against the authority of the knife would be dispensed another course of antibiotics and another kind of douche. The variety of douches prescribed for "chronic PID's" (pelvic inflammatory disease) was staggering. It ranged from cold tea to warm vinegar, and I remember one ancient gynecologist, who faithfully continued his weekly clinic session though he was over eighty, insisting that wormwood oil douches would cure almost everything. I attempted to reason him away from this herbal medicine one slow afternoon, but I was stoking a liner that would never leave the dock.

A little different story with the private patients.

If you were the resident on the private service, the call would usually come at seven or eight in the evening, a short time after office hours. The private physician would be on the other end of the line advising you that he was sending in Mrs. Buggins with heavy vaginal bleeding, the diagnosis being incomplete abortion—that is, miscarriage. He wanted to do the D and C in a couple of hours, so would you please prepare her for the O.R. and inform the anesthesia people? Yes, sir.

After Mrs. Buggins had arrived and settled comfortably in her private room, you would knock discreetly at the door and ask if you could have an audience with her to take down her history and perhaps examine her heart and lungs. She would invariably appear

in an astonishingly blooming state of health and her sanitary pad would have a single dime-sized stain of blood on it. The annoying preliminaries over, she would be wheeled into the O.R. and coaxed gently to sleep by a solicitous anesthesiologist with all means short of a bedtime story. Then the private physician would arrive to be ceremonially gowned and gloved for the operation. The large amount of fresh tissue recovered from these procedures never failed to surprise me. When I attempted to discuss the matter with Leon Motyloff one morning over breakfast, he smirked broadly and said, "Now look at dot, my dear. Don't be a Communist." Cryptic.

A senior resident, who had overheard this conversation, explained to me later in the O.R. locker room that there were several schools of thought among private gynecologists on the best way to foster the false scenario of spontaneous miscarriage in progress before presentation at the hospital. Some rehearsed the patient in a short but convincing script with appropriate special effects: groaning, crying, even slight twisting. Others added a soupçon of color to the performance by supplying a sanitary pad stained with beef or chicken blood to be offered to the admitting nurse with a flourish. Still others, perhaps disciples of the Stanislavsky or Method school, would scratch the cervix with a speculum in one or two places to start a little bleeding. That way the patient would wear a sanitary pad with her *own* blood, and would even continue to bleed while in the hospital awaiting her D and C, a playlet almost thrilling in its meticulous attention to detail.

Au fond, the private patients had their pregnancies terminated in a clean and surgical manner, those who insisted that their private gynecologists terminate the pregnancy and had the wherewithal and the persuasiveness to subsidize their insistence. Besides those with money, there were the doctors' wives or girl friends and the nurses who were able to make arrangements. Some of the same gynecologists who railed against abortions on the West Side were known to do them at certain tiny, circumspect private hospitals on the East Side.

When I first became aware of the rather widespread dissembling, deception, and hypocrisy going on in the matter of abortion, I became disdainful, even contemptuous of those private gynecologists whom I knew to be participating in this loathsome

little charade. This in contradistinction to the carnage casually wrought upon the poor women who fell into the hands of incompetents in their search for an abortion. As a resident, though, I was not charged with the care of private patients and could not know the immense emotional and financial pressures which were brought to bear upon the physician caught in the cruel dilemma of an unwillingly pregnant woman. I became more charitable after several years in my own private practice, having been a participant in those tense consulting-room psychodramas which followed the confirmation of an unplanned pregnancy. The pregnant woman leaning forward (expectantly?) in her chair, beseeching eyes fastened on the physician, waiting. The physician recoiling, burrowing a bit deeper in his swivel chair, feeling the unbearable necessity to make an offering, wishing she would go away.

I suppose that in fury at my own impotence to aid my patients, and particularly in anger at the egregious inequity in the availability of abortions, the germination of an idea began: the need to change the laws. There seemed no time for the luxury of contemplating the theoretical morality of abortion or the soundness of freedom of choice. Something simply had to be done.

I began not with the laws but with my own patients. If I refused to become one of those gynecologists who participated in the Theater of Abortion (the coaching of patients and preparation of a script to fake the necessity of a D and C), I resolved to help the pregnant women who turned to me. I had to have some place to send them. I began by finding a physician in Puerto Rico, whom I'll call "Juan Rodriguez," to do the abortions in a humane manner and in a clean setting.

"Juan Rodriguez" had done a year of training in the United States, spoke excellent English, and was the proprietor of his own "hospital" in San Juan. I cannot now recall how I obtained his name; probably from a patient. I had a guarded phone conversation with him shortly after I began to refer women to him for abortions in 1963. He told me that he had his own anesthesiologist who administered sodium pentothal, that he had patients rest in a recovery room for a few hours following the procedure before discharging them to their hotels, and that he charged \$700. At the time this seemed a bargain (though well beyond the reach of the ward patients). With air fare and hotel room, the package

usually ran between \$1,200 and \$1,500. Abortion was not legal in Puerto Rico either, of course, and I suppose that the dispensing of baksheesh from his proceeds allowed the practice to prosper without police harassment. I later learned of several other San Juan physicians who did abortions, but patients who returned from "Rodriguez" told me of his unusual courtesy and attentiveness. (So attentive that he attempted to romance a few of the more attractive and monied women.) Since his medical results seemed eminently satisfactory, I had no reason to transfer my referrals. Once in a while I would send down a friend or the wife of a physician colleague and phone him with exquisitely encoded discretion to obtain "professional courtesy" for them. (In other words, no charge.)

In 1964, while changing planes in San Juan after a vacation, I decided on impulse to visit "Rodriguez" and called him from the airport, then took a taxi into the old section of town. The "hospital" was a rather modest wooden structure closely resembling, from the outside, a blockhouse at the Kennedy Space Center. "Rodriguez," a tall, rugged-looking man, showed me through his facility with a certain pride, while I manfully attempted to conceal my chagrin. His consulting room was expensively decorated, the walls thick with diplomas and certificates which on closer inspection turned out to come from obstetrical organizations so obscure that I had never heard of them. The more obscure, it seemed, the larger and more multicolored the diploma. One had a handsome scarlet sash running diagonally across it, which lent such an academic air that it should only have been viewed against a swelling chorus of the Recessional.

The so-called Operating Room was what raised a few thoughtful furrows in my brow. The "surgical suite" was rather cheerful, with cream-colored walls and two large windows open to the street. There was an indefinable air of the Latin marketplace there, flies buzzing around, two cleaning ladies conversing rather loudly in a corner, and an ancient, rickety examining table as the centerpiece. The whole ambience was so unsurgically informal that it was almost endearing. "Rodriguez" conceded that he had not quite told me the truth: He had no anesthesiologist. He himself would shoot the sodium pentothal into the vein, then scurry down to the end of the table to perform the abortion before the

patient woke up. I remained impassively polite and grateful to the man for the (not inexpensive) care he had given my patients. Inwardly, I was shaken. Still, I mused on the plane home, if it wasn't the only game in town, it was probably the best. I had reliable reports that the other two abortionists in San Juan were operating out of pigstys.

I continued to refer my patients there for the next four years though his fees steadily moved upward. He had, after all, not seriously injured anyone I had sent. The patients were required to phone ahead from the U.S. to confirm their "appointment" before taking off for San Juan. Every so often I would get a frantic call from a patient telling me that his phone did not answer, or that he would be gone for two weeks. From time to time the *gendarmierie* in San Juan would mount a surveillance operation—I suppose to increase the payoff—and he would retreat to Europe for a little vacation, throwing the doctors who used him into panic. In the mid-'60s, the state of "Rodriguez'" health, both legal and physical, was a continuing source of concern to the gynecologic community in the eastern United States. I would guess that a fourth of all abortion referrals from gynecologists in the northeast in those years went to him or to another doctor in the same city who filled in for him. The other doctor also acted as his own anesthesiologist and insisted on using the more hazardous spinal anesthesia, not pentothal. To me this was just too risky.

By 1967 other cracks in the wall began to appear. Isolated reports began to filter into western medical literature from Japan, where permissive abortion commenced in 1948. A few patients who went there told me that Japanese physicians were fearless in that they set virtually no time limit on the state of pregnancy at which they would attempt abortion (one woman reported having one at twenty-nine weeks) and that the fee was only \$25 to \$50. However, the plane fare was formidable, and the bedside manner of the Japanese physicians left something to be desired. But it was an option to Puerto Rico, though not ideal.

The Colorado legislature had just adopted the model statute proposed in 1962 by the American Law Institute (A.L.I.), which allowed abortion in cases of rape, incest, serious threat to the life or health of the mother, or of a fetus with grave physical or mental handicap. North Carolina soon followed, and California

passed a law listing all but the fetal indication. I phoned a friend in Boulder, Colorado, who had been a resident at Woman's Hospital and inquired whether he would accept abortion referrals. He told me that all abortions were being done in hospitals, that strict three-doctor committees judged each applicant, and that out-of-state residents were banned. (He was wrong on that. There was no residency requirement in the law, though all gynecologists in the state were led to believe there was one by hospital administrators.) I met with similar discouragement upon calls to other friends practicing in California and North Carolina.

That same year a new abortion act was passed in Great Britain, providing for A.L.I.-type cases and adding to the list the danger of a child whose birth would constitute a risk to the physical or mental health of already existing children. The latter "economic indication" was so inelegantly phrased that it seemed to consider the newborn as some malignant tumor infiltrating the family. In any case, the law became operative in 1968, making the English Connection a workable escape valve for us, though again, only for the affluent.

I began referring some patients to Dr. David Sopher, who was considered a conscientious physician by the Clergy Consultation Service (of which more later). I had a number of trans-Atlantic phone conversations with him about mutual patients, and eventually met him in person when he came to the U.S. in 1973 to speak at various abortion seminars. Sopher was an ethnic oddity, having been born into an Anglo-Jewish family in India. He was in London eking out a reasonable living in the frustrating bureaucratic maze of National Health when the abortion act passed. He began doing abortions in a small London infirmary and word got round that he was amazingly skillful, particularly with late abortions from 14 to 26 weeks, which he did by D and C, a technique virtually never used after the twelfth week because of the difficulties for the doctor and the risks to the patient. At the time of his U.S. tour he was doing perhaps six a day at a usual charge on the order of \$800, for a substantial annual income. He offered special rates for the Clergy Service, and did some of their "jobs" free.

At the Planned Parenthood meeting in Des Moines where I first met him, Sopher spoke at length on his late abortion technique. He would have a trained doctor administer general anesthe-

sia. The cervix would have been prepared the night before by inserting a laminaria, a seaweed-based substance that would absorb fluids and swell, dilating the cervix in a matter of hours. He would break the bag of waters and quickly dismember the fetus blindly with a polyp forceps. He became so incredibly expert that his total operating time averaged three minutes, compared with the typical thirty or so minutes. He illustrated his lecture with slides in color, showing the fetus reconstructed at the end of the abortion like a grisly jigsaw puzzle. One could see where the arms and legs had been ripped from the body and removed separately, how the spine had been snapped in two and removed with dispatch, how the skull had been crushed and the brain drained out before the bony parts were removed. Surgically, a bravura performance. Sopher, however, had a most disconcerting nervous habit of loosing a bolus of giggles at the end of a sentence, and the more outrageous the statement, the more explosive the giggles. Even that audience in Des Moines, prepared to be enthusiastic on the subject of abortion, was a little dismayed at what it saw—and heard.

Let me not be misunderstood. David Sopher was a gentle, decent man. There were masses of women who were unwillingly pregnant, he was a highly skilled technician, and it was legal. He was one of many people in the abortion movement who saw the issue in these artless and ingenuous terms. There was undeniably money to be made, but it was, in their terms, honorable and hard-earned money.

4

AN ENLISTEE IN THE REVOLUTION

There was also something of an Irish connection. Toward the Christmas season of 1960 my second wife, Rosemary, noticed that I was looking a bit etiolated and was staring into the middle distance more than usual. With a remarkable display of diagnostic acumen, she guessed that I was afflicted by terminal boredom. As it turned out, the source of the boredom was the marriage itself, which collapsed one year later, but to stimulate my energies she gave me as a Christmas present the biography *James Joyce* by Richard Ellmann. Her prescription worked. Joyce became for me a compelling intellectual interest, then something more, an obsession, even a mystical experience. I began to collect first editions, letters, Joyceana of all sizes and descriptions, made four pilgrimages to Dublin, wrote some articles on Joyce, taught a few adult evening classes on *Ulysses*, and became little less than a monomaniac on the subject.

By the mid-'60s I had concentrated the bulk of my practice at Woman's Hospital, and in 1967 a good friend there decided that I should meet Bill Ober. A pathologist at the Knickerbocker Hospital, Bill had written a series of articles on physicians who had left their mark on history in other areas, e.g. Thomas Browne, Berlioz,

Marat, and Oliver Wendell Holmes. Joyce had started medical college three times, so we had a considerable mutuality of interest. On Friday, June 2, 1967, my wife, Adelle, and I drove out to the Obers' place in New Jersey for what proved to be a fateful dinner engagement. On that warm evening as we sat having drinks, Ober quickly collared me to show me some of his source material on Oliver St. John Gogarty, a name that is almost anathema to any true Joyce buff. Gogarty, a prosperous ear, nose, and throat man and later member of the Irish Senate, was the model for Buck Mulligan in *Ulysses*, and Joyce treated him with less than overweening kindness in that work. So the talk went until it was time to sit down to dinner.

The dinner companion on my right was Lawrence Lader.

Lader was rather tall and lean, with a cavernous face and intelligent, deep-brown basset-hound eyes. He had the carefully enunciated, accentless drawl of one educated at prep school and quickly let me know that he was a Harvard graduate. He appeared so priggish in his button-down collar and tight three-button suit that I immediately dismissed him as another boring Ivy League retard and decided to switch my attention to the dinner companion on my left (whose name now escapes me completely). Lader then seized my attention; he mentioned that he had just published a book titled *Abortion*. It was the one subject that I wanted to talk about even more than Joyce.

Lawrence Lader was at that time forty-seven years old. He had been born into a New York City family of considerable means and had pursued a conventional upper-class education. But he early interested himself in radical politics and revolutionary thinking, though in a cautious way. In the early '40s he had worked for Vito Marcantonio, a New York Congressman of such leftist opinion that it was widely suspected that he was a Communist. Following a World War II Navy hitch, Lader returned to New York, divorced his wife, and became a magazine writer with a special interest in matters in which he discerned a social injustice.

Well-provided-for by his father, who had died when young Lawrence was in his early teens, he was a man of spartan habits. At the time I met him he was living with his second wife, Joan, an operatic singer of modest success, and four-year-old daughter in a prestigious old building on lower Fifth Avenue. The apartment

was well turned out, but without fat. There was a grand piano for Joan and the remainder of the furniture was characterless and non-sense New England: functional coffee table, a few reasonably comfortable armchairs, a sofa that seated three strangers or four friends. The bedroom was Hilton Modern—two single beds and the jewel of the entire place: an air conditioner. When we would hold abortion strategy meetings in spring or summer we would all drag our chairs into the bedroom to confer. The dining room was small and spare, which meant that it always matched the dinner fare.

Intellectually, Lader was an interesting chiaroscuro. He was erudite, widely read in history and philosophy, but infuriatingly precocious and pedantic. Impeccably reasonable on most matters, in pursuit of a cause he had an armor of righteous perseverance that would have defied a regiment of tanks. Though a champion of women's rights, he could only be described as a male chauvinist feminist. Lader ran a patriarchal household. When in his estimation Joan's agent was not pushing her career along aggressively enough, he persuaded her to fire the man and appointed himself as her agent, though he had no experience in the field. When he would weekend with Adelle and me at our country place, he proved to be an early riser accustomed to a formal breakfast and would whine piteously until one of the women would come down to the kitchen to dole him out his bowl of cornflakes and slice the bananas into it herself. Later, Lader and I vacationed together on several occasions on the island of St. Croix, leaving "the women" behind; I doubt that Joan would ever have dreamed of asking him to allow her to vacation herself.

For the remainder of the June dinner party, Lader told me that he, Ober, and several others were moving toward some sort of challenge to the New York State abortion law, but they had no formal organization as yet. The only group that even concerned itself with the issue at that time was the immaculately respectable and strictly academic Association for the Study of Abortion, a group of doctors, lawyers, and civil libertarians. It met from time to time to deplore the appalling injustice of the laws prevailing throughout the U.S., issued a fastidious little newsletter about as inflammatory as the Department of Agriculture budget, and kept itself virginally apolitical, since it cherished above all its tax-ex-

empt status. In all, a fairly ineffectual bunch. Lader felt that a more dedicated and militant group was needed.

Lader and his crusade came to me at the right moment. I was upset over the health hazard from illegal abortion, and had moved from disillusionment to cynicism to anger at the inequity and hypocrisy in the abortion business. And I came to Lader at the right moment. I was a doctor who was willing to break ranks with my colleagues, and yet I was a member of the gynecological Establishment. By that time I was the senior member of a thriving East Side private practice, an Associate Attending Gynecologist at Woman's and at New York Hospital, and an Assistant Clinical Professor at Cornell Medical College. I was about to undertake a fifth responsibility as Director of Gynecology at the non-profit Hospital for Joint Diseases in Harlem. (Despite the name, this is a general hospital.) The Harlem post was unsalaried; I had put in a decade of unsalaried clinic work at Woman's and would put in a decade more. Perhaps some idealism was involved in this, but I considered it a necessary means of polishing skills, and I enjoyed teaching the residents at Woman's, which is affiliated with the Columbia medical school. Still, I had seen poor patients in every imaginable situation of pregnancy and had handled as many cases of poverty childbirth as any obstetrician in the city.

I was a willing recruit. I was not mesmerized, brainwashed, or deceived, and Lader never misrepresented his radical purpose: total abolition of abortion restrictions. I was as enthusiastic and as cooperative a confederate as one could wish for in a revolutionary movement as profound as this one. Larry and I and others were to devote hundreds of hours of our free time to the cause in the coming years. I was almost yearning to be radicalized in a cause. This was 1967. The country was being racked by the Viet Nam convulsion, and challenge to authority seemed the order of the day, particularly in the intellectual breeding-grounds of the northeast. Though I was forty, I believe that I secretly longed to be part of the youth movement that was sweeping the country, demanding justice, pledging change, exalting "love." So my indignation, my rebellious nature, and an undeniable urge to "join the kids" combined to move me into the public arena. It did not seem a time for careful analysis of the issues.

The social calendar that Adelle and I kept for the remainder of

1967 and through 1968 shows frequent meetings for cocktails or dinner with the Laders. They then lived several blocks from our own apartment, and each couple had one preschool child. We took many short dinner trips out of the city. I would always drive; the Laders had no automobile because Larry maintained that it was too expensive for city use. On a typical outing, October 7, 1967, a lovely autumn day with a hard sun burning in an azure sky, we drove down to Bucks County, Pennsylvania, for a day with the children. I was at the wheel and Larry leaned ahead from the back seat and droned into my right ear. He was expansive, talking of his next book—on death, another area emphatically in need of a public airing in our society. We even drew up between us a chapter outline for such a book, but inevitably, as it always did, the conversation veered to abortion.

“Well, Bernie, you know what Margaret always said. ‘No woman can call herself free who does not own and control her body.’” I knew of his 1955 biography of Margaret Sanger and that he still worshipped the birth-control crusader, but his use of her first name in so familiar a manner jarred me a little. Remarkably, Margaret Sanger had always *opposed* abortion.

“Larry, that’s the feminist line, and I’m not especially keen on it. Seems to me there have to be some restraints. I mean, prostitution is a long way from being legalized, and what about suicide?”

As he was to do so many times over the next few years, Larry ignored my question. Single-minded. Telescopic. Determined.

“If we’re going to move abortion out of the books and into the streets, we’re going to have to recruit the feminists. Friedan has got to put her troops into this thing—while she still has control of them.”

Betty Friedan had organized the National Organization for Women the year before and was at that time already contending with dissension in its ranks from the Trotskyite left, the Lesbian libbers, and the more rabid pro-abortionists. For my part, I had inherited some of the outlook of my patriarchal upbringing, I suppose, and rejected the dogmatism and militance of the hard-line feminists. Even then, I considered abortion to be a broad social issue that feminists should not arrogate to themselves. Most important, I figured that if the feminists appeared to take over, the

necessary abortion reform would be dismissed by moderates without a fair hearing. I was dead wrong, of course. Lader's marriage with the feminists was a brilliant tactic.

Then Larry brought out his favorite whipping-boy.

". . . and the other thing we've got to do is bring the Catholic hierarchy out where we can fight them. That's the *real* enemy. The biggest single obstacle to peace and decency throughout all of history."

He held forth on that theme through most of the drive home. It was a comprehensive and chilling indictment of the poisonous influence of Catholicism in secular affairs from its inception until the day before yesterday. I was far from an admirer of the church's role in the world chronicle, but his insistent, uncompromising recitation brought to mind the Protocols of the Elders of Zion. It passed through my mind that if one had substituted "Jewish" for "Catholic," it would have been the most vicious anti-Semitic tirade imaginable. I attempted a mild remonstrance.

"But, Larry, the Catholic Church isn't *all* bad. Don't forget that among other things they did more or less keep the intellectual world together in the Dark Ages."

Even his wife, Joan, a diminutive Scotswoman with a sense of humor and booming laugh, joined me in temperate dissent, and this distaff resistance seemed to annoy him unreasonably:

"Now honey, *please*. Let's not regress. I think you and I have covered *that* subject pretty thoroughly before, so no backsliding if you don't mind." She subsided, but I was still alive.

"Well, Larry, what do you think? Is the Catholic hierarchy identical with the anti-abortion forces? Aren't there *any* others opposed to abortion?" As I nosed the car into the Lincoln Tunnel traffic, he set the intellectual tone for the next eight years with a single word.

"No."

Larry and I grew closer through 1968. Our many long phone calls and home-and-away dinners concerned themselves with activating a push for total repeal across the country. At the time, Larry was working on his piece for *Look* concerning the results of his survey of the post-abortion attitudes of 282 women he himself had referred to abortionists. It appeared in the January 21, 1969, issue, and stands even today as a remarkably prescient piece of

work. There were the inevitable lapses into sloganeering and a cheap quasi-populist fillip or two, but on the whole it was a careful and honest *arbeit*. He debunked the prevailing certainty that abortion produced a crippling backwash of guilt. Although its scientific method left much to be desired, the conclusions of his project in this one important area stand today as quite valid in the light of numerous psychiatric studies on aborted women in the '70s.

On Christmas Day 1968, Adelle and I took our two-year-old son, Joey, over to Larry and Joan's for drinks. His dowager mother was there along with other relatives, holding court near the piano. Larry brought me my Bourbon and soda (one ice cube, filled only halfway to the top) and pulled me into the bedroom to give me the news. (Adelle had been relegated to Joan for *her* drink.)

"Well, Bernie, the Chicago thing is definitely on. We're moving ahead, and I know it's going to work. You'll be there, won't you? We need every vote we can get because we can't settle for anything less than total repeal."

I assured him that I would be in Chicago for the abortion conference.

"We can't take a chance on Ruth Smith and the other right-wingers seizing the convention. Everything would be lost. They'd push through some A.L.I.-type thing, and we might as well never have had the conference." (The A.L.I., you will recall, had proposed health, deformity, and other justifications for abortion, rather than outright repeal of all restrictions.)

"I understand, Larry," I reassured him. "Don't worry. I'll be there." I was beginning to feel like a talisman.

"The money's beginning to come in. We're really getting off the ground." He peered at me; a little exophthalmos goes a long way in underlining one's sincerity. "If only we can keep —— sober." He referred to one of the Midwest liberal clergymen who were helping out on the Chicago meeting. It was a well-founded worry.

"We'd better get back to our women. You've met my mother, haven't you?"

I said I had, but I hadn't. Another time, maybe. Despite my congenital skepticism and my well-founded doubts about Larry Lader's ability to organize anything larger than a small dinner

party, I was beginning to feel that this curious man might just be brewing up a revolution. I felt a growing sense of excitement.

Larry and I had numerous meetings and innumerable phone calls between then and the actual opening of the long-awaited meeting on Friday, February 14. I had told Larry that I would not be able to join him in Chicago till Saturday, since Adelle and Joey were returning from Barbados. He was terribly concerned that I might not get there at all, and tried to persuade me to fly to Chicago with him and let Adelle come separately the next day. I declined.

We caught a Saturday morning flight to Chicago and checked into the Drake Hotel by early afternoon. I was not in the room five minutes before Larry had located me and was on the phone assuring me, a little more lugubriously than usual, that the conference was marvelously well-attended but was coming apart politically. He couldn't hold it together on a platform of total repeal of all abortion laws, and begged me to come downstairs immediately to help him put the coalition together. Many participants, including some influential types from the Midwest and Far West, were backing only a moderate A.L.I.-type law.

I went down to the convention area of the Drake. It was a surging madhouse. Violent streams of bodies rushing up and down the halls, shouting slogans, and waving papers. Wild-eyed feminists bounding in and out of workshop rooms, brandishing placards, and shaking pale smooth fists. I recall one rather bulky young woman working feverishly under her filthy plaid work shirt at what appeared to be the pulling off of her bra, all the while screaming a litany of obscenities. I took her for one of your militant feminist types and edged past her carefully. The last I saw of her, she was imploring an ally to help her. Was the catch of the bra stuck? Was the bra making a political statement?

The remainder of the weekend was chaos. People were grabbing at the microphones and screaming unintelligible shibboleths or long droning perorations, submerged in a ferocious surf of screeching, squealing, wailing, and chanting voices. In the hallways outside the main meeting room were milling hordes and little agitated colonies, pecking and crowing at each other.

I recall a wedding party from another part of the hotel, caught in our churning wake, being screamed at by outraged feminists

and marauding Lesbian bands. The bride was dumb-struck. The groom grabbed her and with (presumably) the best man and maid of honor forming a rear guard, pulled and tugged her out of there. I shudder to think what that wedding night must have been like.

By the time we had packed our bags and headed for the 5 P.M. plane that Sunday, we had coaxed a compromise out of the mobocracy: a twelve-member Planning Committee, including Larry and myself, would work out the organization of a National Association for Repeal of Abortion Laws (N.A.R.A.L.) to be based in New York. The conference made the "split" page of the Monday *New York Times*, but we felt that the press had covered our enterprise only barely adequately. Still, I was satisfied, even a little elated. We had an embryonic organization which, with energetic instruction and enlightened guidance, could be brought around to the correct militant posture: Total Repeal. No more laws regulating abortion.

5

A MEDICAL END RUN

Meanwhile abortion was a continuing problem in my private practice. Five months before the Chicago conference, Alice came into my office clutching a lab report showing pregnancy, which I quickly estimated at seven weeks. No particular medical problems. We discussed the options, and she was adamant that she wanted an abortion. Her parents were rather well-to-do and her boyfriend was a banker, so money was no problem. I handed her a pen and a blank piece of paper (not a prescription blank with my name on it, mind you, nor would I ever write in my own hand). As she wrote, I dictated "Rodriguez'" name, address, and phone number as I had done so many times in the past, told her to call and arrange an appointment, shook her hand, and instructed her to see me two weeks after the abortion for a checkup.

At 9:30 at night eight days later my answering service reported that there was a young woman who claimed to be a patient of mine who thought she was dying. I called the number back immediately and it was Alice. She told me that the abortion had been done the day before and that she had flown back feeling fine, but this morning her temperature had risen to 104°, she was vomiting

uncontrollably, and her abdomen was markedly distended. Off to the hospital and let's see what is happening, I said.

Physicians are steeled to a certain amount of exaggeration from patients and discount it in advance. If someone tells me they are hemorrhaging at home, I envision one bloodied pad and a few spots on another during a twelve-hour span. But Alice was undeniably sick. (The word "sick," by the way, is an accolade in medical practice, bestowing upon the poor patient a grudging recognition that she really *is* seriously ill. The doctor using the word thereby apologizes for having doubted her from the first phone call.)

After several hours of lab tests, X rays, intravenous hydration, massive antibiotics, naso-gastric tubes for intestinal decompression, and blood transfusions, we moved her to the Operating Room for exploration. The uterus had been perforated and a section of the lower small intestine had been lacerated in several places. There were already about two quarts of bloody pus in the abdominal cavity. We repaired the uterus as best we could, resected the mangled intestine and closed her up with several drains. She had an unusually stormy post-operative course involving the need for several more pus drainage procedures, a pulmonary embolism (lung clot), and a severe infection of the abdominal incision with ultimate evisceration of the abdominal contents. That is, the whole incision came apart and her intestines spilled out of her abdomen onto the bed on the sixth day after the operation. She made another trip to the O.R., and this time we put the wound back together with large strands of braided silk which remained in place for two weeks. In all, she spent thirty-five days in the hospital, sustained five different operations, and emerged shaken to the marrow, physically and psychologically. In the next six years I was to operate on her four more times for the results of this dreadful experience. She later married but has been unable to conceive—nor, in all probability, will she ever.

My usual contact had not been responsible for this carnage. He was on one of his periodic sabbaticals, and another physician covering his practice had mutilated her. Nevertheless, a congeries of doubts, resentments, and indignations were crystallized by the tragedy of Alice into a resolve to find another way. I knew that things simply could not be allowed to go on like this, the whis-

pered conferences, the sending of women out of their own country to obtain what ought to be easily available to them here. Not to mention the unavailability of abortions for the poorer women.

The answer seemed to be a quiet but concentrated assault upon the Therapeutic Abortion Committee. The concept of consultation with other physicians to validate the necessity of an abortion dated back to the first statutes in the nineteenth century, but the formal committee appeared circa 1950. It came in several sizes and shapes, ranging from a group of two or three obstetricians to a mixed bag (one internist, one obstetrician, and one psychiatrist, perhaps). Its purpose ostensibly was to re-evaluate the indications for therapeutic abortion in the light of post-war medical advances such as antibiotics, the emergence of anesthesia as a specialty, blood-bank technology, radioisotope research, and the like. In addition, the theory ran, a psychiatrist on the committee could explain to the obstetrician how to deal with a patient's emotions and life situation to cope with the pregnancy. In bald fact, the hospital accreditation commission and other regulatory bodies had put pressure on the hospitals to lower the already excessive rates of therapeutic abortions performed for "psychiatric" reasons. Assigned that function, the committees had succeeded in tightening things in the '50s.

The typical hospital abortion committee required that all appeals be submitted in duplicate, accompanied by two letters from consultants who agreed with the obstetrician-advocate. Thus, in the case of psychiatric indication, two psychiatrists on the staff of that hospital must write letters on behalf of the patient. In a typical instance, the committee would meet one morning each week in the office of the director of obstetrics and gynecology. The obstetrician would have to appear in person, armed with the documents and prepared to defend his application. Fair and workable, in theory, though the "old boy" network among doctors sometimes produced a special advantage.

The attack had to be made in the weakest area, the psychiatric indication, which was inexact, unmeasurable, yet sufficiently threatening. Once a breach was made in that area, once a few precedent-setting cases got by, then we could pour them through in unlimited number. The supposed threat of suicide was the logical battering ram. It was just a question of finding a squad of

complaisant psychiatrists. I knew a number of staff psychiatrists, had socialized with them and delivered their wives, and knew that they were in general a liberally oriented breed. I had drawn a few of them out and found them sympathetic to expanded psychiatric indications for therapeutic abortion. The pieces fell nicely into place. The Psychiatric Harlequinade of 1969 began, and the script—unvarying and, after a few months, boring—went something like this:

“Doctor, are you sure I’m pregnant?”

“No question about it.”

“I simply can’t have this baby. I (a) am not married, (b) don’t have the money, (c) can’t disgrace my parents, (d) can’t have my husband find out, (e) am not ready to be a mother.”

“Well, if you’re really desperate about this, I mean to the point of *suicide* or something, then if you were to see a couple of psychiatrists who would attest to that, we could terminate the pregnancy for you.”

“Oh, yes—anything. Whom shall I see and how soon can I see them?”

Out would come the little notebook from my back pocket for a quick consultation to see which two I had sent the last woman to (I didn’t want to impose excessively on my psychiatrists), and I would pick a pair I hadn’t used in a while. Their letters in hand, I would make my appearance at the weekly Grand Guignol.

A word about those letters. At first, early in 1969, they were detailed and patently serious in their attempt to limn the psychopathology involved (as in Motyloff’s laboratory, something *always* was found), and a psychiatric diagnosis was rendered. Often an attempt was made to quantify the suicide threat. The letters were clearly the product of a fairly searching psychiatric interview. As the year wore on, and especially the following year when abortion came to debate in the New York State legislature, the letters became shorter and shorter. Every patient suffered from a “reactive depression” (and who wouldn’t given the circumstances of the pregnancy) and all were imminently “suicidal.” One particular psychiatrist was reputed to conduct his interview in five minutes and to charge \$100 a letter. To be fair, not all members of the psychiatric staffs cooperated. A few held their ground, resisted the easy money, and even spoke out against their colleagues in the

game. We quickly learned who these "reactionaries" were and struck their names from our lists.

As for the committee, in early and mid-1969, its hearing would be formal and serious. But the rule that the consulting psychiatrists be from the staff of the same hospital was the exploitable flaw built into the system. If the psychiatry official on the committee evidenced any skepticism about the mental state of the patient and the probability of suicide if she continued her pregnancy, one would modestly point out that he was a simple obstetrician and defer to the judgment of experts on the psychiatrist's own staff. Surely he had personally screened and appointed these men with great care for their integrity and their qualifications. Checkmate.

Like the letters, the meetings subtly deteriorated in 1970. The obstetrician metamorphosed from humble appellant to truculent intercessor. The committees were approving virtually all applications, rejecting only those in which the paperwork was inadequate or incorrect, or in which the obstetrician failed to show up altogether. The committees were not only aware of the gathering political force of the abortion movement that year, but also that, having approved the first few abortions on psychiatric grounds, they could hardly reject the next hundred when the letters came from the same staff psychiatrists, couched in the same ominous though opaque psycho-jargon.

Latterly, the obstetricians appearing before the committees made it all too clear that their valuable time was being wasted, that the perfunctory appearance before the committee was a decided imposition upon them, and why bother? The committees, to their credit, did attempt to maintain a formal and dignified tone to the meetings, but the voices of physicians, waiting their turn in the anterooms and making coarse jokes about the whole charade amid loud laughter, defeated the committees. The members struggled bravely until the liberal abortion law passed the legislature and then quietly yielded up the ghost.

With the wall breached by the private physicians, the social workers took up the cudgels for their constituency. They brought pressure on residents in obstetrics to steer the clinic patients, too, through the psychiatric shoals. By the time the liberal law went through, the number of "psychiatric" abortions for clinic patients

was running roughly equal to the number of private abortions. We may have been devious, but we were democratic.

It was in the midst of the psychiatric game that I first made the acquaintance of by far the most impressive figure of my years in the abortion movement. The Reverend Howard Moody—along with his colleague Al Carmines, a writer of Off-Off-Broadway musicals—was the spiritual leader of Judson Memorial Church in Greenwich Village. He had once struggled against the De Sapio political machine, and by 1967 turned to what he conceived to be a great injustice in our society, the abortion laws. He organized the Clergy Consultation Service on Abortion, a group of Protestant ministers and Jewish rabbis who counseled women with unwanted pregnancies and, in effect, functioned as an abortion referral system.

Moody developed the idea over lunch along with two Episcopal priests, John Krumm, now a bishop in Cincinnati, and Lester Kinsolving. Kinsolving, who became a journalist, years later was temporarily thrown out of the State Department Correspondents' Association because he had received stocks from South African government agents at a time when he was attacking the apartheid regime's ecclesiastical opponents at annual meetings of various corporations. Kinsolving contended that this was only a speaker's "honorarium" and that other journalists had done similar things. Howard Moody, too, has evolved. At this writing his current crusade is Prostitute Lib. The Judson Church is putting out *The Hooker's Hookup: A Professional Journal*, in which Moody not only refuses to throw the first stone at the adulteress but neglects to speak Jesus' advice to her, "Go and sin no more." Moody sees this free-form ministry of moral support to these "working women" as a continuation of his parish's work to decriminalize abortion and to help the oppressed. As he puts it, "The street prostitute is fast becoming the 'nigger' and 'pinko-faggot' of the '70s, and the only crime they are being jailed for is bartering their sexual services to satisfy the unfulfilled sexual desires and fantasies of our husbands, brothers, and sons in this society."

Howard Moody was a ruddy-faced, bluff Texan with a crew cut and a self-effacing country-boy style. He wore an ill-fitting black suit as if borrowed from the wardrobe trunk on the set of *Elmer Gantry*, and had a good-old-boy's appreciation of all manner of

sour-mash Bourbon. He was undoubtedly the most deft and elusive puppet-master on the New York social-reform scene. Here was an ex-Marine with the sociology of Engels, a country bumpkin with the finely honed tactical sense of an Alekhine or a Morphy at the chessboard. In short, an immensely capable ally, and a thoroughly dangerous foe.

Moody's *soi-disant* secretary and assistant (actually his agent provocateur, interpreter, advance man) was a columnar woman with a beehive hairdo named Arlene Carmen, who in 1978 achieved fame through her work in the prostitute ministry. She was an archetypal New Yorker, street-wise, a little adenoidal, but not unattractive in a dark, secret way. The two were inseparable and had perfected the cops' good-guy/bad-guy routine with a coed coloration. If an underling in one of Moody's pet projects failed to carry out his duties satisfactorily or—heaven forbid—evidenced an unseemly interest in good business sense or profit making, Carmen would be designated to call him and explain with folksy menace, "Howard is, ah, I think, ah, a little worried that you might be over-extending yourself. Why don't you come down to the church and talk to Howard about it? I'm sure everything will get straightened out." The recipient of this summons of such Italianate finesse would audibly pale, stammer out a string of wretched echolalia, and scurry down to Judson to do secular penance in Moody's study over Bourbon, with Howard chuckling and stroking him by turns.

The final member of the Judson troika was a reticent, splendidly sideburned little man named Arthur Levin. He, too, was a mysterious figure who seemed always to be scuttling from shadow to shadow whenever an inquiring eye caught him in the beam. He was said to have made large sums in "business" and then to have retired to open a Village art emporium called the Flatsfixed Gallery. Whatever the source of his income, or his age, equally indeterminable, Levin was unswerving in his loyalty to Moody, and could instantly pick up the scent of any profit-making operation, which he would chase down with single-minded dedication. Later I was to have considerable dealings of my own with Arthur Levin.

Howard Moody was a cagey crusader, for he sought the advice of veteran civil-liberties lawyers such as Ephraim London, before activating the Clergy Service so as to function marginally within

the law. The service expanded, and at its zenith encompassed some 1,200 clergyman-counselors. It was a courageous, even defiant project, but it still did not confront the issue. Moody's battalions were forced to refer women to Puerto Rico (my San Juan connection was also nibbling on that pie), to England, and to abortionists in other states, including a gentleman named Hale Harvey down in New Orleans.

In January 1969 I also became part of the network. Carmen and Moody began calling me to handle some abortions for them—principally those past twelve weeks and too far along for simple D and C—and to run them through the psychiatric gauntlet at the hospitals. Invariably these were young, black, and impecunious women who had allowed the pregnancy to advance too far, either through ignorance or the fear-denial syndrome. I helped out by doing them at no charge.

Then, as now, there was no safe and consistently efficient method for abortion in the "gray zone" between the twelfth and sixteenth week of pregnancy. After twelve weeks the uterus and the products of conception are too large to "scrape out" by D and C. Incredibly, so great is the demand for a full spectrum of abortion availability that the abortion experts at the U.S. Public Health Service in 1978 began broaching the idea of breaking the twelve-week line. The late D and C has even been given a new (actually an old) label, "dilation and evacuation" or D and E. This strikes me as rash and irresponsible, except with a rare virtuoso like David Sopher. The surgeon is working blind, the womb is soft from pregnancy, and the relatively large chunks of jagged bone and cartilage wreak havoc if they are not removed with great skill.

For the "late abortions," that is those after sixteen weeks, we used the "saline method" almost exclusively until recent years. In it, a needle is inserted into the uterus and a measured quantity of amniotic fluid is withdrawn. Through the same needle an equal quantity of a 20 per cent ("hypertonic," or highly concentrated) salt solution is injected. If done correctly, the fetus invariably dies in a matter of minutes. Eventually contractions of the uterus ensue and a miscarriage occurs, with the woman expelling a dead fetus and the placenta.

The saline method was first tried in the U.S. in the early '60s,

and I picked up on it in 1965, quite early in the development of the technique. In my first case, I made the mistake of treating the woman as an ordinary laboring patient, examining her vaginally at the usual intervals and breaking her bag of waters at what seemed the appropriate time. She developed a massive infection after expelling the products of conception, but survived. I mulled over the procedure for another year before my second attempt. This time I kept my hands off the woman once the saline had been injected—no examinations or breaking of the bag of waters. There was no infection and the patient went home in good condition.

However, the procedure consumed what I considered an unacceptably long time, sixty-five hours from injection to expulsion. I mulled that problem over for half a year and decided to experiment with using intravenous oxytocin, a drug long used by obstetricians to enhance contractions of the muscles in the uterus and thus either induce or hasten labor. When my next late-abortion candidate came along in October 1966 (an *honest* psychiatric case, by the way), I injected the saline and also connected the patient to an intravenous dextrose solution with 10 units of oxytocin. To my satisfaction she expelled all the products in twenty-eight hours. We finally had a workable and safe abortion technique short of opening the womb surgically for hysterotomy—a mini-Caesarean section with a rather high incidence of medical problems. With one minor modification (50 units of oxytocin instead of 10), this hands-off method is precisely the one used everywhere for “salting out” abortions today.

6

INTRAUTERINE POLITICS

When I returned to my usual rounds that February Monday after the 1969 Chicago conference on abortion laws, I noticed that a certain respectful distance had developed between me and my colleagues. I was publicly identified with a cause which in the past had been associated with the stereotypes of failed defrocked doctors or of filthy old women in grimy kitchens or hotel rooms. Though in the radicalism of the late '60s abortion was crossing over into acceptability, I felt that I was being eyed with the same circumspection as one who had come down with active TB. (That affliction, too, had a certain glamour—Keats, Thomas Mann's *Magic Mountain*, etc.—but it was, after all, communicable and very likely deadly.) Even my partner, Stuart Oster, seemed a little more wary than usual. He persistently refused to broach the subject (he was and is an extraordinarily kind man who would rather suffer horribly than disturb a friend). I cornered him that week in the O.R. locker room and asked bluntly,

“Well, Stu, what do you think of our organization?”

“I don't know, Bernie. Maybe we ought to just stay where we are. You know, just getting the psychiatrists to help us out. Why rock the boat?”

"Because I'm tired of all the hypocrisy. Let's be honest. There are no goddamn psychiatric indications for abortion. This is stupid. Besides, it costs these women unnecessary money for the psychiatric 'consults.' No, we've just got to lay the issue out and damn the torpedoes."

Stu lapsed into a thoughtful silence. He was clearly uncomfortable with it all. He seemed to be wishing for a restoration of the status quo, sensing that some crucial bridge had been crossed and that I had established a dangerous little bridgehead in some unfathomable, hostile country.

The Planning Committee of the National Association for Repeal of Abortion Laws held its first meeting at 12:30 P.M., Tuesday, February 25, in the office of Stewart Mott at 515 Madison Avenue. Larry Lader chaired the session. Great Britain had had an Abortion Law Reform Association since 1936, but it was tiny until its membership swelled to 1,000 in 1966 in the wake of the thalidomide disaster. Despite this modest following, the organization was largely responsible for the sweeping British reform law the following year. Perhaps we could do as well.

Our host sat in a corner, away from the large rectangular desk around which the rest of us gathered. Mott was a beefy, pasty-faced man in his early thirties with an alarmingly receding hairline. It was not that he was uninterested; more that having allowed us to use his office he had made his contribution and decided to rest until someone else made an equally momentous move. He subsequently drifted away from the movement.

Mott was one of two heirs to a man reported to be the single largest stockholder in General Motors. He had committed himself at some time in the recent past to beating the halo of wealth into a golden shovel, funding a variety of liberal causes with which he felt a '60s *simpatico*. He wore the obligatory fitted jeans and rode a bicycle here and there, and his office was also emphatically self-effacing. Mott was later an ardent supporter of the ill-fated Presidential campaign of George McGovern. Still later he suffered considerable pain at the hands of the media when he threw a tantrum over resistance by neighbors in his co-operative building to his plan to surround his \$3.5 million triplex apartment with what amounted to a small truck farm (organic, of course). The neighbors feared that the untold tons of earth up there would cave in

the building. There was no mention of any livestock to roam the skytop estate.

Larry Lader's opponent at virtually every turn within N.A.R.A.L. would be a woman named Ruth Proskauer Smith (she always insisted upon the three names). Her distrust of Lader was regrettably to be proven correct in a monumental fight during 1973. Smith had been an early advocate of liberalization but only reluctantly embraced total repeal. Her father, to whom the daughter was fiercely devoted, had been a well-known judge and political figure on the New York scene for decades. A lean, soldierly woman in her late fifties, she had the no-nonsense bearing of a headmistress of a particularly severe turn-of-the-century school for English gentlewomen. Her flinty exterior concealed a heart of steel. But say this for her: Of all the people I met in the abortion movement, she was the most uncompromisingly honest.

To her pole of N.A.R.A.L. "reactionaries" she recruited Mrs. Beatrice McClintock, the wife of a stockbroker of no discernible distinction. Smith and McClintock had worn together the battle ribbons of various discreetly liberal causes, including the Association for the Study of Abortion and the Association for Voluntary Sterilization. She was useful to the movement principally for her money and the money it would in turn attract. She was, after all, one of the daughters of the Kellogg family, of cereal fame. Smith could also rely upon Mrs. Ruth Cusack, a woman given over to largely purposeless and endless waffling on everything from how to mount a demonstration to what color to paint the new office. Another of the conservatives was Mrs. Marc Fisher, a stout, pugnacious black woman who was obstructive and outspokenly disapproving of the methods and aims of our radical faction. She finally stormed out of the meeting before official adjournment, disappearing in a cloud of finely divided disesteem.

Larry and I, the radicals, could only be sure of one loyal ally in the fights to come: Conni Billé Finnerty. She was voluptuous and jolly, and even at twenty-two, a veteran of the anti-war movement, the women's movement, the campus rebellions, and the soft-drug scene. The gentleness of her cynicism in no way impaired her commitment to total repeal, but she retained a humorous perspective on the proceedings and a decent toleration for middle-aged types like myself just getting their feet wet in revolutionary poli-

tics. She would sigh, "Nathanson, where were you all when we were getting our heads bashed in in Chicago in sixty-eight?" My standard reply, "Finnerty, I never trust anybody under thirty."

Our axis also included Betty Friedan, who was dedicated to repeal of all abortion laws, too, but could not be depended upon to guide N.A.R.A.L. to a militant position because she was so involved in the internecine problems of her National Organization for Women. Percy Sutton, the black Borough President of Manhattan, was preoccupied with his perfectly obvious (and frustrated) aspirations to higher office. The rest of the fledgling committee was either of unknown persuasion or else "reactionary" (supporting the moderate A.L.I. policy).

Stewart Mott was assigned to write up the program objectives for N.A.R.A.L., and sleepily assented. The meeting achieved little else. The organizational plans were to be worked out by Larry and me. He had suggested that we leave the "girls" behind and take a vacation by ourselves at a beach house outside Frederiksted, St. Croix, which he would rent from friends. Adelle and Joan were agreeable, and we departed two days after the meeting in Mott's office.

The house was attractive, the weather unexceptionable, and life settled into a pleasant routine. Larry and I would meet in the kitchen around nine for breakfast, he would pack a small lunch for himself, and we would trudge past the library and the Seven Flags Bar to a club where we would pay an admission fee and spend the entire day on the sandy beach. The conversation was always light, and there was little talk at all once we got to the club, where reading, sunbathing, and mild ogling of good-looking women were the only allowable activities. I repaired to the bar early and often; it was hot, and the various flavors of frozen daquiris all had to be investigated in the most meticulous and scientific manner. I took my lunch at a small table in the bar; Larry would bring his lunch over and the conversation would remain tropically lightweight. We would proceed back home about five, have a drink or two in the garden, then get dinner in any of the half-dozen passable restaurants in town.

Only after dinner did we hold business conversations, usually back in the garden over yet another drink. To begin with, Larry said, we had to consolidate power for our side in N.A.R.A.L. by

packing the committee with those sympathetic to our cause. For president, we needed someone pledged to activism and politically astute. Of course it had to be a woman, though Larry figured to actually run N.A.R.A.L. as chairman of the Executive Committee. We determined that we should have two nominal vice-presidents as good ballast for our side. Betty Friedan seemed logical for the East Coast. The West Coast vice-president would be Lana Clarke Phelan, an early abortion activist and close associate of Pat Maginnis. (Maginnis was the abortion revolutionary whose idea of helping womenkind was going about the country lecturing and hawking material on how to self-abort.) We needed some gentleman of the cloth in with us. Howard Moody had let it be known through emissaries that he had no interest in an official position with N.A.R.A.L. That penchant for covertness. We settled on Jesse Lyons, one of the assistant ministers at the blue-blood Riverside Church and an early member of Moody's Clergy Service. He should be a reliable vote, too. Lyons proved to be a male activist counterpart of Ruth Smith: totally independent, a little abrasive, and in all a rigorously honest figure. Conni and I would be on the committee, and in addition I would be designated chairman of the Medical Committee, only a paper fiction at the time. With the votes of myself, Larry, Conni, Lyons, Friedan, Sutton, and Phelan, we were assured of an unbreakable radical grip on the committee.

Having settled housekeeping matters, we turned to the larger questions of N.A.R.A.L. strategy. Larry taught me the basics of revolutionary politics.

"To begin with, Bernie, we're not tax-deductible, being political, so we can't spend a lot of money on PR. We have to create our own publicity, which means demonstrations, disruption, lawsuits, and a ruthless courting of the press and the TV. Most of the young women reporters for the big papers and TV are committed to our cause, especially here in the East where the media are, and we really have to stroke them." True, but was there no way around the tax exemption, I wondered? "Well . . ." He cleared his throat three times, as he always did preliminary to some pronouncement. "We might be able to funnel some through a church, maybe Riverside, maybe Ethical Culture. We'll have to

work on that later." As far as I know, nothing was ever done about this.

We decided upon an early demonstration, both to seize the initiative in the committee and to build on the modest media interest we had stirred with the Chicago conference.

"We've got to keep the momentum going, Bernie. We can't let up for a minute. We must make those legislators in Albany aware that we're here, that we're watching them, that we're potent. And angry." So it became clear that our first political assault would be against the New York State law. That was logical. A reform bill had been in the legislative hopper for several years. The media, many openly sympathetic to some sort of change, were here in New York. And the nubile liberal establishment—willing to marry anyone smelling of what it conceived to be a humane and mildly shocking cause—was languishing in the boudoir, waiting. Even though N.A.R.A.L. was a national organization, a quick breakthrough in New York would provide incalculable impetus for the movement across the nation.

On our last evening on the island, we sat over a fish dinner and a bottle of cold white wine in a small harborside restaurant, and Larry read me my last basic lesson in the political primer.

"Historically," he said after the usual throat-clearing ceremony, "every revolution has to have its villain. It doesn't really matter whether it's a king, a dictator, or a tsar, but it has to be *someone*, a person, to rebel against. It's easier for the people we want to persuade to perceive it this way." I conceded that. It was good tactical strategy. "Now, in our case, it makes little sense to lead a campaign only against unjust laws, even though that's what we really are doing. We have to narrow the focus, identify those unjust laws with a person or a group of people. A single person isn't quite what we want, since that might excite sympathy for him. Rather, a small group of shadowy, powerful people. Too large a group would diffuse the focus, don't you see?"

I nodded. Where was he going?

"There's always been one group of people in this country associated with reactionary politics, behind-the-scenes manipulations, socially backward ideas. You know who I mean, Bernie."

Not the Catholics again?

"Well, yes and no." Throat-clearing again. A heavy thought coming. And I wasn't wrong. It was his devil theory.

"Not just all Catholics. First of all, that's too large a group, and for us to vilify them all would diffuse our focus. Secondly, we have to convince liberal Catholics to join us, a popular front as it were, and if we tar them all with the same brush, we'll just antagonize a few who might otherwise have joined us and be valuable show-pieces for us. No, it's got to be the Catholic *hierarchy*. That's a small enough group to cone down on, and anonymous enough so that no names ever have to be mentioned, but everybody will have a fairly good idea whom we are talking about."

His syntax was as careful and as surgical as his daily shave. It was irrefutable. The only thing that was a little jarring, even to my untutored mind, was that the original nineteenth-century laws in New York and elsewhere had been placed on the books mostly by doctors when there were few Catholics around. I raised that question, hesitantly.

"Bernie, we're talking politics now. Watch and see how respectful of facts the opposition will be once our campaign gets going. Just listen to the opposition."

The opposition. Now I remembered. That was how Trotsky and his followers habitually referred to the Stalinists. Was this a purposeful designation, or was it coincidental? Larry thought everything—everything within his control—out very carefully. The opposition, though he did not say so, was the right wing, the Falange, the Tories, not to mention the Catholic hierarchy. And especially the Ruth Proskauer Smith axis.

For their part, of course, the Catholic bishops were to play right into our hands, by their heavy-handed politicking, making abortion appear to be purely a "Catholic issue" rather than an interreligious one. They also weakened the credibility of the anti-abortion forces because of their unflinching opposition to the major alternatives to abortion: artificial birth control and voluntary sterilization.

Larry and I divided the dinner check exactly in half. Mercifully, it was an even total. There was always the problem of the tip with Larry. I never knew whether to divide that, too, or just say the hell with it and cover it myself. I forget what I did that night.

On the way home Larry was thoughtful, murmuring something

about "consensus politics." Then he said not another word until we walked into the garden and sat for a moment in the dying tropical light.

"We've got to keep the women out in front," he asserted. "You know what I mean." Yes, I did. And that made eminent political sense, too. "And some blacks. Black women especially. Why are they so damn slow to see the importance of this whole movement to themselves?" Interesting. I didn't know the answer to that one. But he was touching all the bases. "All we've got is Mrs. Fisher, who is somewhere to the right of Marie Antoinette," he gloomed.

Consensus politics came to the fore as we flew back to New York. We spread out our papers and organizational charts on the middle seat, ordered some drinks, and proceeded to consider what seemed to Larry to be the only major unfinished business of the trip, the picking of various officers. The honorary officers were, of course, only figurehead posts, yet figureheads undeniably have their uses. They had to be women, not only to solidify our ties to the feminists but to rally politically uncommitted women to our movement if they disagreed with the feminist aims. Popular front.

"Margaret," he mused, staring out the window at the Caribbean below. "She was an incredible woman, but she failed to understand how important political preparation is." He was referring to Margaret Sanger. I got the eerie feeling that although the woman had been dead for nearly three years he was going to propose her as honorary and posthumous president. Having been her only authorized biographer, he was still quite evidently bewitched by her. There was considerable gossip among pro-abortionists about the details of his relationship with the aging Ms. Sanger while the biography was being written.

We must have sifted through fifty or more names for honorary president. What we needed were a white Establishment figure (let's not get too radical and alienate the grass roots) and also a black (to counteract those who thought abortion was "genocide") and also a female. Even by the third drink, it was unavoidably clear that these three requirements simply could not be combined in the same person. Former U.S. Senator Maurine Neuberger seemed the snuggest fit. As it turned out, she declined the presidency but consented to fill the post of honorary vice-president. Shirley Chisholm (no self-respecting reform movement could

afford to pass *her* up in 1969) and Dr. Lester Breslow, an early advocate of reform in California and at the time the president of the American Public Health Association, were to divide the president's title between them.

The second N.A.R.A.L. Planning Committee meeting convened at 6 P.M. on Monday, March 10, again in Mott's office. There were some new faces. Lee Gidding, a young woman who had formerly been the proprietor of an undistinguished radio interview program in New Jersey, was present to be hired as executive director at the princely salary of \$10,000. Ruth Smith had found her and Larry Lader agreed on hiring her. It was a house-keeping job: finding a permanent office (no easy job on a first-year N.A.R.A.L. budget of \$30,000), handling filing and mailings, arranging press conferences, and similar chores. But Gidding was an unusually bright and perceptive woman who brought immense energy to the job and navigated between the rival factions with rare skill. She was indispensable to the movement in those early years.

Because George Pierce of Boston had found it impossible to be legal counsel to an organization that was New York-based in its early years, Roy Lucas had volunteered his services. Lucas was a slender young man with the boneless accents of North Carolina and that faintly irritating habit, so endearing in *women* of the Old South, of ending a declarative sentence with a question mark. He had interested himself in the question of abortion law and had published a modest paper or two on the subject. He was enterprising and charming enough to convince several wealthy women to fund for him the "James Madison Constitutional Law Institute," President, Roy Lucas, Esq. With his financial base secured, he undertook to advance abortion reform in courts throughout the country and to defend a number of abortionists. One must admit that he was extraordinarily successful. He was one of the attorneys who argued the case of *Roe v. Wade* in the U.S. Supreme Court in the 1971 term which resulted in the epochal 1973 decision striking down every existing abortion statute in the nation. Lucas was later to be unceremoniously dismissed from the N.A.R.A.L. board.

There was a second attorney at the March 10 meeting, designated in the minutes as an "observer." But after the proceedings

were under way about ten minutes Cyril Means, Jr., steamed into the center of the action, all legal guns blazing. A force to be reckoned with, he later engaged Professor Robert Byrn of the Fordham Law School in the 1971 contest over the fetus as a "person" under the law. Means was a portly gentleman of fifty years with a shock of flaming red hair slicked back in classic Stacomb manner. He taught at the New York Law School, one of the city's less-distinguished training grounds, and insisted on being addressed as "*Professor Means.*" Indeed, he was the only academic I ever knew who had the designation "Professor" emblazoned on his personal stationery. Means had only recently come to an interest in abortion. For some years, his avocation had been the Channel Tunnel Study, which dithered endlessly with the question of building a tunnel under the English Channel.

We elected the officers of the Planning Committee at that meeting. Larry Lader was duly elected chairman by a 7-2 vote. We threw Ruth Smith the bone of vice chairman. Ruth Cusack was secretary and Bea McClintock, treasurer. As we had planned.

Organizational matters disposed of, we moved right into street politics. We proposed that a hospital sit-in be mounted to dramatize the failure of the medical establishment to adopt a more humane—and liberal—position. I was assigned to come up with a tactical plan for capturing as much media attention as possible and to mull the question of *which* hospital to target. Smith objected strongly to the whole concept of Demonstration Realpolitik, pleading for a more mannerly approach, but her objectives were quashed by our little group, which included Cindy Cisler acting for the absent Betty Friedan. The meeting adjourned with a rather desultory reading of Stewart Mott's list of N.A.R.A.L. "program objectives." His paper contained no surprises: Citizen action committees for all fifty states; recruiting of the maximum possible membership; frequent newsletters, buttons and bumper stickers and such; national position statements and surveys; national media PR; fund-raising toward an annual minimum of \$1 million to push the cause; expansion of referral services; enlisting of prestige names for repeal from medicine, religion, law, social service professions, civil rights groups, politics, philanthropy, business, women's groups, and poor people's organizations. The final

point referred to the Department of Defense, a separate target for action, as the "fifty-first state."

Larry and I had a short post mortem on the taxi ride downtown to our respective apartments. We were satisfied. We had established workable political control and had pointed N.A.R.A.L. in an activist direction. He urged me to move quickly on the hospital demonstration before Smith's right-wingers could organize to block it. We agreed that PR was essential. No point demonstrating without TV cameras present.

INTO THE EYE

We had dinner again at the Laders' on March 21. The women were sent into culinary exile in the kitchen to watch the lamb roast while Larry and I plotted the next N.A.R.A.L. meeting scheduled for the following Monday. He was also concerned over the keeping of the financial books. I offered to speak to my accountant with an eye to engaging him for the job. Poor Lou Mintz. He supervised N.A.R.A.L.'s books for a year and never got paid a cent. I never really knew what Mintz's attitude was toward abortion repeal, but he made a significant contribution to the cause.

Betty Friedan made the Monday meeting and she dominated it, as indeed she did most gatherings she attended. She was a stumpy figure whose body seemed composed of stacks of various-sized auto tires. Her nose tyrannized her face. It hung, suspended, like a magnificent belvedere over her mouth. She would remain slumped in her chair, heavy-lidded and otiose until roused by a word or idea. Then that marvelous calculator of a mind would galvanize the whole organism to instant action. The eyes would flash wide open, the body would stiffen in the most unexpected way, and the words would come tumbling from her mouth. Axones vibrated.

Thoughts queued at the root of her tongue. The whole system was as visibly overloaded as Con Edison on a day of record heat. No time to finish a sentence: “. . . even if we delayed/Dolores could never understand/and if there weren't two factions in the/what I propose for the black woman is/Larry, what time is it? Gottogo.”

But that woman with her midwestern quack was one of the most captivating females I've ever known. She loved men, and she always had a brace of interesting males in tow on the many social occasions we shared. She adored a good dirty joke, and was an inspired raconteuse. There was a quality of little-girl diffidence, even innocence, about her that was infinitely appealing. She was *sui generis*, and I fell quite willingly under her spell.

Her deputy Lucinda (“Cindy”) Cisler was there again as an “observer.” She was an early and enthusiastic recruit to feminism with a thin-lipped stubbornness and a sullen integrity which had won her grudging respect in the movement's ranks. She was an architect by profession, though by all reports she worked harder at her politics than her vocation. Though Friedan privately deplored Cisler's ferocious distrust of most anything with a Y chromosome, she relied on her and delegated to her many of her less-interesting obligations. For the most part, that included the abortion crusade.

The only male item that Cisler seemed easily to tolerate in her life was James Clapp, a fellow NOW activist. They were virtually inseparable, Clapp usually wearing pants held up with a rope, so poverty-stricken did he appear. He was a painfully thin and shabby young man with a scraggly unkempt beard and a high whine for a voice. He would use his right index finger to great advantage, wagging it prophetically when he made a point. He looked as if he would be quite at ease with a shepherd's crook in his other hand. No one seemed to know what he worked at, but his politics were plain. He was a feminist somewhat to the left of Cisler. He was also outspokenly scornful of the medical profession, though he kept a respectful distance from me, viewing me as a well-intentioned but muddleheaded reformer. The Cisler-Clapp relationship was a source of endless amused speculation among pro-abortion politicians.

Cisler and Clapp, along with Arlene Emery, Barbara Gelobter, and Emily Moore, organized the New York State chapter of

N.A.R.A.L. In accordance with Stewart Mott's blueprint, we had determined that N.A.R.A.L. itself would be a national superstructure sitting atop various state lobbies for repeal. The New York chapter underwent a violent power struggle in 1970 at the worst possible time, just when the abortion bill was coming up in the legislature. Cisler and Clapp seized control and steered the affiliate far to the left of the stated objectives of national N.A.R.A.L. They espoused free abortions, and abortions to be performed by paramedical personnel such as nurses, midwives, and trained lay technicians. They went so far as to refuse to back the breakthrough Cook-Leichter bill, which allowed nearly wide-open abortion and, when it was signed into law that year by Governor Nelson Rockefeller, gave New York the nation's most liberal statute. Cisler and Clapp fumed that Cook-Leichter was such a "cop-out" to the "medical establishment" that the existing tight ban was preferable.

It was a lovely cool Thursday morning in October 1977. I caught my usual 7:30 A.M. subway at Twenty-third Street and settled back to read the *Daily News*. I enjoy the anonymity of the subway in the early hours, and it is usually the only moment during the day that I can read a newspaper, so I am resentful if some acquaintance gets on and interrupts my reading with banalities screamed over the subterranean roar. So I was a bit chagrined when a young man opposite me caught my eye and asked, "Aren't you Bernie Nathanson?" I admitted the fact and held the *News* a little higher. He persisted.

"I'm Jim Clapp."

Now he had me. I hadn't seen that feminist anarchist in five years and curiosity gripped me. I looked at him again, searchingly. Was it really Jim Clapp? The beard was neatly trimmed, the hair fashionably coiffed. The gentleman was wearing what looked like a Patek Philippe watch on his wrist. There was a high shine on his modish shoes. The *Wall Street Journal* lay in his lap, carefully folded to the editorial page.

"What's been happening with you, Jim?"

"Well, I graduated from Columbia Law, clerked for a judge, and now I'm with a firm downtown."

"Great, Jim." I did not have the stomach to ask if "downtown"

was as far as Wall Street. We exchanged a few more pleasantries, then I detrained and wore a faintly wolfish I-told-you-so smile all the way across the Columbia campus into Woman's Hospital. The chairman was wrong. A revolution may not start as a dinner party, but it seems rather often to end that way.

That March 1969 meeting was tedious with N.A.R.A.L. organizational trivia. There was, however, a general discussion on the desirability of enlisting the Protestant and Jewish clergy throughout the nation to speak on abortion from the pulpit, all on the same weekend. These, of course, would be "our" clergy. Also, I was assigned the task of bringing in a detailed plan of action for the proposed demonstration against local hospitals which refused to open up to a more liberal interpretation of "therapeutic abortion," that is, to make their Therapeutic Abortion Committee into a rubber-stamp operation. The next two Planning Committee meetings were given over to my project.

It started as a "Mother's Day demonstration" against hospitals. We changed it from Sunday to a weekday to cause more disruption of the hospital routine and, far more important, to get more media attention. The thorniest question, at least for me, was the choice of a hospital. Clearly, it could not be any of the three hospitals where I worked. It should also be a hospital that would be accessible to the media. That ruled out Brooklyn, Queens, the Bronx, Staten Island, and Long Island. It obviously must be a hospital that maintained a rigid abortion committee, that is one where the psychiatric tactic had not yet wedged open the door for us. I mulled this for two weeks and decided that it had to be Lenox Hill Hospital. The choice was wise in terms of our publicity plan, but it turned out to be ironic. Two years later, I was desperately to need a favor from Lenox Hill.

The hospital is a sizable volunteer institution on Park Avenue, which caters largely to a rather well-off clientele and has a small clinic population. This contributed to our choice of it as a target since, in the best populist-revolutionary mode, we had decided to strike at the rich rather than the poor. (Granted, that was somewhat fuzzy-headed, but it *was* 1969.) Finally we were taking our movement into the streets.

The Department of Obstetrics and Gynecology at Lenox Hill

was headed by Hugh Barber, a former All-America football player at Fordham who had established a national reputation in gynecologic cancer. We were casual acquaintances as fellow staff members of New York Hospital. Most important, Barber was a practicing Catholic who had stood adamantly against the widening psychiatric indications for abortion in his department. So we struck him.

The public unveiling of N.A.R.A.L. took place at noon on Thursday, May 8, a fine sunny day. We marched thirty or so strong on a picket line in front of the hospital for an hour or so, chanting a few slogans ("Children by Choice" was one favorite) and carrying signs. Howard Moody's placard read, "You Don't Have to Be a Woman to Know This Law Is Wrong." Adelle marched, with our three-year-old, Joey, in tow. He was delighted with the attention he got from the TV crews and gleefully brandished his ice cream cone in the cause. We also managed to recruit a few nurses, residents, and interns from Lenox Hill to join the line. A considerable crowd of onlookers gathered to watch the lunchtime action and swell the numbers so that, to the three TV stations covering the event, we looked moderately impressive as demonstrations are measured. We made the "Six O'Clock News," the *sine qua non* of street politics. There were protests in eleven cities the same day. The one which New Jersey N.A.R.A.L. mounted in the state capital of Trenton was considerably more effective than ours in terms of media coverage. With theatrical flair, they had conscripted a corps of young mothers to wheel baby carriages as they chanted the slogans. Still, New Jersey was to prove one of the more recalcitrant states in the coming fight.

What had we accomplished? We had surfaced. We were discreetly vociferous; no one had been arrested and there had been no ugly incidents. Our judicious insurrectionism was designed to appeal to the middle-class group, slightly to the right of the Viet Nam protesters: the New York *Times* editorial page readers lusting, cautiously, for intellectual adventure. We had made abortion repeal a genuine in-the-living-room issue. We had seized leadership of the movement, leaving the Association for the Study of Abortion primly disapproving, and even Planned Parenthood floundering behind somewhere. We were blooded, and we were confident.

And I had, on the public record, set myself apart from the medical establishment. My hospital colleagues continued to be a little careful with me, watching anxiously. Some few were openly antagonistic. But I felt good, vindicated. I was *doing* something about this abortion problem, and I was doing it in the most effective legal way I knew. But where do we go from here?

Larry and I turned again toward consolidating our hold on the final structure for N.A.R.A.L. We determined to call the first annual meeting in late September to organize the paper Board of Directors and the key, the Executive Committee, successor to our loose Planning Committee. Lonny Myers, a Chicago anesthesiologist and Planned Parenthood activist had indicated that she would seek the presidency. She was not one of "ours," and we needed a counter-candidate. Carol Greitzer was the logical choice. She had just been elected to fill a vacancy on the New York City Council, representing Greenwich Village, and before that was district Democratic leader for the anti-De Sapio reform team that included Edward Koch, now the mayor. She was also a member of the liberal New Democratic Coalition and an activist on civil rights. Altogether an admirable candidate for us.

Our cause seemed natural for her career, too, but she needed persuading. It was a daring move for a white female politician to associate herself openly with an abortion group, even in 1969. I met her for the first time in July at Larry's apartment, and the three of us discussed the pros and cons of her accepting the presidency. She was afraid that opposing Myers might be fatally divisive to N.A.R.A.L. We assuaged her fears about that and about the impact on her own political career, and she assented. (Today Greitzer is still on the City Council with no glittering prospects on the political horizon. Whether her position in the vanguard of abortion reform helped or hindered is indeterminable, since she early allied herself strongly with all the other components of the feminist movement.)

At the first annual N.A.R.A.L. meeting on the last weekend of September in New York, our political muscle and cunning were tested and vindicated. Our slate of directors was approved, Larry won the single most powerful post (chairman of the Executive Committee), Greitzer was elected president, and Friedan, vice-president for the East. I made the Board and retained chair-

manship of the Medical Committee. We mollified the conservatives: Lonny Myers was given the Midwest vice-presidency, Ruth Proskauer Smith was treasurer, and her sidekick Bea McClintock was assistant treasurer.

Meanwhile, the pace of "psychiatric" abortions in New York City quickened. I was then doing two or three a week. Even my partners in practice, more circumspect than I in the abortion matter, were doing a few. There was talk of a new push for repeal in the legislature. The climate was right. The war protesters had securely captured the media, male hair was coming down, grass was the white middle-class party drug, all the women were on the Pill. The times, they were a-loosening.

On the national abortion scene that fall, the central personality was Milan Vuitch, a hulking, fifty-three-year-old Yugoslavian who had ostensibly been practicing surgery in Washington, D.C., since 1955. He was arrested in May 1968 by the D.C. police while performing an abortion. As it turned out, he had assiduously practiced that art since at least 1957. I did not learn his name until after our psychiatric gambit made the Puerto Rican "out" no longer necessary. Vuitch charged only \$300 an abortion and did a few for nothing; the Puerto Ricans by then charged \$600, not including air fare. His arrest forced him back to the more mundane corridors of surgery (hemorrhoids, hernias), but to his evident delight the pro-abortion forces rallied and he became a cynosure. When a federal judge struck down the D.C. law as unconstitutionally vague and acquitted Vuitch in November 1969, he was instantly lionized. Within weeks, he had equipped new quarters and was soon conducting a prosperous abortion practice.

Larry was determined to refer all women seeking abortions through N.A.R.A.L. to Vuitch, but asked me to fly down to Washington just to check out his technique (though he had been referring women there for several years without taking this precaution). I arrived to watch him at work on December 30, having announced my intentions to him via phone four days earlier. Vuitch was plainly not overjoyed to see the New York inspector general, and his wife, the nurse-receptionist-business-manager, was openly hostile. I watched him do several procedures, from the interview (terse, condescending, affectedly good-humored) to the final pat on the shoulder (perfunctory). But the man was an even better

technician than Sopher, perhaps the best abortionist I've ever seen. So nimble was he with the dilator, so elegant with the curette that one felt impelled to forgive him his minor lapses in sterile technique, such as failing to use sterile gloves or antiseptic solutions to prepare the vagina. It would be like carping at Arthur Rubinstein for playing the piano barefoot. Even the occasional failure to wash hands between cases, a cautionary basic even to a veterinarian or a chef, did not seem as heinous as it should have.

By the time I returned from my inspection trip, events had already passed me by. Larry was incensed that although the Vutch decision had, in effect, removed illegality from D.C. abortions, the major hospitals there continued their restrictive policies. He wanted N.A.R.A.L. to open its own clinic in the District, with me as director. The new year saw me trying to organize an abortion clinic without ever having seen one. (Another bagatelle was that I had no license to practice medicine in the District.)

I was openly pessimistic about the clinic prospects as Larry and I left for another St. Croix vacation on January 22. He insisted that it had to offer abortions absolutely without charge, and I wondered where the money was to come from. My other concern was getting doctors. Before we departed I had called several ob-gyn friends, and they had all politely declined my invitation to take part. One only half-jokingly expressed some concern for my mental well-being. We had also tried to enlist some residents at the Johns Hopkins Hospital in Baltimore, where Irving Cushner had initiated outpatient abortions for only \$90, but aroused no interest there either.

Frederiksted was delightful. We stayed at the same house and fell into the routine of the year before: breakfast *al fresco*, a day in the sun, theatrical sunsets, evenings full of good talk. Only reluctantly, Larry came to see that the clinic was quixotic and ultimately unworkable. We had endless discussions over the subject of his next book. He was taken with the idea of a biography on his onetime employer, Congressman Marcantonio. I held out in favor of one on Paul Robeson, the singer, then living in bitter self-imposed exile in Philadelphia. In fact, Lader's next book was to be on birth control again.

At the next N.A.R.A.L. meeting we conceded that the D.C. free clinic was dead and proposed instead that Vutch perform

free abortions each Saturday, with N.A.R.A.L. giving him a token payment in return for permission to reap the publicity by announcing that the Saturday clinic was under N.A.R.A.L. auspices. This more workable plan ultimately was discussed to death in several more meetings, and events in Albany allowed the whole project to die with dignity.

At the same time, Conni Billé and I presented an idea that we had fun working out: Lysistrata Day. N.A.R.A.L. was at first a little skeptical, but we put it to them that the pro-abortion movement was acquiring as grim and uncompromising an image as the anti-abortion group. Perhaps a little innocent levity—in the cause, of course—might be helpful. Although we projected this little leitmotif for a dozen cities, it flowered only in Philadelphia. Lysistrata, the heroine of Aristophanes' humorous play of that title, organized a sex strike among the women of Greece to end the war between Athens and Sparta. Their favors denied, soldiers decided that this was too high a price for pursuing victory. In 1776 Abigail Adams wrote a letter to John threatening the same tactic if he and the other founding males did not cease their chauvinism. The Associated Press wire account of the great day appeared as follows in the March 19 Los Angeles *Times*:

PHILADELPHIA—The daughters of Lysistrata donned their togas and laurel leaf crowns, and in the grand tradition of Abigail Adams dramatized their demands for repeal of all abortion laws.

About half a dozen young women raised their fists in revolutionary style and announced their determination Tuesday to use "the tactic Lysistrata found so effective."

Members of Philadelphia Women's liberation solemnly pledged "to abstain from love and love's delights." But it was only for one day, a symbolic gesture.

"But it dramatizes the fact that our bodies are not our own so long as the law can dictate that we must bear unwanted children," said Connie (*sic*) Bille Finnerty, a spokesman . . .

The contrast between the propriety of the account, i.e., calling Finnerty a "spokesman" and addressing her as "Miss" in a later quotation, and the radical aim of the demonstration was so striking as to seem almost ludicrous. Another blow for publicity, and Conni told me later that everyone had such a good time that

the reporters and the demonstrators subsequently repaired to her apartment for wine and grass together.

For all this period, Howard Moody kept the N.A.R.A.L. parvenus at fastidious arm's length, pursuing his own abortion-law grand plan. At the original Chicago meeting he conveyed in cathedral tones his gratitude for my taking referrals at virtually no charge and for my courage in defying the medical establishment, but through his recitation I had the feeling that Howard was holding himself away from the crowd. By late 1969 his Clergy Service was functioning smoothly with only rare encounters with the authorities, but he was not resting. On November 21 he summoned me to an important meeting and asked me to pledge not to repeat anything of it to N.A.R.A.L. Oddly, Moody was never on any of the central organs of the association and only occasionally observed its gatherings. I suspect that he neither liked nor trusted Lader, and certainly they did not get along.

I was intrigued. Moody was innovative, if nothing else, and I agreed to confer. He met in my home six weeks later with the omnipresent Arlene Carmen. What he proposed was daring and inventive, and I bought it. Disappointed at the failure of the reform bill in 1969, and skeptical of the prospects in the legislature during 1970, he had secured the consent of the Clergy Service to open its own abortion clinic in New York City in what would appear to be open defiance of the existing law but actually was to be marginally within the law. The abortions would be on an outpatient basis (i.e., outside the hospital, not strictly a violation of the law), with two pro-abortion psychiatrists providing letters attesting to the "suicidal" tendencies of one and all. The letters would be rubber-stamped by a Therapeutic Abortion Committee picked by us. The fee would be \$50 to \$75 per abortion. I agreed to work for nothing.

On March 5, 1970, we met at Judson Memorial Church and Moody/Carmen took me to an old deserted brownstone behind the church in which they proposed to house the new clinic. We paced off the dimensions of the various rooms, and I listed equipment we would need for an April launching. So I was planning one clinic, sworn to secrecy, while discussing a second one for N.A.R.A.L. The Judson plan seemed much more workable than

Lader's pie-in-the-sky projects, and Howard Moody was a doer, with as little patience with red tape as I had.

Howard and Arlene assured me that one other gynecologist, Richard Hausknecht, was committed, and I met him at my apartment on March 14 to work out the surgical mechanics. I had never met Hausknecht before. An intense, voluble man in his early thirties, he at first bubbled with enthusiasm over the project. As we talked further, his pristine excitement seemed to dampen, especially when we came to the hard questions about the legality of it all. I reminded him of the virtual certainty of arrest, since the publicity surrounding the enterprise would challenge authorities to act, under Catholic Church pressure. At this he paled a little and indicated he would like to rethink his position. It was the last I ever heard of him on this project.

Two days later the Judson trio (Moody, Carmen, Arthur Levin) and I met with Ephraim London, the civil liberties lawyer. He was a tall distinguished gentleman with a striking mane of silver hair and the grave mien of a funeral director. I found myself hoping that the black suit he wore was not a legal assessment. With exquisite care he led us through the legal minefields, spending what I thought was an inordinate length of time on the mechanics of bail bonding. In the silence that followed his performance, I found myself wondering what kind of place jail really was, leaving aside the movie and TV versions. Howard and I looked at each other for a long minute, then his hamburger face split into that wide, confident grin. Let's do it!

I spent the next several weeks compiling equipment lists, interviewing nurses to hire, and reading extensively what limited literature was available on the Eastern European and British experience with mass abortion. It was during this very period that two of the hospitals where I worked softened their abortion policies by requiring only one psychiatric letter instead of two. The number of "therapeutic" abortions nearly doubled.

On March 25 we met again on Project Judson. I reported the results of my interview with Hausknecht. The Moody troika was understandably disappointed and queried me closely regarding my commitment. I reaffirmed; I was in it to the end, whatever it meant. We discussed further the mechanics and financing, then gradually turned toward the issue of publicity. Were we to oper-

ate on a clandestine basis, just go ahead and function with indifference toward what the authorities knew and taking publicity as it came, or should we make a public announcement and openly challenge the law? I was the militant, in favor of challenge. It seemed to me that beyond the service to as many women as we could handle, we had a higher duty—to mount a serious attack on the law and to destroy it in the courts. Old laws were reeling in many parts of the nation, according to reports coming into the N.A.R.A.L. office, and federal courts were getting involved. The momentum was palpably building and we needed a big push, a dramatic arrest and trial that might well topple the remaining conservative bastions.

Howard demurred. He had had spectacular success with the Clergy Service by quietly pursuing his ends and eschewing any confrontation with the authorities. Further, he felt that during all the time we would be tied up in a lengthy and noisy trial, the clinic and perhaps even the Clergy Service would be closed and no abortions would be done. Carmen and Levin backed him, and I was outvoted. We would do our work openly but without seeking a confrontation. We adjourned late that evening with a new target date of July 1 for opening the clinic. I left the church buoyant and optimistic. As usual, Howard's last words were, *please* don't say anything to Larry Lader! He made me feel a little like a bigamist.

THE JAWS OF VICTORY

Two weeks later legalized abortion virtually fell into our laps.

On March 30 the Cook-Leichter bill came up for its first vote in the New York State legislature and was narrowly defeated. Quickly tabled, it was saved from ignominious demise. This ultra-liberal reform measure required only that abortions be performed by a licensed physician, and up to the twenty-fourth week of pregnancy. The revolution delivered itself of its runts and mutants: While Lader and others lobbied like mad for passage, Cisler and Clapp led their N.A.R.A.L. dissidents in a venomous campaign against the bill because of the stipulation on doctors.

Half a year later I had the opportunity to ask Assemblywoman Constance Cook about how the architects of the bill had arrived at that twenty-four-week limit. She told me, a little apologetically, that doctors regarded the twentieth week as that point at which the expulsion is no longer an abortion but a premature delivery, and the fetus is an "infant" born alive, or a "stillbirth" if born dead. The older English common law figured viability, the point at which a prematurely delivered fetus had a reasonable chance to survive, at twenty-eight weeks. At this point in her exegesis she

paused a beat or two, then said: "We split the difference." And that, children, is how laws are written.

The debate in Albany was white-hot on April 8 when I appeared by invitation at the New York City chapter of Planned Parenthood. N.A.R.A.L. had frequently voiced disappointment at Planned Parenthood's indolence and timidity on the issue. Although in 1968 Dr. Alan Guttmacher, then international president, advocated repeal, we felt that this massive organization, with its almost limitless funds and extensive facilities, was dragging its feet inexcusably. I did not mince words. I took them to task for what we saw as their fearfulness and stinginess. I virtually demanded that the New York chapter, at least, fall into step, set up abortion units in its clinics, and give us funds to push the fight. I did everything but pound the table, Khrushchev-style, with my shoe. I concluded to a hostile silence and nervous drumming of fingers. Dr. Sherwin Kaufman asked for questions. There were none. He extricated me from the meeting as painlessly as he could, uttering soothing reassurances while guiding me to the exit. Had it not been for his gentlemanly solicitude, perhaps the assemblage would have fallen on me like ravening wolves.

The events of two days later wiped this experience from my mind. The law passed! We had won what Larry characterized that memorable day as "the impossible victory." Governor Nelson Rockefeller's signing of the bill the next day was a foregone conclusion. That evening Larry and I appeared with Carol Greitzer on the local public TV channel to discuss the victory and what it meant to New York and the nation. We were all a little lost in wonderment and the discussion had an aura of unreality. The light and cameras intimidated me, and I even forgot one of the provisions of that bill which we had watched so intently and for which so many had fought so hard. Greitzer had to remind me that only physicians could do the abortions. I floated out of the studio in a daze. Then radio interviews, more TV, press conferences. We continued to find the media sympathetic and helpful. Many of the reporters, as Larry had figured, were young women committed to our cause. I forged some friendships in those woolly days that have continued to the present (remarkably, all but one of the women reporters have since tempered their views on abortion, as have I).

The April 17 N.A.R.A.L. meeting was an orgy of self-congratulation, crowing, and euphoria. Only Larry remained somber. He reminded us that our task had only begun. Not only were there forty-nine other states out there, but the new front lines in New York were the economics of abortion, sheltering the law from sabotage, and education of the medical profession. He was right, as usual.

When the kissing stopped, we realized that *where* to do abortions was now of paramount importance. A new crisis was upon us. Dr. Robert Hall of the play-it-safe Association for the Study of Abortion insisted that abortions be confined to hospitals, as did the New York State Medical Society on May 25. The city health department proposed the same restriction. I wrote the malpractice insurers for the state's physicians, and they replied on May 26 that abortion would be considered "major surgery" and that failure to follow the city health and state medical society guidelines "would make a malpractice suit arising out of an abortion more difficult to defend." They added ominously that lawsuits from such cases "would undoubtedly reach the attention of the Company Underwriter and could therefore jeopardize the continuation of the particular physician's insurance." No insurance, no medical practice.

Till then all abortions had been in hospitals. But it was evident to all but the invincibly obtuse that when the law took effect on July 1 the city would become, as it was later characterized in the *New York Times*, the "Abortion Capital" of the nation. As soon as the bill passed I publicly predicted that an avalanche of abortion-seekers would descend on the city on the order of 250,000 to 500,000 in the first year. I was scorned as "moonstruck" by some so-called authorities for that estimate; in fact, the first-year total was remarkably close to 250,000. It was simply not remotely possible for the city's hospitals to accommodate that number. Some more innovative and realistic solution had to be worked out. The guidelines were not only contrary to the spirit of the new law, N.A.R.A.L. argued, they were entirely unworkable. If the major hospitals were to admit abortion patients to their beds, there would simply be no room there for *any* other medical business. The entire medical machinery of the city would choke over the

abortion glut. If this did not happen and they refused all abortion business, the reform law would mean nothing.

There was also the question of price. Since Blue Cross at the time refused to cover the costs, hospitalization would put abortion out of the reach of most women who wanted it. Poor women would still be forced to the back alleys. The law would be made a mockery.

The only answer was outpatient abortion; that is, walk-in, walk-out abortions in doctors' offices or special abortion clinics. There were no good statistical studies on the safety of this procedure, but in the emergency we would have to move boldly. Though I was the leading, probably the only, medical advocate in New York of clinic and office abortions, I must admit that I had some carefully concealed reservations. I had been trained entirely in high-powered institutions with virtually limitless facilities. The idea of carrying out a surgical procedure in my office was not a comforting one. Further, American medicine has traditionally operated on the "catastrophic" philosophy: make preparations for all possible catastrophies, no matter how much it costs and how remote the chance, so that you are fully prepared if the remote chance occurs. European medicine has done the opposite: Assume everything will be normal, make no elaborate or expensive preparations for the remote emergency, and do the best you can if it happens.

The feasibility of outpatient clinics was enhanced by a virtual revolution in abortion technology that was just then occurring: suction curettage. It made safe, cheap, mass-scale abortion possible just at the time the laws began to change. The technique was pioneered in Communist China in 1958, spread to other Communist nations, and was first reported in Israel, Sweden, and the U.S. in 1967. My three-man partnership was one of the first in New York to purchase a machine, in the fall of 1969, in anticipation of New York repeal. It is strange to reflect that we who were campaigning to scrap the law had not only failed to come to grips with *where* the huge numbers of abortions would be done, but *how*. Up to that time abortion was a cottage industry, performed by hand through D and C, scraping the wall of the womb with a sharp curette, and pulling out pieces with the polyp forceps. A cautious doctor might spend thirty minutes or more, using a delicate touch because the wall of the uterus is soft during pregnancy.

A lot of perforations of the uterine wall, and resulting infections, from mass abortion would justify the hospital restriction. It might even keep other laws from toppling.

With suction, a plastic hollow tube (vacurette) is used, with the caliber varying to match the tightness of the cervix. A clear plastic tube leads from the vacurette to one empty bottle where the bodily remains are trapped in a gauze bag; the blood seeps into the bottle below. A second bottle sets up the suction. With the vacurette, the operator quickly pulls the conceptus from the wall of the uterus. If this is done after about ten weeks, one can see identifiable parts of the fetus's body dismembered and trapped in the gauze bag, which caused stony reaction from nurses in the early years. The later one gets in the "first trimester" (the first twelve weeks) the more likely the suction must be alternated with the hand-operated forceps to dismember the fetal body in the womb and extract pieces, working blindly in that large, soft chamber. When everything is out, the uterus signals completion by contracting; the bleeding slows markedly.

The battle was joined. Not only did N.A.R.A.L. have to convince the doctors of the city and state that outpatient abortion was safe and workable, but we had to instruct them on how to do it. To that end I put together the "First Symposium on Non-Hospital Abortion Procedure" for July 1, the first day that the new law was in effect, in a hall at the New York University Medical Center. To ensure a good turn-out, I sent a form letter to every physician in the city:

Dear Doctor:

On July 1, 1970, New York State's new abortion law will go into effect. According to the law, abortions may be performed by a licensed physician before the 24th week of pregnancy. There are no restrictions prohibiting office or clinic procedures, despite attempts by state and local authorities to subvert the intent and meaning of this epochal law.

Now that the right of a woman to terminate unwanted pregnancy has been established by statute, it is the responsibility of government and the medical profession to enable that right to be exercised fully and freely . . .

I then described the symposium and invited attendance.

At the symposium, I delivered two lectures, one on my saline

technique for late abortions, the other on medical details on handling out-of-hospital abortions. Richard Hausknecht surfaced long enough to speak on the new vacuum method (he confided to me before his address that he had little actual experience with it, though he had read up on it in the Eastern European literature). A social worker and a psychiatrist spoke to the counseling aspect. In those long-gone days there was much concern about psychiatric trauma after abortion. Now, as Lader had prophesied in *Look*, we know better.

The symposium was a somewhat qualified success for N.A.R.A.L. We had very good media coverage and a pleasant lunch with Borough President Percy Sutton at a nearby Italian restaurant. But only about eighty doctors showed up, for several reasons. Physicians are notoriously reluctant to involve themselves in political action and that letter of mine was unquestionably political. Abortion was still a distasteful subject to the body politic of established medicine. In fact, a majority of the nation's physicians opposed a change in the laws, even though American Medical Association delegates had lined up with the A.L.I. proposal in 1967. The idea of carrying out the relatively new suction procedure in my office was enough to make *me* pause; to the average physician, with no experience in the technique, it must have been a little frightening. Finally, I had been increasingly defiant in the media since the law had passed, and my name alone on the letter might have put off many doctors. The medical profession does not love a maverick.

A few hospitals tried to come to terms with the July 1 onslaught in a responsible way. At Woman's Hospital, an outpatient program did go into effect on July 1. The patients arrived at 8 A.M. with previously done blood and urine tests in hand, and were required to wait until all the usual Operating Room business had been concluded, and afterwards rested in the Recovery Room for three hours under observation before they were discharged. Was the long wait without food or fluids a subtle protest against this offensive procedure? Perhaps. Still, credit must be given to Harold Tovell, the obstetrics-gynecology director, and Mrs. Avril Lawrence, the O.R. supervisor, for executing what appeared at the time to be an imaginative response.

The situation in private offices and gynecologic clinics in New

York City exceeded chaos. The scenes resembled those seen in wartime photographs of civilian populations fleeing before invading armies. Women were arriving from all areas east of the Mississippi. (Those west of that boundary descended upon Los Angeles and San Francisco, where the A.L.I.-type California law was being obligingly bent to accommodate the hordes.) They came without appointments, their baggage still clutched in their hands. No hotel reservations. Nothing. They simply camped in our waiting rooms, in the lobbies of the buildings where our offices were located, on the sidewalks, in cars parked at the curb with the motor running. It was my predicted avalanche, and more.

The most pathetic were the girls, so young they had not suspected pregnancy until it was too late, too frightened of their parents to confide the problem to them, too bewildered to know what to do even though they knew they were pregnant. They sat on their suitcases in our standing-room-only waiting rooms that unforgettable summer, their faces pleading, their eyes infinitely sad. We had to tell some that they were too far advanced in the pregnancy to do an abortion: twenty-one, twenty-eight, occasionally thirty-two weeks—eight months! These patients would return to the waiting room and sit back down on their suitcases for a while, then importune the secretaries and nurses. Could the doctor have been mistaken? How was it possible to be so far pregnant? It can't be. Who else can help me in this city?

Those who passed under the twenty-week limit but were beyond the first trimester would have to be booked into a hospital, which is necessary for the saline abortion. The wait for beds for "salting-out" that summer ranged from two to eight, even ten weeks. In desperation, we handed our nurses the task of informing many poor women that the wait would put them over the time limit. I quickly learned that if I told them myself my time would be consumed by consoling them, wiping away their tears, occasionally cajoling them out of suicide threats. I could not do so with the hordes still milling around in my waiting room.

For those who passed the time requirement and for whom we could secure a bed in a reasonable time, there was the money problem. Because no hospitalization insurance would cover elective abortions, the hospitals naturally demanded money in advance, when the patient checked in. Only certified checks or cash

were accepted. To be sure, it was impossible to verify personal checks from so many out-of-town banks, but the rules carried an inescapable hint of humiliation.

The resistance of the medical establishment continued on down the line that summer and fall. Because saline abortions had to be done from a hospital bed, the hospitals used this as a means of controlling not only the traffic but the law. The law clearly stated that abortion could be performed up to the twenty-fourth week of pregnancy. Gynecologists knew that this figure was nonsensical, but women seeking abortions were led to believe by the state legislature that this was the time limit, and we had to explain that most hospitals in the city still insisted on the medical tradition that a procedure after twenty weeks is not an abortion but a prematurely induced delivery. Therefore, no woman beyond twenty weeks could be admitted to these hospitals for "salting-out." We were caught between the hospital edict, following medical teaching, and the legislature's invented line and the unrealistic expectations it produced.

The hospitals sought to control the traffic, in part, by squeezing the gynecologists. In many, an arbitrary quota system was set up which permitted each staff gynecologist only a certain number of abortions per month. The excuse given for this unparalleled limitation of the private practice of medicine (involving a now-legal operation) was that it would assure each staff member equal access to beds and operating rooms for abortions. Of course, this was aimed directly at those few of us who had been publicly outspoken on abortion reform, since we got most of the out-of-town referrals. The many physicians who would not do abortions at all were assigned the same number as the rest of us. I quickly exceeded my quota, as did another busy gynecologist, and we were informed that on September 1 we could no longer admit women for abortions. Imagine informing a physician that he had done too many gall bladders in August but could still admit patients for hernia repairs. When I was informed of this atrocity at a special meeting to which I was summoned, I was furious, and vowed to fight the ruling—publicly, if necessary. When I returned from a vacation in mid-September, the quota system had mysteriously disappeared.

Nor was that the end of my personal harassment. I was referred

to privately as the "Abortion King," "The Scrapper," and other considerably cruder designations. There was a serious move afoot that summer to terminate my privileges at one of my hospitals, St. Luke's-Woman's, on some vague grounds of "unprofessional behavior," or so I was told later on. Though I have never been privy to the minutes of the committee involved in this move, it was leaked to me that the motion was defeated soundly for lack of a shred of objective evidence. But many physicians who had formerly referred me their patients for gynecologic care dropped away. I was told by a friend that if a patient asked for me by name, she would be told, "No, you don't want to see him. He's not a doctor; he's an abortionist." This from a few men whose wives I had treated in the past. Contrary to the image of "profiteering" on abortion, my practice and my income declined because of my political activities.

At the Hospital for Joint Diseases, where abortions were reluctantly tolerated, even though I was the Director of Gynecology I was told that late abortions could not be done there since there was no obstetrics department. There was a sliver of logic in this, in that if a fetus survived—then an exceedingly remote possibility with the twenty-week limit—there would be no personnel and equipment to care for the live-born infant. The fact of the matter was that gynecologists are always trained obstetricians, that necessary equipment was easily procured, and that ambulances were available to transport infants to a nearby hospital nursery in a mobile isolette. In many hospitals, admissions personnel were subjected to harangues and threats from doctors desperate to get their patients a bed. Rumor had it that considerable sums of money were being passed to admitting office personnel for "special consideration."

With hospital intransigence, a rainbow of markets appeared to fill the demand. A number of doctors did first-trimester suction abortions in their offices. A few even did late abortions, injecting the saline there and sending patients back to their hotels or buses to abort in some unknown location. A few small private hospitals such as Park East and Park West converted their entire plant to late abortions and were filled to overflowing. Outpatient clinics independent of hospitals began springing up for first-trimester abortions.

Ironic that I, the leading proponent of office abortion in the state, should never have performed a suction abortion in my office, nor did my two partners. St. Luke's Hospital had refused us permission to do suction abortions in the hospital-owned building where we maintained an office, and we decided that our East Side office was too small and crowded to perform any procedure. Subsequently, we sold the unused suction apparatus that we had bought in anticipation of the new law.

By mid-August, the waiting time for a hospital bed was still two weeks. The late-abortion patients were especially pitiable in that if they went over the twenty-week line while waiting, they would have to bear the child. No amount of begging, pleading, or raging at hospital administrations could shake loose an extra bed. Finally, there seemed no alternative but to perform late abortions in the office. This was contrary to the state and city "guidelines," but was not illegal. Still, it was an act that I would not have performed or encouraged except in an emergency. Hausknecht and I each picked our two more desperate women, including one who had scraped up her last few dollars to travel in from Oklahoma and was exactly twenty weeks pregnant. We assembled them in my office on Sunday morning, August 16, explained in great detail all the inherent risks, and each of them begged us to go ahead. We did so, kept them in the office for observation an hour after injecting the saline, then sent them home with printed, detailed instructions on what to expect, when to call their local doctors, and what the danger signs were (they were all from out of town). We gave them each a prescription for oral antibiotics and impressed upon them the importance of calling us back to report what happened after the abortion was over. We made no charge.

Along with grateful calls from my two patients that following week, I received a pair of outraged calls from their respective physicians, accusing me of everything from attempted homicide to advocacy of overthrow of the United States government. Each was livid, abusive, and at times incoherent. The gist of their vividly phrased complaints was that I had abandoned my patients and "dumped" them on the local community. I attempted to remind them that our bed shortage was critical and that if their home states had done their duty and passed a decent abortion law there would be no need for such problems. The next week Hausknecht

and I performed our final four office saline abortions, and with no further reaction from Middle America.

My daily diaries for that summer of 1970 are all but unreadable with tiny entries for hospital suction abortions, for saline abortions, conventional gynecologic surgery, N.A.R.A.L. meetings, TV and newspaper interviews, all jammed into the small spaces of my yellowing books. I found myself taking the phone off the hook for periods of time for a little surcease. My long-suffering wife, Adelle, began to communicate with me by notes left jammed into the mirror edge, since I would return home at one or two each morning and begin work at six. Even with that early start I was bound to be an hour late for commitments by mid-morning. The abortion revolution was cycloning through that summer of '70, and I could not keep up with it any longer. Exhausted, I finally escaped in mid-August for a month-long tour of the Soviet Union.

9

THE MERCHANTS OF ABORTION

Undeniably, our movement attracted some odd creatures. One of the earliest recruits was a short, rumped young man with a laconic air and an engaging sense of humor named Paul Krassner. When I first met him at the Laders' in late 1969 he was the editor of an iconoclastic little campus-type magazine called *The Realist*, of which I was a devoted reader. Imagine an eight-page pulp-paper version of *Mad* magazine as edited by Lenny Bruce and you have some idea of *The Realist* in the '60s. Krassner was openly defiant of the prevailing abortion laws in his pages and pursued his advocacy in those years with unswerving devotion. Like many others, he also ran an informal abortion referral service at no charge.

One of the few abortion clinics in the state that was willing to help N.A.R.A.L. in the wars after the liberal law passed was the Parents' Aid Society, a modest two-story structure in Hempstead, Long Island, that housed both an abortion clinic and a birth-control service. Mercifully, the name was later changed to the Baird Clinic, after its proprietor, Bill Baird. Baird was the sort of flamboyant eccentric that social revolutions (not always the most diligent practitioners of contraception) will occasionally spawn.

When I encountered him in 1971 at several N.A.R.A.L. board meetings, he was thirty-nine years old, with hair in '20s "Flapper" style—shoulder-length and straight—framing a pugnacious face which in the course of argument would mottle alarmingly. That occurred frequently, for Baird adored an argument.

Baird had grown up in Brooklyn in what were evidently straitened circumstances. The people in the movement described him variously as "a former medical student" or a young man who "dropped out of medical school because of lack of funds." Like many of the exotic figures in abortion, he found it to his advantage to allow himself to be mantled, however scantily, in the professional hood. In any event, Baird went to work for a manufacturer of contraceptive foam and in a trice or two found his real calling: challenging the Establishment. In the swinging '60s, he and the media fell deeply in love with each other, and he managed to have himself jailed at least four times—once for thirty-five days in Massachusetts for lecturing Boston University students on birth control, distributing packets of the ubiquitous foam to twelve unwed coeds, and reading off the names of abortion clinics in Tokyo. Though these hijinks sound more naughty than daring today, they won Baird deeply satisfying chunks of newspaper space and TV time. Nevertheless, Bill Baird was an important figure in that several of the cases in which he was involved resulted in the overthrow of antiquated anti-contraception laws. But by the turn of the decade the focus of media action had shifted from the relatively sedate birth-control issue to abortion, and poor Bill Baird was left endlessly mumbling his account of glorious bygone cavalry charges. In various N.A.R.A.L. functions I was forced to endure vicariously Baird's Massachusetts jailing three separate times, until I knew the weekly menu of the Suffolk County Jail by heart.

Among those who performed abortions themselves, perhaps the most efficient merchant was an acquaintance of mine, an adept gynecologic surgeon who had set up a successful practice in Detroit. He became interested in the abortion scene, purchased a suction apparatus on wheels and informed, among others, Moody's Clergy Service around 1969 that he was available for referrals. He soon began receiving patients from the eastern half of the United States. His *modus operandi* was to book a block of rooms on re-

tainer basis in a motel near the airport. The women would check in and each morning the doctor would make his motel rounds, wheeling his machine from room to room and floor to floor to vacuum out the wombs. He was an assembly line abortionist for the town of Henry Ford.

In New York, after abortion became legal, clinics began springing up around the city to meet the incredible demand. Because N.A.R.A.L. had publicly pledged assurance that the new law would work in a safe manner, we took it upon ourselves to evaluate these clinics. Since N.A.R.A.L. favored out-of-hospital abortion, it was crucial that these clinics function at a high level of safety, and we had to be sure that if we referred the immense numbers of women calling us, that the clinics (at that time unaffiliated, i.e., non-hospital) were of the highest quality. So on top of everything else that was going on Larry Lader asked me to look into the clinics.

On one of these visits, just after the law went into effect, I inspected the Bergman Clinic at 5 Carmine Street in Greenwich Village. My preliminary inquiry established that Mike Bergman had indeed graduated from the New York Medical College, had done some ob-gyn training on Staten Island, and after his recent discharge from the armed services was running a modest clinic under the auspices of a women's liberation group. He charged an incredible \$50 per abortion.

When I rang the bell I was greeted by a surly, unkempt young woman in a muu-muu, ragged sandals, and a filthy Indian headband. She identified herself as the receptionist, as well as one of the paraprofessional "nurses" and "counselors." At first she was disinclined to admit me until I explained that I had made a prior appointment, that I represented N.A.R.A.L., and that if the clinic met our specifications it would be assured of many referrals. With that, she beckoned me to follow her down a winding flight of stairs into a dark cellar where, she airily informed me, the abortion rooms were.

The basement was a damp brick-walled expanse better suited to serving as a wine cellar than as a medical facility. Thick padded steam conduits ran overhead. Off to one side was an unshielded electric water heater. The room was divided into tiny cubicles by yellow denim curtains hanging from overhead rods, each cubicle

with a table. To the right was a little Pullman kitchen with a bar refrigerator. I was told that this was the "lab" for processing blood and urine specimens. All this time I was clinging to a fading determination not to allow my classical, probably too formalized, medical training to interfere with an objective evaluation.

Bergman was occupied with an abortion but would be with me in a moment. As I turned to inquire about the availability of whole-blood transfusions should they prove necessary, I was seized by the lapels, in the manner of the narrator in the *Ancient Mariner*, by a long-haired, vacant-eyed woman. She dreamily informed me that she had just had an abortion by Bergman and "it was absolutely fantastic. It was the most uplifting spiritual experience of my life."

"Did it hurt? Was it uncomfortable at all?" I queried.

"It was, like, incredible. I want to do it again. Soon. Wow!"

"How much pregnant were you?"

"Man, I dunno. I just know that my Karma is complete."

I hoped Bergman would be more coherent, and made a mental note to ask what sort of premedication or anesthesia he was giving these young women. At this point Bergman strode toward me, wearing doctor's whites and a vile, bloody apron. A particularly noxious cigar protruded from beneath his Stalin moustache.

"Yeah," he said. "What can I do for you?" I explained that I was the man from N.A.R.A.L., which seemed to impress him not at all. "Lissen," he said. "I got a lot of work to do, so why don't you just look around, and if you have any questions, ask somebody."

"Well, to begin with, what kind of anesthesia do you use?"

"We use local. A little infiltration of xylocaine [a local anesthetic] into the cervix. No pain at all."

"Have you had any accidents or complications?"

He dismissed me with a "Naaagh, nuthin' to it" and ambled off into another of the curtained "procedure rooms."

I wandered around for a few more minutes, determined to obtain some more information to be as fair as possible in my report. The receptionist seemed, if not eager to talk, at least accessible, and I asked her if the clinic was using Rhogam (the injectible antibody to prevent Rh problems in future pregnancies). She furrowed her brows thoughtfully, then rewarded me with a *mal'oc-*

chio powerful enough to have stopped a charging rhino. I beat a hasty retreat.

My report to N.A.R.A.L. on Bergman was predictably adverse, and the clinic folded several months later, whether due to financial problems, surgical mishaps, or both, I could never ascertain. Bergman himself later found employment at an abortion clinic that I was to take over, but his brief tenure ended abruptly just prior to my arrival. In the process of a simple early abortion he perforated one young woman's uterus so extensively that she had to be transferred immediately to Flower-Fifth Avenue Hospital for a hysterectomy.

After 125 hardy souls attended the national N.A.R.A.L. convention in Boulder, Colorado, and again gave political control to the Lader party, we pursued our attack on the New York "guidelines" and their requirement of in-hospital abortions. A new threat was to incorporate this restriction into the city health code. N.A.R.A.L. called a public hearing October 16 on the safety and necessity of clinic and office abortions. We invited the members of the city Board of Health, none of whom showed up. And since press coverage was scant, we were only talking to ourselves. Nevertheless, we presented our evidence to Borough President Sutton, a stalwart on the N.A.R.A.L. board, and Congressman Ed Koch, a political crony of Carol Greitzer's. John Holliman, a prominent black physician who was later to serve as chairman of the city's Health and Hospitals Corporation, complained of the hospital backlog during his testimony, and said there was no evidence that hospital abortions were safer than non-hospital abortions. (In truth, there were no reliable figures or statistics at all in that frantic autumn.) Howard Moody delivered an impassioned sermon on the same text, followed by his newfound abortion clinic operator, Dr. Hale Harvey. This fascinating abortion entrepreneur was shortly to have a strange impact upon my own career.

I then took the stand to present formal proposals that I had prepared on behalf of N.A.R.A.L. (see full text, Appendix A). It was a mixed bag: a farrago of mild rabble-rousing and obligatory 1970-style pummeling of the Establishment, a call for more abortion clinics (prophetic), and for lower prices (quite modest—my \$300 proposed ceiling soon compared with a typical \$150 to \$200 clinic fee). The heart of my platform was the brazen and then-ir-

responsible assumption that first-trimester abortion was a simple procedure about as demanding as dental hygiene, so that it was certainly performable by non-physicians. This after a total experience of three months with mass-scale abortioneering. Irresponsible hubris, to be sure.

All in vain. Three days later the city health department went ahead and incorporated the "guidelines" into the health code, restricting abortions to hospitals or hospital-affiliated clinics. These rules did not quite have the force of law, since the state handled licensing, but they put a damper on clinics. I was disappointed, but Larry was absolutely outraged, and he began work on a piece for the Op-Ed page of the *New York Times*. Besides a spirited attack on the health department, it contained the typical thinly disguised indictment of the Catholic hierarchy, saying that they were not content with impeding the new law and were backing a drive by a combination of Right-to-Life groups, the Conservative Party, and the Republican Party to cripple the law with amendments.

Larry also lauded several clinics for operating at low cost, including Hale Harvey's operation (which, unknown to us, was facing a threat of state shutdown) and one called the Woman's Medical Center, about which he had no solid knowledge of standards. It was through the latter clinic that I encountered two of the more memorable rogues in the abortion movement, Merle Goldberg and Harvey Karman. Shortly before Larry's article was to appear, Bea McClintock told me that she, Ruth Smith, and Stewart Mott were considering putting some money into this clinic and asked if I would evaluate it as a potential investment. I found the concept of N.A.R.A.L. board members using abortion clinics as financial vehicles disturbing, and brought this to Larry's attention, but agreed to take a look.

I presented myself at a gloomy brownstone on the corner of Irving Place and Eighteenth Street at 2 P.M. on New Year's Eve, 1970. Goldberg ushered me in and immediately launched into a long and enthusiastic disquisition on the virtue of this particular clinic, which she operated jointly with "Doctor" Harvey Karman. The abortion movement had by this time worked up a fairly sweaty amour with Karman, who had prowled the crepuscular world of illegal abortion for at least fifteen years before landing in New York City in the post-legalization immigration. Somewhere

along the line Karman had hooked up with Goldberg, a bright, personable PR expert of satiny persuasiveness. With great panache, she showed me around the five-story brownstone, using an ancient elevator just capable of handling two emaciated adults, much less an incapacitated patient. Even a cursory inspection of the premises convinced me that it was totally unsuitable for an abortion clinic.

Midway through our inspection tour we encountered Karman, a thin, swarthy figure clad entirely in black: black-leather jacket, black-leather pants, black turtleneck sweater, black boots. He muttered what passed, I supposed, for pleasantries, then slipped past us to disappear into the darkened back stairs.

Before I left, I asked to speak to one of the para-professional nurse/counselors on the staff. Reluctantly, Goldberg produced "Lois," a young feminist I had already met at several N.A.R.A.L. meetings. I drew her aside for a candid appraisal of the clinic's cleanliness, finances, and the quality of the staff. She looked furtively for a moment, swore me to protect her anonymity, then told me the whole place was "weird, a sinkhole."

"What exactly do you mean?"

"Well, this guy Karman, the one who's supposed to be in charge of the clinic, is strange. He skulks around all day and at all hours of the night in that black outfit, and he materializes like a ghost, anywhere. In the middle of an abortion yesterday he sprang into the operating room like a ballet dancer or something, glared at the girl on the table, mumbled something to the doctor which I didn't hear, but which upset the doctor, then disappeared. Maybe dematerialized." She added an allegation that he had made advances to certain women patients. She admitted, however, that she had never seen such incidents.

"How about Merle?" I continued.

Lois peered at me for a moment, sighed heavily, and said, "She's nice, but there's something pretty crooked going on here and she knows it and doesn't do anything about it. When they get a patient who's a little better off than most of our patients, Karman seems to appear out of nowhere and tell the girl that there's a better abortion clinic across the street and writes out the address for her. I happen to know that this fat doctor from Kansas has an apartment across the street where he's doing abortions. I

think most of his patients come from Karman. In fact, I wouldn't be surprised if Karman has some sort of financial relationship with this guy and they're screwing this clinic out of their full-pay patients. I don't know if Merle's involved."

"Thanks, Lois. See you around."

I reported the hard information that I had collected, and the swirling rumors that I had picked up, to Smith and McClintock. They were profuse in their thanks. Then they proceeded to invest a large sum of money into that clinic, along with Stewart Mott. They lost most of it when the venture folded some months later.

Harvey Karman was the putative designer of the "Karman cannula," a hollow plastic tube which was of such small bore that it could be inserted into the cervix for an abortion without prior dilation. It resembled a slightly curved straw with the opening along the top rather than at the end. Suction was applied to the cannula and the conceptus was vacuumed out, as with conventional suction curettage after dilation. Since the pain from abortion stems largely from the forcible dilation of the cervix to make room for the conventional size suction tube, Karman's system required no anesthesia and was ideal for covert or for office abortions. It might work in very early pregnancy on women who had previously borne children so their cervixes were partially open to begin with. But it could not be used without dilation and anesthesia in the first-time mother. Further, the bore was so small that significant amounts of tissue could not be sucked through the cannula without clogging. Even in early pregnancies, this limited capacity meant that the abortion took a long time, which increased the risk of infection. Finally, though Karman claimed that his device was so pliable that it could not perforate the wall of the uterus (the most serious complication in first-trimester abortion), I inspected the device carefully during my trip to Eighteenth Street and was convinced that this claim was inaccurate and irresponsible.

Karman also billed himself, here and in Europe, as the inventor of "menstrual extraction," which meant inserting his tiny cannula into the uterus of a woman who had avoided birth control during the preceding menstrual cycle, a procedure done either at the time her next period was due or up to ten days after that. The theory was built on the exceedingly fuzzy premise that if women were in

fact pregnant, the "extraction" (nothing more than miniature suction curettage) would terminate the pregnancy. If she were not pregnant, it would induce bleeding sufficient to be called a menstrual period! The appeal of this curious method rested on ignorance. If the woman did not know for *sure* whether she was pregnant, she could undergo "extraction" without any qualms about having an abortion, by telling herself she was only regulating her period. Ecumenical, too: Catholic women could deceive themselves.

In practice, the method is immoral, illogical—and unsafe. Failure to tell a woman that there is an accurate test for very early pregnancy when she has missed her period by a few days and fears she is pregnant is an ethical violation of her "informed consent." It robs her of the opportunity to make one of the momentous decisions of her life, whether to bear a child. It even violates the feminist canon about "the right of a woman to control her own body," since she cannot control it if she does not possess all the facts.

As for logic, it is inarguably an abortion if the woman is pregnant. If she is not, the operator only provokes slight bleeding in the womb, not a true period, which involves the complete sloughing off of the lining (endometrium) as a result of complex hormonal processes. With "extraction" only some fragments of the lining are removed. Further, the true reason for the delay in the period is obscured. It might be caused by an ovarian tumor or some endocrine malfunction, diseases that would remain unidentified while the woman goes on thinking her menstrual cycle has been "restored."

The method is unsafe because it fosters such ignorance. It is also unsafe in that the "Karman cannula" with its small bore can easily miss a very small and young conceptus, while the bleeding it causes can lead to a mistaken assumption that the woman cannot possibly be pregnant when in fact she is. Above all, despite the small bore and a certain flexibility, Karman's cannula has serious potential for mischief by perforation, with the devastating result of abdominal surgery or hysterectomy. To subject a woman to *any* surgical procedure without a clear medical indication for it, in particular "menstrual extraction," is thoroughly unsound and unprofessional.

Regrettably, a number of reputable gynecologists were at first carried away by the Karman mystique, alongside the boosting of the technique by feminists. It was embraced for a while on both coasts and in England. A June 15, 1972, dispatch from London to the *New York Post* reported on Karman's claims to have invented the "two-minute abortion" and predicting that "the method is likely to find widespread use in Britain before the U.S." Quoth Karman, his technique "would eventually be recognized as the only way to tackle the world's population." At this time Karman was identified as the "Director of Medical Research" at San Vicente Hospital, Los Angeles. Contrary to what that might imply, San Vicente is a small hospital, not a research center, and Karman never held a staff position as such. The administrator who severed all ties with Karman shortly thereafter says that he was involved mainly in publicity and in referring abortion candidates to the hospital.

One thing in Karman's favor: He had the courage to come right out and advocate abortion as a primary means of birth control while the rest of us altruists were dodging that issue. Happily, "extraction" is now largely in desuetude, due to the highly accurate blood tests for early pregnancy, a cooling of feminist fever, and the settling certainty that no matter how early, abortion has hazards that cannot be ignored.

Karman's third and later contribution to modern medicine was his promotion of the "supercoil," which we were told would terminate late pregnancies with great speed and ease. It is axiomatic in gynecology that pregnancy tissue is highly vulnerable to infection, and that if the pregnant womb is invaded by any foreign body (coathanger or whatever) it is prudent to assume that an infection is in progress and that the pregnancy tissue must be completely removed as soon as possible. Infected pregnancy tissue gives rise to unusually virulent infections which often result in endotoxin shock, a total collapse of the circulatory system that in many cases leads to death. Any pregnancy tissue that remains unremoved will harbor virulent bacteria and, despite antibiotics, can precipitate violent infection and endotoxin shock.

The supercoil was nothing more than a tightly coiled plastic spiral. The technique, if it can be dignified with that word, was to push a number of the coils into the woman's pregnant womb

through the closed cervix, then pack the vagina tightly with cloth to prevent the coils from falling out. The coils would be removed sixteen to twenty-four hours later (just time enough for infection to obtain a solid foothold) and, supposedly, the pregnancy would immediately fall out. For good reason, the coils were described as "high-class coathangers" in U. S. Senate testimony in March of 1973 and have been condemned by responsible medical authorities.

Like a malevolent phoenix, Karman appeared in Bangladesh in March of 1972, as part of a five-man team invited by the Bangladesh government and put together by the International Planned Parenthood Federation and the New York-based "National Women's Health Coalition" (a Merle Goldberg creature). Karman's crew reported to United Nations relief officials on the project. Their purpose was to abort women who were raped by marauding Pakistani soldiers and to train paramedics in that country to perform future abortions by Karman's two methods. According to a panegyric in the *Los Angeles Times*, 1,500 abortions were performed and 100 doctors and 100 paramedics were trained in "Dr. Karman's so-called 'non-traumatic' abortion procedure." The Karman cannula would work in a "simple office process" within ten seconds to a minute, it was reported. And the supercoil, which "has gained wide acceptance internationally," was said to produce abortions "up to the seventh month" without any anesthetics, surgical instruments, or dilation of the cervix.

Karman next popped up in Philadelphia on (yes) Mother's Day of 1972, where he was reported to perform supercoil abortions on eleven black women bused in from Chicago, while the TV cameras of the New York public TV station hummed away. Merle Goldberg helped arrange this publicity. The District Attorney later reported that one of the women suffered profuse bleeding and had to undergo a hysterectomy, while two other women had to be hospitalized before they returned to Chicago—an inexcusable 27 per cent complication rate. The D.A. slapped Karman with eleven counts of illegal abortion and eleven counts of practicing medicine without a license. After denying that he had done the abortions, Karman later admitted it and was found guilty, but a judge overturned the conviction because data on the charges were not specific.

Karman styled himself as "Doctor," and the inference drawn would be that he was an M.D., though if pressed, he would concede that he only had a Ph.D. in clinical psychology. Why the latter degree would embolden him to perform operations is unclear, but I suppose it offered more cachet than his true academic standing. According to the *Los Angeles Times*, he possessed a master's degree in theatrical arts from U.C.L.A. and told the newspaper that the claimed Ph.D. was from the "International University of Geneva." The most casual check would reveal that no university of that name has ever been authorized to grant degrees in Switzerland.

That wasn't the half of it. It turns out that the Los Angeles District Attorney has filed nine felony cases against Karman since 1953. In that year he was convicted of grand theft and put on probation. Two years later he was charged with murder and illegal abortion after he used a nutcracker to abort one Joyce Johnson in a motel room; she quickly died of the infection. He was acquitted on the murder charge, but the abortion conviction plus the theft probation violation sent him to state prison for two and a half years. Since then he has been charged with illegal abortion six more times. In the same month as the televised supercoil drama, he pleaded no contest to a consolidated group of cases and was given a \$2,500 fine and five years of probation. During those years a group of Los Angeles feminists, charging that he was still performing abortions without medical training and thus endangering women, raided his Los Angeles clinic. Three days after his probation ended, in January, 1979, Karman was allegedly back in business and under arrest for performing five illegal abortions and injuring two women in the process, with the related charge of practicing medicine without a license. The clinic's director, none other than Merle Goldberg, was charged with aiding and abetting the abortions.

Planned Parenthood. The United Nations. The government of Bangladesh. Public television. Pretty fast company for this ex-con with his degree in theatrical arts. With what consummate thau-maturgy did Karman manage to establish his raj in the abortion scene? With the advent of the abortion revolution, Karman's criminal record of illegal abortion activity became an asset. When the movement was gathering steam in the late '60s, its folk mar-

tyrs were men like Robert Spenser of Ashland, Pennsylvania, and W. J. Bryan Henrie of Grove, Oklahoma, both physicians celebrated for performing enormous numbers of illegal abortions for very modest fees. Styling himself as "Doctor" Karman, he insinuated himself into this august company of saints and martyrs, gathered the feminists unto him through the good offices of his suave cohort, Merle Goldberg, endeared himself to the anti-Establishment abortion forces by espousing the training of non-medical personnel, and presented to the world his magic coil and the flexible straw through which he would vacuum up the intrauterine population of the earth.

Feminists are sometimes so intent on denying the "right to life" of the fetus, and so intent on the absolute right to abort, that they forget that the *woman* has a "right to life." The womb is no place for non-surgeons to tinker with experimental hardware. The same syndrome appeared in a far different context in the 1977 trial of H. Benjamin Munson, M.D., of Rapid City, South Dakota, for manslaughter in the death of a woman he aborted. This was a very controversial case for many reasons; the publicity made it a Midwest version of Boston's Kenneth Edelin case of 1975. According to testimony reported in the *A.M.A. News*, the unfortunate Linda Padfield died of an infection as a result of the abortion three days before. No wonder—an incredible 240 grams of fetal material were left behind in her womb when the doctor dismissed her. The problem seems to have been that the patient weighed 194 pounds, and the doctor mistook the length of her pregnancy, using the inappropriate suction curettage technique even though she was eighteen or more weeks pregnant. The judge acquitted the doctor because he did not intend to leave the fetal parts in the womb or intentionally fail to remove them. The significant thing, however, is not the fact that Munson is innocent under the determination of the law, but the way in which feminists and pro-abortionists turned the doctor into a hero and vilified those who investigated the case. The fact that a woman was dead did not dampen their enthusiasm in the slightest. The Abortion Cause was rated higher than the sisterhood of one Linda Padfield.

C*R*A*S*H

The last week of January 1971 contained the usual potpourri of office hours, student teaching, and patient rounds, as well as three routine gynecologic operations, five suction abortions, and four "salting-out" abortions. I fired off a letter as Director of Gynecology to my superior at the Hospital for Joint Diseases, demanding more beds for surgery. Our three-member private-practice group had a meeting about rescheduling office hours. And I had a long conversation with Lee Gidding at N.A.R.A.L. about a newspaper article on fetuses that survive second-trimester saline abortions. I assured her, as I had before, that this was the result of faulty technique: not enough amniotic fluid removed, not enough salt injected, or a serious error in estimating fetal age. The weekend was quiet—not a single delivery, not one emergency—until Sunday night the thirty-first.

At eight o'clock Arlene Carmen was on my phone. We exchanged a few forced pleasantries (I knew it was Howard Moody who was lurking behind her) and then Howard came on. In a voice more conspiratorial than usual, sort of a booming whisper, he reviewed with me briefly the history of the Hale Harvey abortion clinic, how essential it was to preserving the concept of low-

cost, humane abortions, how his Clergy Consultation Service was now referring virtually all of its women there . . . and how the clinic was now in serious trouble.

Dr. Horace Hale Harvey III was a slender, bespectacled figure of about forty with a bizarre coiffure resembling a hairy helmet, beneath which he peered at the world through bemused eyes. In addition to his 1966 M.D. degree from Louisiana State, he had also earned a Ph.D. in philosophy. His dissertation was on decision-making, and nobody could waffle as artfully on a decision as Hale Harvey. He had run a rather flourishing illegal abortion enterprise in New Orleans, and was one of the mainstays for Moody's Clergy Service. He was a skillful operator with the requisite disdain for money that Moody so admired (though he charged \$300 an abortion). After the liberal New York law went through—and even before it went into effect—Moody convinced Harvey to move his operation up to New York and go to work. With Moody's clergy funneling in hordes of pregnant young women from across the Eastern states, the operation grew like Pinocchio's nose. From a modest thirty or forty abortions a day in the summer, the succeeding months found numbers climbing precipitously: eighty, ninety, now one hundred abortions a day. There were two shifts so the place could be open from 8 A.M. till midnight. At a fee of \$200 per, the clinic had amassed a reserve of nearly \$400,000, placed in gilt-edged short-term U.S. Treasury notes, by the end of the year.

Moody was ignorant of one small fact. Harvey had no license to practice medicine in New York State. Word of this embarrassment was getting out and I was told that the *Village Voice*, the Greenwich Village weekly noted for its investigative journalism, had carried an item several days before that the state Attorney General's office was preparing to get a court order to shut down the clinic. There was no comparable abortion clinic in New York, Moody said, or at least none that he would send *his* women to.

I listened to this breathless recitation politely, making a few soothing sounds from time to time, wondering what exactly he wanted of me. Did he need N.A.R.A.L. to work up a brief for the upcoming court case? If so, he might come to me about it, given his relationship with Larry Lader.

"No, Bernie, what I'm asking—I know this is presumptuous since you're one of the busiest OB's in the city—but could you *possibly* take over the clinic, run it, get it out of trouble, and carry it along till we get it licensed?"

"God, Howard!"

Unfazed, the reverend persevered. "Well, I know it's a big order, and I'm presuming a lot on our friendship, but—"

"God!"

There was a long and (appropriately) pregnant silence. I was overly busy already with my private practice, my post at Joint Diseases (or "the Joint," as it was jokingly called), my work at Woman's, and my teaching assignments at Cornell, alongside my extracurricular work in abortion politics. Still, what a challenge! And Howard Moody was one of the few people in the abortion movement that I had maintained an unqualified admiration for. Less than a year before I had even been willing to risk going to jail with the man. On the other hand, the professional damage in taking this position would be considerable, given abortion's shady social position at that time. ("Oh, I used to use Nathanson as my gynecologist, but he became a full-time abortionist" and so forth.) I was sure my two partners in practice would not think much of the idea at all. Dangerous politically, too. Certainly more minuses than pluses.

"O.K., Howard. I'll give it a shot. I'll give you six months."

He breathed audibly into the phone. I suppose it was a clerical sigh of relief. From any other clergyman I would have expected a benediction.

"Great, Bernie. I knew we could count on you. Now, the administrator of the clinic, Barbara Pyle, will be up to see you tonight just to give you a rundown on what's going on there. She'll be calling you shortly. She's a real ball of fire, twenty-four years old and running a terrifically complex operation up there. Thanks again, Bernie. See you."

"Yeah, Howard. Take care."

Pyle called twenty minutes later. I told her to come up in half an hour. *That* conversation took no more than thirty seconds. The ball of fire was evidently a woman of few words.

At the appointed moment, Barbara Pyle swept into my home. She was a short, pudgy girl with straight hair falling just below the

shoulders and a pale, lightly freckled face. She was extremely bright and not unattractive, though her backside, as I was often to remind her, looked like the rear end of a 1947 Buick. The calves were sheathed in shiny black-plastic boots. She came from Pauls Valley, Oklahoma (6,000 pop.) and had a Southwest twang that might have put Merle Haggard to shame. I thought, I've been locked up with a mad Okie.

Harvey and Pyle had met at Tulane, where she was an undergraduate while he was working on his Ph.D. and doing abortions for Moody's ministers. In the spring of 1969 she had traveled to England and the Continent in connection with the student travel service she operated, and while there had done research on sex education, abortion technology, and related matters for Harvey. She returned just in time to make the plans—after conferring with Moody—for opening the New York clinic. Harvey and Pyle loaded several station wagons and pickup trucks full of medical gear, contracted for some offices on the fifth floor of a professional building at the corner of Lexington Avenue and Seventy-third Street, and opened shop precisely on July 1, with Pyle running day-to-day operations.

"Well, Miss Pyle, what are the actual problems confronting the clinic at the moment, aside from Harvey and his license?"

I might as well have asked, "Aside from that, Mrs. Lincoln, how did you enjoy the play?" or "Job, please list for me your medical problems." Pyle sat on the couch opposite me, all business, her eyes engaging me fearlessly, and unzipped a black leather briefcase. A veritable blizzard of notes, papers, and letters cascaded to the floor. She ignored them and proceeded to tell me in detail the history of the Harvey clinic and of the morbid anatomy of its present state. Her face was suffused with an almost incandescent air of suffering, and I listened with what I hoped was an impassive countenance.

"Well, to begin with, we've got labor problems. There's a strong move afoot in the clinic to organize with Local 1199 of the hospital workers' union, and if the counselors succeed with that, it's going to cost us a bundle. Man, what with health insurance plans, pension funds, strict work rules, and the union breathing down our back on almost every major decision, this clinic is going to be out of luck. And that union is just dying to get in to estab-

lish precedent, so every other abortion clinic in the city can be organized.

"Then we have the feminists. The Libbers. They are so set against the male establishment that it's outrageous. By now they insist on wearing whatever clothing they want to the clinic, and they're pushing to do the actual abortions themselves. Hale's been allowing them to size the patients [examine the women to see how far advanced the pregnancy is]. See, they don't trust the doctors to tell the truth. They think the doctors deliberately underestimate the size—they're not supposed to do anybody over twelve weeks—to do more abortions and make more money. The doctors are getting \$75 an abortion. But then some of the feminists think the doctors are *over*-estimating the size of the pregnancy because they're afraid to do eleven- and twelve-weekers, and they claim that some of the sisters who really qualify under the twelve-week rule are being turned away by dishonest doctors.

"And speaking of doctors, they are atrocious. I mean, we've got everything, you name it. Sadists, drunks, incompetents, sex maniacs, thieves, butchers, and lunatics, and nobody to tell them anything. Hale's been staying in his apartment more and more in the past month or two, and there's nobody to tell them what to do. Certainly I can't, being twenty-four years old and not a doctor. We've got a zoo there, and I'm stuck.

"Then we have the problem with a back-up hospital. You know the New York City guidelines now require that every abortion clinic has to have a formal affiliation with a hospital for rapid transfer of patients with serious complications, and it has to be within ten minutes' driving distance. We've been dickering with Flower-Fifth Avenue, and we've even transferred some patients there, but I don't think we can get along with their chief of obstetrics-gynecology, and besides, it's really too far away. So we need a hospital affiliation, and fast, or we'll never get licensed. They'll close us up no matter what happens to Hale.

"Then there's the city and the state. The city has these guidelines we have to adhere to—Article Forty-two in the city health code—and the state has all kinds of requirements for what they call an independent out-of-hospital health facility. And we're on notice that they're going to inspect us within the next couple of weeks. Between you and me, old buddy, we haven't got a hope in

hell of passing that inspection. So one of our first problems is to convince the city and state that we're reorganizing the place and that we intend to conform to their rules. We *got* to get that inspection postponed till we're in shape.

"Now. We have a small problem about the board of trustees. See, up to this point it was a private operation, just me and Hale. Now Howard is hinting that we should become a non-profit operation with a board. That way we'll look better in the public image, and also look better to the state so we'll probably get licensed quicker. We'll be able to reduce the fee from \$200 to \$150. But Hale and I are going to lose that \$375,000 we've got put away. And I don't particularly want a board of trustees looking over my shoulder, either."

(\$375,000! Silently to myself, like a canticle: Whatever Howard wants . . . Howard gets.)

". . . and of course if we don't go non-profit, Howard can just pull out all of his referrals and we're on the street. We've got these clergymen on our back, anyway. I mean, any time a girl comes through for an abortion and thinks she's been mistreated, she goes back to her referring clergyman and sings him a long sad song. Then either I get a nasty letter from the guy or a sharp little phone call from Arlene—usually at one or two in the morning—asking me for some kind of explanation. Sometimes I think it's not worth it.

"Anyway, one of our biggest problems is Hale. It's been leaked to us that unless we totally split him off from the operation, they're going to close us down. Now how the hell do we get rid of him? I've tried talking to him about it, but I don't think I'm getting through. Now I've turned the problem over to our lawyers at Spear and Hill, but Hale can be very stubborn. And after all, he started the whole thing so why *shouldn't* he be stubborn?

"Then there's C.S.I.E.S. See, one of the things that Hale's really into is sex education, so he's organized this Community Sex Information and Education Service which answers any and all anonymous telephone calls about anything related to sex. They'll send out informational brochures, they've planted ads everywhere about the service, and we're getting a pile of phone calls. It's operating out of the basement of the building we're in, but they want better quarters and more money. Hale and I and Ann Welbourne

are the officers of that caper—Ann really runs it—but if we split Hale off from this place, what's going to happen to C.S.I.E.S.? I'm sure that one of his conditions for leaving, if he ever really consents to discuss it, is going to be a healthy continuing subsidy for C.S.I.E.S., and if we reduce our fees—as it looks like we're going to have to—then where's the money coming from?

“Now, we really have a problem with space. Bill Berg [the architect hired by the clinic] and I are drawing up plans for a new, much bigger facility. We're negotiating on the lease right now. But that won't be ready for another six months. In the meantime, we've taken over all the offices on the fifth floor for our use, except one. This idiot M.D. refuses to give up his office to us even though we've made him an outrageous offer. So we're just running our abortion operation around him. How he can see patients with all the commotion of the clinic around him, I don't know.

“One more thing. You got to get those doctors shaped up. I mean half of them don't even wash their hands anymore before doing an abortion, let alone scrubbing. They refuse to use masks or caps, and their moustaches are dragging into the suction machines. I swear, one of these days we're going to lose one of those guys right into the suction trap and the lab is going to tell us the tissue is pregnancy tissue and the abortion is complete. One guy refuses to take the cigar out of his mouth while doing the abortions. Even the counselors aren't *that* crazy.”

Pause. At last, it's over.

“Oh, and one other thing. Our garbage problem is impossible, and it's getting worse every day. I mean, there are these huge piles of our stuff stacked up in the hallway. Man, we use a lot of disposables, and the building refuses to help us with it except to make the usual garbage rounds once a day. Anyway, they don't want to handle it because it's bloody and all . . .”

Silence. Was that all? Could there possibly be more? Had Howard known all this when he phoned me—an honorable gentleman? A man of the cloth? Pyle assumed an open-mouthed smile with the eyes rolled up into the upper recesses, as if she had just told a particularly clever smutty joke and was waiting for me to laugh so she could decently join in. Sometimes, though, her trademark grin looked dangerously like a convulsive seizure was not far behind.

“Barbara.” That was my whole sentence. I was busy stroking

my brow, wondering how to make my way through the minefield that Howard Moody had just laid for me with only a twenty-four-year-old "ball of fire" with a mad-brained grin at my side.

"Yeah, Bernie?" In adversity like this, in the very Taj Mahal of affliction, I suppose there was nothing to do but be on a first-name basis right from the start.

"O.K. I'm coming in tomorrow—by the way, do you have an office there, or what?—and we'll try to straighten out some of the more immediate problems this week. Like trying to get the state from closing us up this week." *Us?* Yes, us.

"When you come in, ask for Marchieta. She'll tell you where I am. But wait a minute. Are we through? I mean, I haven't even gone into the financial situation with you."

"No, Barbara, I'm just not up to that tonight. Hold onto that until my sanity returns. Anyway, it's 12:30 and I've got to get some sleep. 'Bye."

"O.K., Bernie. See you later." And with that she was gone, sweeping out as she had swept in, like the Ajax white tornado.

"Wait," I called after her. "Who's Marchieta?" She yelled something back at me, the front door slammed shut, and I heard her rickety Volkswagen with the Rolls-Royce grille gunning on down the street.

I spent most of that night sleeplessly pursuing the ends of the knot. If I could just figure out what to pull on first, maybe the whole impossible problem would come apart into manageable components. I decided that the very first thing was the hospital affiliation. Not only was it required by the city health code, but operating without it was unsafe. Patients with serious complications from abortion had to have emergency facilities available. And a respectable hospital affiliation would lend a little credence to the whole operation. From Pyle's account, it was as improbable and as unorthodox a medical enterprise as one could possibly imagine. It needed all the respectability it could get.

Monday morning I instructed my secretary to make an appointment with David Thompson, the executive director of New York Hospital. That seemed my best shot. After all, I had taken some of my training there and had been an attending obstetrician-gynecologist on the staff for thirteen years. That day I had my usual office hours, made hospital rounds, culdoscoped one woman, and did a diagnostic D and C on another, performed three suc-

tion abortions, and confirmed a 5 P.M. appointment with Thompson to plead my case for affiliation. But first I would stop by my clinic for a little orientation. Why did I feel like I was facing a root-canal appointment?

A canopy fronted the five-story building at 133 East Seventy-third Street on the corner of Lexington, and the fripperies on its façade marked it as a neo-LaGuardian structure. The lobby resembled a lush Naugahyde forest. The floors were of a cheap black-and-white plastic and the furniture was done, ingeniously, of the same cheap and unspeakable plastic as the floor. At the information booth to one side of the lobby there was a population of indolent, gum-chewing young women behind the desk. (I later discovered that each of the two competing abortion clinics in the building had its own representatives there, each more slothful than the other.) I inquired of the only one who seemed to be in full command of a little more than her vital centers where the "Center for Reproductive and Sexual Health" was located. I was presented with a spectacularly blank look, a series of mumbled inquiries to her comrades-in-sloth, an assortment of what appeared to be purposeless athetoid motions of the upper extremities, and finally a thumb jerked skyward (I half-expected another digit to be used) and the strangled word, "Fifth."

I later learned that the clinic was known almost exclusively to the denizens as "Women's Services." The "Center for Reproductive and Sexual Health" was Hale Harvey's baptismal name for the clinic, producing the regrettable acronym of CRASH, which is how the staff commonly referred to it. In retrospect, such a name for an abortion site is one of those ultimate euphemisms that our century uses to hide the enormity of what mankind is actually doing.

When the elevator door opened to the fifth floor, I was greeted with a mob scene of such unparalleled grandeur that it compared with the riot sequence in Eisenstein's film *Potemkin*. Young women in the most prodigal variety of dress—and undress—surged back and forth across the tiny lobby, bawling at each other, brandishing sheaves of papers and fistfuls of instruments. One of the more surly-looking types bumped into me just as I stepped off the elevator and we glared at one another for a long moment, sizing each other up: Me in my conventional gray suit, white shirt and tie, recently shined shoes, and attaché case. She in her Mao cap,

khaki paratroop jacket, harem pants tucked into government-issue scuffed combat boots. No automatic weapons, at least.

"Excuse me. I wonder if you could tell me where I might find Marchieta?" I ventured.

"I'd like to find that bitch myself, goddamn it. Shit, man, I got more things to do than let you jerk me around."

Such behavior and barracks language, I soon discovered, were endemic to this curious institution. With a few expletives of even coarser level, she broke camp and marched off into the perspiring host. I stared after her in disbelief. Was this one of the staff counselors or some deranged patient or what? Suddenly I was tapped on the shoulder by a boy who could not have been more than eleven or twelve.

"Are you the guy from the limousine service, mister?"

"No, little boy, and what are you doing here anyway? Waiting for your mom?"

A short, thickly-bearded figure smelling strongly of the barnyard grabbed the boy by the shoulders, spun him roughly around, and growled, "Will you get your ass back downstairs where you belong?"

At that moment I spied Barbara Pyle sprinting across the hall in the tumult and hailed her: "Barbara! Hold it! What in hell is going on here? Where is Marchieta? Where can we talk?"

"Right. Doctor Nathanson. Listen, we got a crisis in one of the rooms. Minerva's in trouble again and, listen, why don't you go in here?"—she gestured at a door to the left of the elevator—"and I'll send Marchieta in, and I'll be in myself just as soon as I get Minerva sorted out."

"Well, O.K." I opened the designated door and stepped into a brightly lit supply closet, of generous dimensions for a closet. The walls were lined with metal shelves containing the usual variety of surgical supplies, the one familiar note in this otherwise incomprehensible bedlam. There was a single folding chair in the middle of the closet, and I sat down on it to wait. During the next five minutes, six young women in the evidently obligatory costume-party attire burst in, grabbed supplies, paid me as much attention as a spare suction machine, and careened out, slamming the door behind them.

I had my resignation mentally written out—a dignified but re-

gretful declaration in statesmanlike tone—when the door opened and a remarkably attractive, well-groomed woman came in and took my hand. Despite her harassed and overheated state, she quietly told me that she was Marchieta, that she was functioning as the head nurse now, and “what have the animals been doing to you?” I liked her immediately.

“Marchieta, is it, um, always like this?”

“Just your average, basic Monday, Doctor Nathanson. The animals are a little more difficult today because of the union thing. A bunch of the hard-cores are passing around the N.L.R.B. cards, trying to persuade the rest to sign them for a union election. Also one of the doctors didn’t come in today. One of the other docs shouldn’t have. He’s drunk, and we’re trying to convince him to go home. And the stock boy is sprawled out in the basement, high on something. Classy. Really classy.”

In succeeding months, I was to learn that “classy” was her favorite word for anything slightly disturbing. For matters of crisis dimensions she reserved the word “outrageous.” Marchieta Young Ceppos was of Irish extraction: dark-haired, dark-eyed, and likely descended from the doughty Iberians who survived the Armada debacle and thrashed their way ashore to the rocky coast of southern Ireland: the Black Irish. She was a registered nurse, trying to run what looked like a battalion field hospital in New Caledonia.

“Tell you what, Marchieta. You guys look like you’re fairly busy right now. What I’d like you to do is tell all of the administrative staff that I want a formal meeting with everyone at 4 P.M. Wednesday. And do you think we could hold it somewhere besides this closet? You people *do* have some kind of office, don’t you?”

“Yes. I’m sorry, Doctor Nathanson. They should have sent you over there this afternoon. The clinic offices are on the second floor, just above the beauty salon on the corner. They’re a little disordered right now since we just moved in there, but I think we can manage.”

Disordered. The word had an ominous ring, considering what she thought to be “your average, basic Monday” in the clinic area. She was kind enough to escort me to the elevator. We traded muffled sighs of relief and I departed.

BREATHING ROOM

Still recovering from my visit to the clinic, I met David Thompson at New York Hospital at five, as scheduled. He was a kindly man, a remarkable trait in someone whose administrative post attracted such lightning. I explained to him the functioning of the clinic and the necessity for a "back-up" hospital, and suggested that we join forces. He listened quietly and sympathetically, but I could sense that he was recoiling a little from the proposal of marriage from this maverick creature. I got the feeling that he was too decent a man to gag right in front of me, but probably would not want to involve his institution in such a doubtful liaison. Instead, he put me off gently by suggesting that I first discuss it with Fritz Fuchs, the chairman of the Department of Obstetrics and Gynecology, when he returned from a trip. Mentally, I crossed New York Hospital off my list.

(A week later I did talk with Fuchs and repeated my plea. Fuchs, a frosty Dane of indifferent record in clinical research, regarded my overtures with the fastidious disdain that would have attended my proposing that we turn the New York Hospital into a gambling casino. He candidly disapproved of out-of-hospital facilities for *any* gynecologic surgery, let alone something so disrepu-

table as abortion on demand. But somewhere in the middle of the interview he seemed to come to uneasy terms with the reality that abortion clinics were probably here to stay. He then counterproposed that he would entertain the possibility of an alliance if he were to have complete control of the clinic and appoint one of his full-time staff as director. I politely terminated the interview and left. Moody had chosen *me* for the responsibility of running the place, not some unknown appointee of Fuchs. It was the familiar Medical Empire-building syndrome.)

The following day I essayed my first comprehensive tour of this shabby orphan that I had adopted, not only to grasp the physical layout but also to try to understand its energy, its essence. Accompanied by Marchieta I began, as any patient would, at the waiting room. It was a tiny little box to the right of the elevator. The walls were festooned with rather graphic multi-colored diagrams of the female parts being subjected to various modes of birth control, interspersed with several wall posters depicting the benefits to be derived from joining Local 1199. I gave my first order as director, instructing Marchieta to have the posters removed immediately. Leave the birth-control instruction for private counseling, and the union campaigning for our internal staff circles without bothering the patients with it.

The laboratory for blood and urine processing was a similarly depressing cubicle. From there, patients were cycled to the "counseling room," an even tinier airless closet where they would sit to be initiated into the mysteries of contraception. Each counseling room had a plastic model—in three dimensions, to scale—of the female internal and external genitalia for instructing the patients. There they were also told the step-by-step mechanics of what was to happen to them in their suction abortions. I doubted how much the patients would absorb about contraception while hearing the sounds of an abortion going on on the other side of a wall that consisted of two thin layers of plywood.

The procedure room was, if anything, even smaller and more suffocating than the counseling room. There was an ordinary gynecologic examining table except that the foot stirrups were covered with gaily colored potholders. Marchieta explained, a little apologetically, I thought, that these kitchen appurtenances were reassuring and that they had nothing else to cover the stirrups

with. Well, I suggested, perhaps it isn't necessary to cover the stirrups and we could probably make the place look a little more professional by dispensing with the culinary aids. In fact, I said, have those obscenities out of all the rooms by tomorrow. "Yes, sir." I thought I detected a small smile as she said it.

The recovery room was a warren of two or three similar cubbyholes, with walls lined with what appeared to be military-style stretchers upon which lay groaning or weeping women, coiled into various attitudes of pain. I was told that the rooms were rather dark intentionally, but when I reminded Marchieta that in the dim light a patient could be in serious distress, fainting, or in coma and no one would detect it, she shrugged compliance and said that lamps would be added immediately. When I asked where the attending nurses for the recovery room were, she mumbled something about a union meeting.

If I were an inspecting officer for the city or state, I probably would not only have shut this shambles down forthwith, but would very likely have moved to arrest the author of it all.

Work had to be done as quickly as humanly possible, and I had to mobilize a staff. Jesse first. Jesse Blumenthal was an extraordinarily bright young surgeon trained at St. Luke's and now full-time at Joint Diseases. We had been close friends for years. He was not only an immensely gifted surgical technician who had built an impressive practice in his few years since graduation, but a man of unusually sunny disposition and a remarkable capacity for getting along with people of all stripes. He had had some exposure to gynecologic techniques in the course of his surgical residency at St. Luke's, and I had no doubt he could master the simple suction technique with ease. This abortion clinic, indeed the entire concept of outpatient abortion in New York City, could not have succeeded without the hard work of this loyal and faithful colleague. He proved to be indispensable in troubleshooting here and there, filling in for absentee physicians, soothing ruffled feelings among the doctors, and jollyng the counselors a little. One day when the plumbing lines clogged and we were threatened by a crisis—no sterile instruments—he got out some tools and unclogged the line. When a mouse got trapped in the walls of the building and unnerved the counselors with its squeaking, he devised a means to catch it.

When I phoned Jesse to outline my woes—warning that there were forces at work in the clinic antagonistic to organized medicine—he simply said, “Sounds interesting. When do we start?”

With that boost, I commenced the first administrative staff meeting of the Nathanson regime on Wednesday among the desks stuffed into two offices. Barbara Pyle was there, whipping her hair back behind her ears with her thumb as she always did when excited. She had had a difficult morning with the unionists and feminists who were demanding a labor election. To my right was Felicia Hance, a young physician who had functioned as medical boss in the interregnum. She had just finished her internship and had no specialized ob-gyn training. She possessed a fine, cool intelligence and was a handsome woman in a horsey way, given to wearing blanketing tweeds and boots of such height and intricate lacing that I calculated an hour’s work each morning and evening for managing the footwear. Hance was quite plainly miffed at a male physician taking over. I assured her that she would be invaluable in this transition and asked her to remain on as my second-in-command. She assented, but looked questioningly at Jesse Blumenthal.

Esther Harnos was in charge of supplies. (Quartermaster? No, quartermistress, or is it quarterperson? I had been reminded by Barbara Pyle that the feminists here were “heavy, man, heavy” and that they objected violently to being referred to by the doctors as “girls” or “ladies,” much less the more graphic words. They also opposed the doctors referring to the patients among themselves as “girls,” as they usually do, on the argument that any female old enough to get pregnant is a “woman.”)

Harnos’s face marked her as a fugitive from another, more serene century, unmarred by anything so tacky as worry or sorrow. She was given to an enigmatic, tantalizing smile that removed her effectively from this seedy little enterprise. Behind her back, the others referred to her as “the Baroness.” She had been raised in Hungary, had lived in such places as Australia and Argentina, spoke a number of languages fluently, and produced a mellifluous English lightly spiced with dashes of Magyar and Mayfair. She had started as a counselor, but had been so impatient with the wailing, ululating clientele that she was arbitrarily thrust into the supply department, to which she had brought as much experience

as to counseling. Fortunately, she mastered the job quite well, and I came to respect her evident intelligence and industry. Though everyone's sexual peccadilloes around the place were common marketplace fare, Harnos veiled any such matters, which, of course, further antagonized her co-workers.

Whitney Devlin, Pyle's aide in administration, was the female counterpart to the character in the traditional World War II movie: The American platoon is cut off and besieged and you could always count on some wisecracking, faintly cynical, and finally self-sacrificing corporal. Like the stereotypical corporal, Whitney was from Brooklyn. She had been christened with an unmanageable Italian name, and when she married Charles Devlin proceeded to change it to Whitney. She thought it was shorter and had more style. Whitney dazzled you with an electric Afro that sprang out of her head like the quills of a startled porcupine.

She had worked with Pyle in a student-travel service and had been persuaded to sign on as a counselor. When Harvey began retreating from control, Pyle took her on as her administrative assistant to try to manage the place and to help out in the power struggle with Felicia Hance. With my advent, Pyle had someone to deal effectively with the physicians, leaving her and Whitney Devlin free for administration. With her quick intelligence and inexhaustible taste for gossip, Whitney kept me abreast of much of the subterranean trouble that plagued us from the beginning. She was also a matchless troubleshooter, often sticking her thumb in the dike even before the hole appeared. Whitney was my right hand for a year and a half in that clinic, and in all that time I never heard her utter a dishonest word or tolerate a treacherous act. The *crème de la crème*.

Elizabeth Goncalves—Lizzie—was a Portuguese girl of nineteen from Pyle's travel-service days who kept a tight but tolerant rein on the banks of telephone operators handling appointments, clergy complaints, post-operative questions, and birth-control complications. She doubled as the banker, seeing to it that the deposits got to the bank each week. Finally, there was Ben Markowitz, the accountant. Whitney had hired Ben when receipts reached \$10,000 a day and the auditing firm called in at the insistence of the nascent board of trustees had figuratively keeled over at what laughingly passed for the clinic's "books." I found him

difficult to understand but came to appreciate his piercing honesty. Ben appeared pitifully lost in this demonic confusion, but he did his best.

Surrounded by this octette, I commandeered the desk in the middle and proceeded to lay out my plans. There was no question, I told them, that the first order of business was soothing of the savage regulatory beasts, in particular the New York State Department of Health, which had the legal power to close us down. Once the state was mollified, it was my guess that the city Department of Health would fall in line and at least not molest us for a while. "Breathing room," I intoned, "that's what this operation needs right now, so don't bother *me* with any trivial nonsense. Anything less than cosmic goes to Felicia, Jesse, or Barbara. My plan is to secure a hospital affiliation, and with that in my pocket go to the state and promise, on the strength of my own professional reputation, to make this a model facility within six months. Any questions?" They looked at each other—except for Jesse, who had heard my blood-and-guts lecture before and was smiling easily. No questions.

"O.K., if none of you have any questions, I have one. Where is the men's room in this lunatic asylum?"

The next morning at ten I had an appointment with Hugh Barber at Lenox Hill Hospital. New York Hospital had laid out impossible conditions, and this was the only other first-rate general hospital near enough to the clinic to qualify as a back-up within ten minutes' drive. I was over a barrel, and Barber must have been aware that I was one of the leaders of the street demonstration against his hospital, and his own ob-gyn department, twenty-one months before. With considerable trepidation, I was ushered into his office. We exchanged a few banalities and a little shop talk. (Lenox Hill and Joint Diseases had a one-way exchange program, so his third-year residents would spend six months under my direction in gynecologic surgery. I would even "scrub" with them myself on many cases.) I made my sales pitch as baldly as possible. I had taken over a large abortion clinic which had fallen into hard times and needed a back-up *right now*. I deliberately omitted mention of the impending injunction, not only because that might put too much moral pressure on him but also because I

didn't want the place to appear any worse than it already was. He heard me out patiently, shrugged, and said, "Sure. Why not?"

I have a poker face, I'm told. Indeed, I was almost suspended in my second year at Cornell for being the principal proprietor of a non-stop poker game (two-penny ante, totally honest) which was the occasion for a flood of rueful letters home to parents declaring temporary insolvency. This immensely decent physician had cracked my reserve. I smiled a smile that threatened to split my face and uttered a paean of gratitude. Barber waved it off and told me to forget it. I think he was a little embarrassed. Lenox Hill would have had to accept the patients anyway since the clinic was in its "emergency room district." True, I replied, but you know that that would not involve formal affiliation. He agreed to push the plan with the hospital board for legal completion of the agreement as soon as possible. "In the meantime, if you have any complications over there, send them over. I'll alert my residents and nurses today about our agreement." No conditions, no bargaining. A physician, in the highest sense. True to his word, the formal affiliation was signed with Lenox Hill a number of weeks later.

The next item of business was to upgrade the medical operation so I would have the firm beginnings of a thorough reorganization to report at my scheduled meeting with state officials six days hence. They would demand an immediate end to guerrilla gynecology, so I had to start with the doctors. From close questioning of Pyle and company, and of physicians working in the clinic whom I trusted from professional acquaintance elsewhere, I learned that as Pyle had warned, I was in charge of as picaresque and as venal a band of scoundrels as had been collected this side of Ambroise Paré. Various counselors and nurses reported that two of my band were vicious, even sadistic with the patients. One of the offenders was a woman. I was told that they would use unnecessarily large instruments on women with first pregnancies, or refuse to use the local anesthetic, or show the fetal tissue to the patient when she had not asked to see it. They were sometimes so impatient that they would shout at the patients if they squirmed on the table. I fired these two on the spot.

Richard Hausknecht from the stillborn Judson Church clinic project was also working here and was so angry that Moody had not asked *him* to be the director of CRASH that he cornered me

in the by-now-familiar supply closet and demanded that I make him my assistant director at the very least. When I demurred, he pouted that he simply could not go on working there because of the loss of face. I told him he was free to leave; in fact, that I now officially accepted his resignation. Then he implored me to reinstate him.

"Richard, please. Don't embarrass us both. You can stay till the end of the week. And, on behalf of the clinic, thanks for your good work in the past." The last thing I needed at that point was a nucleus for dissension on the medical staff.

Alexander Sos was an anesthesiologist who was unusually skilled in the high art of abortion. He had been indicted for performing an illegal abortion in the pre-1970 era and although the indictment was still hanging over him during his early months in the clinic, that did not seem to faze either him or Harvey. He was a man of middling years with a courtly manner, perpetually in the throes of some vast inner amusement, and a terrific abortionist. I kept him on, and later designated him as one of the teachers to indoctrinate new physicians in our techniques.

Eliezer Shkolnik. A fine villain indeed, a *capo di tutti capi* of the abortion scene. I was told that he worked simultaneously in the East Side Medical Group, an abortion clinic on the third floor of our building that functioned just this side of the law. They were known to steal our referral patients from out-of-town, not only in the lobby downstairs but by misleading them at the airport, and it was even alleged that they required no pregnancy tests to make sure the abortion was required. When things would slow down at CRASH, Shkolnik would descend two flights and do business there, and it was rumored that he had far-flung interests in other clinics in Manhattan, Brooklyn, and Long Island. Orwell once remarked that by age forty every man has the face he deserves. Shkolnik's was that of a nineteenth-century Russian count hopelessly addicted to the fleshpots of St. Petersburg. He skulked around for a few days after I assumed hegemony, then faded away, never addressing me directly or submitting a resignation. (I had already decided to fire him when I learned of his split-level activities.) Shkolnik subsequently became involved in a host of disreputable activities so offensive that the State of New York pulled his license in October 1976, and he was forbidden to practice

medicine thereafter. Among other things, he was accused of involvement in the Central Women's Center, an abortion clinic allegedly so corrupt that a sample of male urine submitted to its laboratory for a pregnancy test was reported as "positive."

Incongruously, I also inherited Karlis Adamsons, a starved-looking Scandinavian who was a professor of ob-gyn at Mount Sinai Medical School and one of the most original minds in obstetrics and gynecology. An unusually skilled technician and an excellent abortionist, he was in stunning contrast with that grubby company. Adamsons remained throughout my tenure. I dropped his name shamelessly at every opportunity with the regulatory authorities when attempting to establish the credit of the clinic in those early days.

So I pruned and praised, keeping the ten best from Harvey's crew of doctors. Then Jesse and I went into the marketplace to lure a well-qualified cadre of new people, after reviewing lists of respectable obstetrician-gynecologists and surgeons. My scheme was to assemble a spotless staff list before my state appointment. In order to lure, seduce, charm, snare, and entice quality doctors to the clinic, the only thing we had going for us was money.

The clinic was paying physicians \$75 per abortion. While I was, and still am, a firm believer in the capitalist dogma of the free marketplace, that figure seemed excessive, even to me. Doctors were earning more than \$1,000 on an eight-hour shift, with two abortions an hour and, in some cases, three. Some worked two shifts a day and doubled their income. Not only did \$2,000 a day reinforce the disreputable picture the public already had of abortion, but the per-abortion pay system encouraged abuses. Physicians would fight for the paying cases, find reasons not to do the patients whom the clergy had sent with a request for reduced rates, and disappear altogether when asked to do the free cases.

The pay system inspired incredible situations. Bill Walden, one of the skilled board-certified obstetrician-gynecologists I kept from Harvey's staff, later told me that when he first started, the practice was that a "senior" doctor with more experience at the clinic would have to confirm the newcomer's estimate on how far along the pregnancy was. One day he estimated a woman at sixteen weeks, and called in a "senior" with a solid reputation outside the clinic who told him, "She's only ten weeks. You can do her."

Walden started to work and soon was in the middle of a treacherous sixteen-week abortion that took him an hour and a half, with blood, bone and fetal parts all over the room. Meanwhile, the "senior" doctor was running through three women and earning three times the pay while he was tied up. Walden told me that the old hands pulled this on a lot of the new boys, to tangle them in impossible cases and reduce the competition for fees. On the side, of course, there was the trifling matter that they were putting the women patients in unnecessary danger. It was also brought to my attention subsequently that the doctors would keep double books. Harvey had put them on an honor system. They would keep a personal list of women who had been done and drop it into a hopper, which Barbara would use to figure out the paychecks. The doctors did not defraud the clinic by padding the lists, but they would often keep a phony list to show to their colleagues, so it would look like they had done fewer abortions each day than they had actually performed. When a patient would arrive, a doctor would say, "I've only done four today; why don't you let me take this one?" The honest men got the short end.

The inflated income for doctors prevailed precisely because there was no free marketplace. What reputable gynecologist, without inducement, would work in an abortion clinic, especially one headed by a strange maverick from Louisiana, staffed by wild-eyed feminists most of whom were not nurses, run by a twenty-four-year-old hypertense Okie, and operating in a shabby suite of physicians' offices? The big money angered the counselors, who got \$50 a day and, more important, it undoubtedly disturbed Howard Moody. I decided that I had to pay well to buy a good staff, but must remove the per-patient salary arrangement. Board-certified obstetrician-gynecologists would be designated as "supervisors" at \$90 an hour, and other doctors would get \$70 an hour (still princely sums).

A word about my own pay. I told Ben Markowitz that I was setting my own salary at \$30,000 a year. For the benefit of those who might suppose that I made a fortune out of the clinic and other abortion-related activities (*There's a fortune . . . in abortion / Just a twist of the wrist and you're through*), my salary was my sole income from the clinic, in which I had no ownership or equity. And far from gaining, my abortion work cost me heavily in

lost income. Because I became such a controversial figure my practice diminished, partly because the clinic consumed so much time, partly because patients were reluctant to come to me because they believed I was too busy to give them proper care, and partly because physicians referred patients elsewhere because I was a maverick and an "abortionist." Because of the enormous demands on my time, I reset my pay at \$1,000 a week for a time, then voluntarily reduced it on two separate occasions for a total of 25 per cent, when the clinic ran into financial trouble. My total income from the nineteen months at the place approximated \$60,000. In all, a quite modest sum for running such a vast medical institution, and far less than what my underlings were making since I never did a single abortion myself in the clinic.

That first weekend I checked through the equipment, firing orders for replacement of substandard items while Esther Harnos trailed after me with pad and pencil. She would wince from time to time as I would direct her to scrap all the Gomco and Sorensen suction machines and replace them with the safer and more efficient Berkeley apparatus (\$800 apiece); to get rid of the absurd little sterilizers designed for the solo practitioner and order two hospital-size sterilizers (\$3,000 to \$4,000 apiece); to order gowns, gloves, masks, and caps for all personnel to wear in the procedure rooms and proper white coats for everyone else (thousands of dollars more); to install sinks with footpedals so doctors could do a proper pre-operative scrub without contaminating themselves; and for heaven's sakes to get some decent operating room lights so they could see what they were doing.

Howard-and-Arlene (they were a single entry in my mind by now) strongly favored one-to-one counseling of patients and would fight any change to group counseling. One reason they chose Hale Harvey to do their abortions in New Orleans when it was illegal was his insistence on counseling patients at great length with genuine compassion both before and after the procedure. Indeed, it was an article of faith with Harvey that women were abysmally ill-informed concerning their own bodies and that they deserved all the factual data about their sexuality, especially before something so momentous as an abortion. Hence, his insistence upon close counseling, and his development of the sexual information phone-in service down in our basement.

When Harvey moved into the massive New York market he was naturally too busy to do counseling himself and hired counselors who met only two criteria: they had to be twenty-one or older, and they had to have had an abortion themselves. Nothing else. Education, degrees, experience were inconsequential to him. When word got out that he was paying an irresistible \$50 a day, those women for whom the abortion issue was closest to their hearts (hard-line feminists) flocked in for jobs. At any one time we maintained about fifty counselors and a smaller staff of nurses, all at the \$50 a day rate. Most of the clinic chaos was at the instigation of a group of fifteen rigid neo-Maoists who would never rest from their rabble-rousing until the entire medical establishment was purged from the place and they assumed total control, including doing the abortions themselves. If they succeeded in organizing a unit of the hospital workers' union, it would be too late to have a free hand in getting rid of them.

I contacted Diane Seide over that first weekend and asked her to take over as head nurse and hold the place together until I could make sense out of the nurse-and-counselor mess. Diane, an accomplished obstetrical nurse at Mount Sinai with a master's degree in nursing, assented after I told her that I had discovered that my head "nurse" on the four-to-midnight shift was not a nurse and knew as much about medicine as I did of needlepoint. Seide lasted but six weeks as supervisor. The intense antagonism and naked aggressiveness of the feminist counselors wore her down. She was accustomed to the polite deference that would have been her due in a similar position at a hospital. Eventually, I recruited Phyllis Turk as the evening supervisor of nurses and counselors. She handled the belligerent feminists with such artfulness and good humor that they came to lean heavily upon her judgment despite the fact that she was the putative enemy: a registered nurse of management rank. When Marchieta took a job at our satellite clinic, the day supervisor became Ann Bauer, who had worked at St. Luke's and had become my office nurse. Bauer's husband was a minister at Manhattan's Church of the Good Shepherd (Episcopal). She had a commanding intelligence and was plainly bored with her office role and jumped at the more exciting CRASH assignment. She was also accepted among the testy counselor ranks with surprisingly little resistance.

The following week I looked ahead to the first meeting of the embryonic board of the clinic (which I got them to postpone), eight operations, three women due to deliver babies, two gynecology lectures, my usual rounds and office hours, a session with Larry Lader on N.A.R.A.L. business, and a meeting to keep Howard-and-Arlene abreast of the clinic situation. A busy schedule, but it *was* all indoor work, there was no heavy lifting . . . and I didn't have to do windows.

The week's major event was my showdown early Wednesday morning, February 10, with Dr. Bernard Weisl, the New York State Department of Health representative who was overseeing abortion clinics. It was make or break for the clinic, and if they closed us down the out-of-hospital abortion movement might very well die with us. I knew Weisl slightly. We were both fellows of the New York Gynecological Society and murmured the usual polite "hellos" to each other at its quarterly meetings. Weisl was another of those comparative rarities of the abortion years, a man of compassion, unimpeachable integrity, and profound vision. We discussed the whole concept of outpatient abortion, and he assured me that New York State was not opposed to it, but merely wanted to satisfy itself on safety standards for the good of the patients. We chatted a few moments about mutual acquaintances, and then he looked at me keenly and asked,

"Doctor Nathanson, do I have your word that you will upgrade this clinic sufficiently so that when we make an inspection on March 9 it will conform to our standards?"

I didn't even know what their standards were yet. No one on the state level had spelled out the rules for clinics since the state hospital code had been written long before. Obviously, however, a state license depended on the upgrading of the actual medical procedures and staff, and plans for a better clinic facility which were in process. We would also have to satisfy the regional Health and Hospital Planning Council of Southern New York, a bureaucratic spawn which had to certify the need for any new health facility to be established in Manhattan. Obtaining a state license at that point loomed like a barefoot climb up the northern face of Mount Everest.

I promised to do my best. Weisl said, "That's good enough for me," and the meeting ended.

PASSING

Thus fortified, I faced my first meeting with the entire clinic staff the following Tuesday. The turnout was good: 50 counselors and nurses, 15 doctors, and 25 or so assorted other employees. I emphasized that I intended to make sweeping changes only in surgical technique and equipment and would not tamper with the sacrosanct counseling system. I informed them that we had negotiated an affiliation with Lenox Hill, and had staved off the regulatory agencies for a few weeks. I intended to remain in the director's chair until we were properly licensed, had moved into an adequate facility, and become a model operation. The militants, if not overjoyed, seemed at least appeased.

Six days later I held a closed-door meeting with the doctors. I lectured them sternly on the unforgivable lapses in surgical technique, even in ordinary hygienic standards. Henceforth all operating physicians would be masked, gowned, and gloved in the traditional manner, and standard three-minute surgical scrubs would be the order of the day. We would keep comprehensive records on all patients, and they would be responsible for completing them. The old per-abortion pay system was out. New equipment would be installed and they would familiarize themselves with it imme-

diately. I was not selected to be the director in order to win a popularity contest, I reminded them, and I intended to revamp the operation to make it into a model clinic for all those that would arise across the nation when the laws fell. If anyone could not live comfortably with the new regime, my desk was always open for resignation letters, and I did not care if they all resigned *en masse*. Jesse and I could very well do all the abortions ourselves. (Fortunately, they never called my bluff.) They left grumbling and I had three resignations within forty-eight hours, all from chronic offenders of the Harvey era. From that point on, I never had any major problems with my staff of physicians.

On the morning of my all-staff meeting I had my first opportunity to size up our legal counsel during an hour-long breakfast meeting in the Tudor Room of the Commodore Hotel. Topic A was how we were going to get rid of one Horace Hale Harvey III. The clinic's counsel was Spear and Hill, an ivy-encircled Wall Street law firm which usually grazed in the fertile hillsides of corporate law. How and why they had descended into the dismal swamps of abortion was a mystery to me. They were industrious and passably efficient, but made it clear on innumerable occasions in a host of tiny ways that the only thing we needed more than a lawyer was a squad of psychiatrists. Barbara Pyle casually dropped just before the rendezvous that the standard Spear and Hill rate was in the range of \$100 an hour, so I quickly ordered a pot of tea and started talking to the trio ranged opposite us:

Eliot Lumbard, the *force majeure*, was a dapper and perpetually tanned man in his late forties, given to wearing garishly striped shirts, impossibly high and stiff collars, and ties with knots big as melons. He was unctuously solicitous with me, often insultingly avuncular with Pyle, and unfailingly short with his two lieutenants. However, he had a reputation as a first-rate, dogged corporation lawyer, which certainly proved to be true in our case.

Richard Estes was one of his lieutenants. He was tall, sleek, and nicely plumped, with a '40s High School Graduation haircut. He was said to be the firm's ace on tax law and had been assigned by Lumbard to work on our tangled tax situation: How much we now owed to what government agencies, Social Security problems, and the obtaining of tax exemption after our incorporation in non-profit status. He earned his money. I am told that my few

conversations with Markowitz and Pyle regarding our tax problems turned me an interesting shade of kapok.

Larry Grosberg was a thoroughly decent boy and an unusually keen lawyer with quick wits and an attractive (and in this case appropriate) gallows sense of humor. He worked night and day in those early weeks unraveling our legal mess with Harvey, the metastasis of our sex phone-in service, the complex negotiations over the lease for the proposed new clinic on Sixty-second Street, our malpractice insurance coverage, license applications, and myriad other legal migraines. Larry subsequently defected from Wall Street to devote himself to public-interest law, a decision in consonance with his sterling character.

At the end of our get-acquainted breakfast, Lombard slapped me on the back and all but exhorted me to win this one for the Gipper. I must have looked a little pained, for he made haste to smooth the area on my back which he had just slapped, as if to eradicate the fingerprints. At the same time he reminded Barbara with heavy jocularity to attend to the bill. Later she told me the clinic was by then in hock to Spear and Hill for something in the \$40,000 range.

I met Hale Harvey officially for the first time on the evening of February 24 in his suite at the Hotel Westbury on the Upper East Side. In preliminary legal negotiations on the turnover of the clinic he had proven rather recalcitrant, particularly regarding the future of the phone service, C.S.I.E.S. To my surprise, Harvey was most cordial, even effusive, assuring me that he had heard that my reputation was unexceptionable and that he could think of no one he would rather turn his project over to. There was not a trace of malice or resentment in his manner.

After the amenities had been observed, Harvey treated us to a two-hour lecture, complete with blackboard, on the history of the clinic, his concept of the anonymous sex information service, and the complex ethical issues involved in the concerted drive to separate him from his clinic and the service. And, oh yes, the financial considerations. Harvey may have been impractical and something of a dreamer, but he had taken the precaution of engaging legal counsel to represent him in this sorry affair of compulsory retirement. His manner was so detached, so didactic, that I found myself involuntarily scribbling notes on a legal pad as though I were

back in a lecture hall at McGill University. When he finally finished, in best professorial manner he asked for questions from the audience. I cringed. A question could possibly lead to yet another two-hour peroration from this curious man. After all his esoteric diagrams, philosophic syllogisms, and propositions, I still had no idea what the man wanted. When we left Harvey and reconvened in the hotel lobby, I discovered that our lawyers did not know either. The best I could offer was that if Harvey called a spot quiz tomorrow they were welcome to use my notes.

The negotiations with Harvey dragged on for months. In the eventual deal, he agreed to resign and to surrender all the funds stashed in the clinic bank accounts and in Treasury bills, a sum of around \$400,000. In return, the newly reorganized clinic would pay him about \$75,000 for salary owed for his tenure and for expenses he incurred in setting up and equipping the place. The clinic pledged to continue a substantial subsidy, around \$15,000 a month, to maintain the C.S.I.E.S. phone banks. All in all, a very modest return on Hale Harvey's investment. Barbara Pyle came out of the negotiations with a remarkable salary of \$41,000 a year, but nothing else. On the evening of May 26 I received the following telegram: HARVEY SITUATION SUCCESSFULLY CLOSED AT 4:15 A.M. 26 MAY 1971 STOP WOW BARBARA PYLE ELIOT LUMBARD LARRY GROSBERG. Hale Harvey quietly left New York and disappeared from public view. He was last reported to be living on the Isle of Wight, reading philosophy and taking nature walks, far from the abortion hurly-burly which he had helped initiate.

The president of the board that took over his operation was Allan Barnes, who was something of a legend in American obstetrics and gynecology. He had been chairman of the ob-gyn department at Ohio State University, then at Johns Hopkins, a prestigious appointment indeed. For many years he had been the editor of the *American Journal of Obstetrics and Gynecology*, the foremost publication in the field. Now he was a vice-president of the Rockefeller Foundation and an ornamental addition to the boards of numerous philanthropic organizations. Needless to say, he was also a friend and admirer of Howard Moody.

I had my first conference with Barnes at his office on March 5, along with Barbara. He was a beefy gentleman with a florid complexion and protuberant, red-rimmed eyes so that he resembled a

genial dragon. He suffered from such a tremor that I wondered how he had ever managed to do surgery. Barnes was not at all condescending toward us and our unorthodox operation, but always seemed in a great hurry, appearing magically to be edging toward the door even while sunken in his chairman-of-the-board leather chair. Barnes had honed the technique of temporizing to a fine edge. "That's certainly a serious problem. Let's appoint a committee [task force . . . council . . . commission . . . fact-finding group] and meet again next month." It was impossible to get a direct, actionable answer from the man.

Twelve days later, at our lawyers' Wall Street quarters, I first met the remainder of the "Proposed Board of Directors of the Proposed Center for Reproductive and Sexual Health, Inc., to Be Formed Under the New York Not-for-Profit Corporation Law." Lumbar's tie that day seemed a foot wide, and his tan was burnished to a particularly high bronze. The board members were, of course, all activist liberals hand-picked by that artful manipulator, Howard Moody. Typically, Moody had no seat on the board even though he had a hand in everything. Judson Church's ubiquitous Arthur Levin was there, however, and soon was designated as treasurer (or, perhaps, Proposed Treasurer of the Proposed Board). The others: The Rev. Jesse Lyons, my N.A.R.A.L. colleague; Ivan Shapiro, a lawyer whose involvement in liberal causes never skewed his shrewd judgments; John McGuigan, an obstetrician-gynecologist who was working at the clinic but soon ended this puzzling conflict of interest by resigning his job; Sarah Kovner, a no-nonsense woman who was a staple of the usual run of liberal-feminist causes; and Helen Edey, the secretary, a psychiatrist and sister of N.A.R.A.L.'s Bea McClintock. Betty Friedan was a board member, too, but attended only one meeting throughout my tenure. Rabbi Edward Klein failed to attend a single one.

Of the "Proposed Board," only three—Lyons, Shapiro, and Levin—showed genuine interest in the clinic. They were faithful in attendance, accepted time-consuming chores, and were generally supportive. The women tended to dither, and Dr. Barnes seemed to be surpassingly preoccupied with goodness knows what or to be appointing another committee-task force-council-commission-fact-finding-group to look into this and that. Treasurer Levin was omnipresent around the clinic, especially after we moved to Sixty-

second Street. I was to see that somber, unsmiling face framed by luxuriant Jiminy Cricket sideburns everywhere except in the actual procedure rooms. Levin was, in my opinion, largely responsible for the clinic's eventual long and painful slide into financial distress.

Howard Moody, Arlene Carmen, and I met three times during March, and invariably the discussion would get around to the pricing structure. They declared that the \$150 fee, reduced from \$200 early in the year, was unsatisfactory, and they figured that the doctors' excessive pay scale was the obstacle to further reduction. They wanted me to do more to slash their income. I resisted, not because I thought my pay scale was just—it probably was inflated since abortion is not a particularly complex or taxing operation. But I was just managing finally to put together a quality staff because of the money. We compromised. As soon as I had what I considered to be a first-rate staff I would cut the rates, though not to levels that would encourage defections.

One more remarkable financial note: In early 1970, before the New York law went into effect, a patient of mine had flown to New Orleans for an abortion at the hands of Hale Harvey. She returned with an incomplete abortion and required another D and C a week later to stop the bleeding and remove residual tissue. She urged me to call Harvey and explain her situation. I did so, and was astonished to hear the man tell me to send my bill to him. He paid it in full. From the inception of CRASH, Harvey assumed all costs to the patient if she suffered some complication as a result of her abortion. This policy was such an innovative and responsible departure from the usual practice in organized medicine that one of my first acts as director was to make sure that it continued.

I pounded into my newly assembled group of physicians in meeting after meeting and in many individual conversations: Safety above all. I insisted on a strict twelve-week limit. Before my take-over the place was so relaxed that there was no strict medical screening of patients, a flexibility perhaps enhanced by the per-abortion pay system. My policy was that a patient was to be referred to Lenox Hill or another hospital if she was over twelve weeks or if there was the slightest question about her general health and ability to withstand an abortion. My list prohibited

women with: cardiac disease; serious lung disease; disorders of the blood or endocrine system (such as thyroid disease or diabetes); previous surgery for cancer; previous orthopedic surgery that would restrict positioning on the table; previous major surgery of the urinary tract, lower intestinal tract, or of the uterus or cervix; those who had had three or more previous Caesarean sections or three previous D and C's; those with major congenital anomalies of the reproductive tract; those with a history of acute or chronic infection of the female organs; and those with a previous history of malignant or pre-malignant conditions of the female organs. The doctors were also instructed to refer women who evidenced severe acute anxiety when faced with the abortion (such as screaming or twisting about uncontrollably when first examined prior to starting the actual procedure) and women with a history of previous psychosis that had required hospitalization or who were currently taking heavy psychotropic drugs.

As our preinspection cleanup campaign ensued, Jesse was increasingly worried about sterilization. The hospital-size autoclaves I had ordered had not arrived, and we were limping along on the tiny and inadequate office equipment. We were forever running out of sterile supplies and having to improvise. The situation was also dangerous. The sterility of instruments could not be guaranteed due to the constant malfunction of the overworked devices. This would be one of the first items for the state inspectors' interest. I mulled it over and decided to approach Jerry Muschlitz. Six months before we had fallen into idle chatter while I was scrubbing for an abortion at Woman's Hospital and he was tinkering with an immense autoclave in the Operating Room suite. He had been a Roman Catholic priest for nearly a decade, became convinced that it was not his calling, and had qualified himself as an autoclave specialist, developing an excellent reputation. He blanched when I asked if he would like to watch the abortion, but during the procedure I noticed him with his nose pressed against the O.R. window. I motioned him to come in, but he refused. A week later he stood over my shoulders and watched another abortion with horrified fascination, and afterward confessed that he was not as shaken as he thought he would be.

I had no idea whether he was still a practicing Catholic or what his views were, but I offered him the job of autoclaving consultant

at the clinic. He agreed so long as he could work when his shift at St. Luke's ended at 4 P.M. "It sounds like a real challenge."

"Jerry, are you sure you will be comfortable with this?"

"No problem, Doctor. I think I can cut it."

Done. The former priest did a superb job, revamping the whole set-up, keeping the expensive equipment in working order, and quickly becoming a favorite among the nurses and counselors. He was, after all, intelligent, good-looking, and unattached.

The weekend before the state team's visit, extra cleaning crews were put to work. Barbara, Jesse, and I had lengthy, sometimes frenzied discussions in our desperate effort to put the best possible face on our operation. We knew that they would primarily be interested in the manner in which the abortions themselves were done. Sterile? Expert? Humane? If we looked reasonably acceptable in the procedure room, it was my hunch that we could buy time until we could straighten out the other areas in which we were deficient, such as records and the recovery room. The counseling staff was to winnow out the calmest patient they could find among the Monday morning group. I assigned the all-important abortion to Bill Walden, who had had considerable experience at the clinic and whose technique I knew, because of our work together at New York Hospital, was above reproach. He was the most reliable man I had at my disposal.

When Bernard Weisl and his state team descended Monday morning the place was spotless. The counselors looked civilized, their white hospital coats concealing their usual outlandish getup. Even Joan Gethers, a Junoesque black woman given to wearing an African tribal costume one day, a Turkish seraglio outfit the next, had a white coat on over her subdued purple sari and foreswore her customary flamboyant headgear. Jesse scurried around six steps ahead of us, tidying up, pleading with the counselors to stash any marijuana, and doing everything but strewing lotus flowers in the path of the party.

Walden's abortion was superb, as I had anticipated. The patient was quiet, the surgery slick, the nurse helpful. Weisl was impressed. He was even encouraging and soothing as he offered a mild critique of our ridiculous recovery room. We chatted about the design of our new hospital-style records and charts, which were just being printed and which delighted him. As he left he

winked and murmured to me, "Don't worry." I knew we were safe for a while.

The very next patient that Walden did an abortion on that morning had her uterus perforated and was immediately rushed to Lenox Hill Hospital in serious condition. If that operation had occurred in Weisl's gaze, he probably would have closed down CRASH on the spot.

MOVING

In late February, even while the clinic was still in chaos, Barbara Pyle came to me with news from the abortion grapevine that a new, fully-equipped abortion clinic was standing unused on Eleventh Street, not far from New York University. Barbara figured that with our surplus funds and experience in the abortion market we could outbid the competition for the lease and run the place as a satellite to our Seventy-third Street clinic. We were bursting at the seams there even though we made no effort to advertise and restricted our patient population to the clergy referrals. With the second clinic we could go into the open market and build up an independent clientele. That, of course, would free us to some extent from Howard Moody's dominance.

It sounded good to me. We inspected the premises and found a very well designed clinic, aesthetically a vast improvement over our crowded little maze uptown. There were three major problems. (1) The lease was held by a shadowy character named Ron Jacobs. (2) There was no fireproofing in the building. (3) The logical back-up hospital would be St. Vincent's, a Catholic institution undoubtedly hostile to abortion.

Barbara was simultaneously negotiating the terms for our move

to the new Sixty-second Street clinic by early autumn. Her schedule, my schedule, and Jacobs's odd ways led to a series of midnight negotiation meetings. I never did discover what the clinic was doing there or how and why Jacobs had acquired the lease. He assured us that the authorities would issue a variance on fireproofing. Finally, in mid-March we took possession by handing Jacobs a certified check for \$54,000 at a clandestine meeting in the lobby of our uptown clinic. At his insistence, this occurred at two in the morning. We named Marchieta as administrator, and I enlisted Leonard Elmaleh, a gynecologist at Joint Diseases, as titular Medical Director. Actually I intended to keep a firm grip on the second clinic to keep it from drifting into the same dangerous waters as the Seventy-third Street place had, union trouble in particular. In search of a back-up hospital, I met with Bernard Pisani, the director of obstetrics and gynecology at St. Vincent's, on March 31. He was characteristically cordial, even receptive to my proposal. Still, I entertained serious doubt that a Catholic hospital would in the end commit itself to do back-up for an abortion enterprise. I assigned Elmaleh to look elsewhere, and he obtained a commitment from the New York Infirmary, a general hospital a few blocks away.

Even before our "University Place Center" opened on May 10, we were under orders from the "Proposed Board" of CRASH to get rid of it. They felt, with some justice, that Pyle and I were overcommitted. So from opening day we were already dickering with various entrepreneurs to sell our lease and equipment which by then represented an investment of \$79,000. The clinic, with a staff of twenty or so, was prospering in terms of business, but suffered a serious blow one night in June when robbers took \$18,000 from the office safe. That summer we finally sold out to Bernard Goz, the contractor who had built the clinic. CRASH lost money on the deal and the whole operation became a legal quagmire. Meanwhile, the Seventy-third Street lease was due to expire June 30, and the landlord, who was paid as a "consultant" to the clinic, was making threatening noises about throwing us out. We knew it was just a bargaining ploy to jack up the interim rent. We managed to nurse him along until the new clinic was ready in early October.

If the reader at this point is confused regarding leases, facilities,

and the multitude of other business considerations, he can only imagine my own state of mind at the time. Besides all the real estate transactions, there was another engagement during those months, equally confused and time-consuming. In March we were forced to call an N.L.R.B. union election after the staff activists had corralled the necessary signed cards. Local 1199 won the balloting by 45-25, though the registered nurses voted down unionization. It was an ominous development, since the union was widely known as uncompromisingly tough and tricky in negotiations, and street-wise in picketing.

I doubt that many physicians have had first-hand experience in collective bargaining. For me, it was a revelation. I had been brought up in a well-defined caste system where physicians were respected if not revered by nurses and the lesser minions. At the negotiations I was just another hostile presence on the wrong side of the table, seemingly trying to deprive workers of their due.

Enter Sidney Orenstein, the labor lawyer whom we hired to represent the clinic. Patient and judicious, he was a veteran of many a tough New York labor struggle. When recounting some of his past campaigns his eyes would become a bit clouded as if he had seen the City of Dis and returned, never to be the same again. To accommodate my absurdly crowded schedule, negotiations were held at union headquarters in the late afternoons and evenings. At the first session on April 19, the four elected counselors' representatives were poised across the table, including two who were the most frequently disruptive and recalcitrant. The "heavy" from the union staff was Vivian Gioia, a hulking woman whose very presence announced an invincible determination not to be placated. Her jaw, and the several chins beneath, was thrust out at such an aggressive angle that it appeared to be a hopeless case of malocclusion. Her voice was piercing, her language would make a longshoreman pale, and she was a consummate actress who would fairly weep in describing the past labor abuses at CRASH. If we responded, after a few milliseconds of cerebration and a bellow of outrage and abuse, she would arrange an astonishingly speedy waddle out of the room for "caucus." They presented thirty-one demands, and Orenstein responded with a "no" to each one—*de rigueur* in labor negotiations. Each "no" was accompanied by Gioia's theatrics. Orenstein never lost his composure, but Barbara

Pyle would bob up and down in her chair like a punchy fighter between rounds. Even the imperturbable Liz Goncalves was openly offended by the charges of abuse from the opposition.

There were five more meetings with the union. At the last one, on May 24, the players went in and out of the game with professional-football frequency. On this day I got my first look at Jesse Olson, the executive vice-president of the union. When he took his place even Gioia was a little subdued, and I sensed that all the preceding sessions had been the obligatory prologue, the time of the picadors. Now the matador was in the ring, and the pageant would climax. We ended at 1:30 A.M. with a number of apparently unresolved issues and a threat of a counselor strike in the air, and me heartily sick of these marathons. At a clinic board meeting the following day Pyle, tossing back her hair at a rate which made it appear like a neurological disability, announced that the negotiations with Local 1199 had ended. I was staggered. After the meeting she grinned slyly and said, "Jesse Olson and Sidney [Orenstein] had lunch together today. Everything got taken care of." So this was how it was done. After all the bravura, the powers convene in camera and strike the deal. Nothing dishonest; just another smoke-filled room.

I was and am convinced that no one who has not participated in collective bargaining can claim to understand how America works. But what did those exhausting nights have to do with the cause of abortion? I was sinking ever deeper into the administration of a \$4.5-million-a-year business and feared that I was losing sight of my original purposes. Rather than getting rid of unjust laws and reforming practices, I was ensnared in boards of directors, labor negotiations, bureaucratic and government tangles without end. Late at night, staring into the darkness and feeling my wife, Adelle, moving restlessly in the bed beside me (she was starting to resent the demands of the clinic on my already limited time with the family) I felt the first pangs of doubt. Not about abortion. That was still an article of faith with me. But about how our victory was being transmogrified into some other surrealistic and unrecognizable entity. Then I would fall into a troubled sleep for a few hours, to awaken at the first light, making long lists of things that must be done that day.

With Jesse Blumenthal installed as chief of staff and the nurs-

ing staff moving toward firm organization, we continued to grind out the abortions. In March of 1971 we did ninety a day and were rejecting six patients a day who failed to meet my safety criteria. In April we averaged eighty-two a day and refused only four a day (by now we had circulated a list of the contraindications for out-of-hospital abortions to the referring clergy so some women were screened out before they came to us). We operated from 8 A.M. to midnight, seven days a week.

There continued to be, shall we say, unusual incidents. Alfred J. Williams, "A.J.," was a solidly built Jamaican gynecologist who had joined the clinic after my warnings about the hostility of many counselors toward doctors. "I can get along with anybody, Bernie," he said with an easy assurance. In his second abortion at the clinic he drew a patient at the upper limit, i.e., twelve weeks, and his room was equipped only with an old Sorensen suction machine since all the new ones I had ordered from the Berkeley company had not arrived. He was also stuck with perhaps the most intransigent of the counselors, a young blonde with an attractive face cast in carborundum. She was so seldom known to smile that when she told a friend that she was being harassed by creditors at her door, the friend advised, "Simply smile, honey. They'll never recognize you that way." A.J. asked the counselor to fetch a Berkeley machine. She was familiar with the Sorensen and refused. He finally called the nursing supervisor, and the machine was then wheeled in as requested. While he was seated in front of the patient preparing his instruments, he was suddenly slapped viciously, just below the left temple. The force of the blow spun him around in his chair, and he fell into a leaden lump on the floor. When he was again able to focus his eyes, he saw the counselor standing over him, smiling sweetly while swinging the metal business end of the Berkeley tubing in her hand like a medieval mace. She murmured solicitously, "Forgive me, doctor. Just a silly accident. Are you hurt?" For the next month A.J. told me that he did abortions using only his right eye and kept his left eye peeled for the counselors.

A queer and pathetic phenomenon surfaced in those early months. I began receiving phone calls and letters from elderly physicians, several of whom were pre-eminent in obstetrics and gynecology in New York City, asking me to take them on the

staff. Some were wealthy and certainly did not need the income, but they were a little adrift after their retirement. Others, I knew, needed the money. Some of the supplicants had only recently been outspokenly against my pro-abortion politicking and even more adamantly opposed to ambulatory (walk-in, walk-out) abortion clinics.

I took pity on one man whom I had personally known and respected. He was by now in his late seventies and his hands shook as his rheumy eyes pleaded with me. Gently I tried to tell him that our techniques were new here (he had never even *seen* the suction machine in use) and the counselors often offensive. I finally buckled to his petitions. He lasted three weeks, during which one uterus was perforated, several cervixes were lacerated, and I received an unacceptable number of other complaints. The poor man was a complete gentleman, writing a gracious resignation letter in which he praised our work and regretted his deficiencies. He saved me what would have been the most difficult task I would have faced at that clinic, firing him. Thereafter I did not take on any other retirees.

I had a memorable crisis with another doctor, June Finer. She was a young English physician who had been recruited by Harvey, though she had no residency training in obstetrics. She was extremely slow, but I kept her on. Toward the end of the summer it became unmistakably clear that Finer was in the latter stages of pregnancy. She was not married and was not at all diffident about declaring this fact, and all the patients could see that she wore no wedding ring. Here was a perplexing new question for a pioneer abortion clinic. Would her pregnant, unwed abdomen constitute a tacit reproach to the young unmarried women upon whom she would be doing abortions? Would her presence in effect say, "Look, I'm not married and I'm having my baby. Why not you?" On the other hand, if I fired her I would probably meet a storm of feminist rage, not to mention a possible sexual discrimination lawsuit. Finer and I discussed it one afternoon, and after mulling things over for a week I decided to suspend her employment and invite her to rejoin us after her delivery. Her presence was just too much of an embarrassment for the unmarried patients.

The expected storm broke. I received anonymous notes condemning me as everything from sexist swine to macho pig. (The

barnyard allusions employed by young militants in those years will certainly merit a Ph.D. thesis some day.) There followed crank calls, nasty looks, and more than the counselors' usual reluctance to comply with my directives. None of this bothered me, but Finer leaked to the board that she was considering a suit against the clinic. Barnes took the first decisive action I had witnessed in six months and ordered me to reinstate Finer at doctor's pay but to put her in the back room, ostensibly for "research" but actually to work on the records. Solomonic!

After innumerable bureaucratic delays, false starts, postponements and setbacks; after seemingly endless inspections by the city and state health departments and the fire department; after reams of documents (mostly repetitive) had been submitted to the regional and state health councils to justify our existence; we were finally granted a license. It was August 11, and our official designation was as a "Voluntary Corporation for the Performance of Abortions and Family Planning Services." We were the first clinic in New York City to win a license and only the second in the state; the first was a relatively modest Planned Parenthood operation in Syracuse.

Much of my January pledge to Howard Moody had been redeemed: the injunction had been turned aside, the clinic had been thoroughly reorganized, and the license had been secured. All that remained of my original commitment was to see the clinic into its new quarters. We moved into 424 East Sixty-second Street on Sunday, October 3, and went right to work the following day. In the former garage, Pyle and Hance, with the professional guidance of Bill Berg, had designed a cavernous and rather cheerless but very functional facility. It had ten operating rooms, each big enough for major surgery and connected to a pair of dressing rooms. The counseling rooms were small and airless cubicles across the hall. (We soon heard about that from the troops.) There were two immense recovery rooms, and we finally had a proper record room, accounting office, telephone room, and administrative center. With my own spacious office, I began to feel less like a gypsy. It was clean, sterile to a fault, streamlined. And perhaps the most depressing medical structure I had ever seen. Ten minutes after we arrived I began to miss the familiar anarchy of our Seventy-third Street slum.

Jesse Blumenthal was so pleased with the new place that he felt we could increase our total of ninety abortions a day. Gradually, we did. He also hinted several times that perhaps we should begin doing later abortions in the new clinic, at thirteen or even fourteen weeks. I deliberately ignored his suggestion. Our record so far was unblemished: not one death in nearly 50,000 abortions. I intended to keep it that way. Admittedly, Jesse had evolved into the most dextrous abortionist on my staff after doing 2,000 abortions in a year, but I could not relax the rules only for him, and I could not raise the risks with those less qualified. Ruefully, I reflected that I, the director of this vast enterprise, had never performed a single abortion at the clinic and my deputy had done so many. I had no hesitations about performing abortions, and in private practice was doing four or five early abortions and two or three "salting-outs" in a typical week. But I knew that my clinic underlings were more experienced in this particular technique and thus more swift and adroit than I was.

With all the space at our disposal, however, I felt that we should expand in another direction: male sterilization. Shortly after the move, Pyle and I went to Chicago to observe the workings of an outpatient vasectomy unit whose staff included Lonny Myers, my old colleague from N.A.R.A.L. It seemed perfectly feasible for our New York facility, and the clinic board agreed. But the spirit of improvisation and pioneering had vanished with the move to the new clinic. With a relatively conservative board and a growing air of financial crisis, the project never got under way even though it was approved by the state and added to our license.

Late in 1971 I began to get suspicious about the laboratory to which we were sending specimens of tissue that was suctioned out of the uterus. Months would go by before we would get the official pathology reports back, all stamped in large black letters, PREGNANCY TISSUE. One of my doctors who also suspected that the lab was giving us phony reports decided to prove it. He went to the morgue at a hospital, took a piece of liver tissue from a cadaver, and sent it to the lab in one of our usual post-abortion specimen jars. Six weeks later the report arrived, stamped PREGNANCY TISSUE. I was furious, canceled the contract, and engaged another laboratory immediately.

This was not only flagrantly dishonest, but dangerous. Among other things, an accurate report is required to make sure that pregnancy tissue has in fact been removed. If it is not and the woman is pregnant, it is most likely a pregnancy in the Fallopian tube, a dangerous condition that must be removed. Something else stirred within me. It seemed a cavalier disregard for something that was somehow just a little more than another pathology specimen, something more than "meat" to be sliced, stained, and stared at, or to be washed down the drain as that lab had probably done. Was the fetal tissue to be respected more than an appendix or gall bladder? An affirmative answer to these questions would lead me into seditious thinking, yet I could not escape the feeling that some indefinable act of violation had been committed. At the time, I determined to put this out of my mind.

Though operations ran smoothly at Sixty-second Street, the financial underpinnings became rather shaky. We ran into staffing trouble on Sundays and cut back to six days a week, so the total of abortions and the income declined. The most dramatic problem was the board edict of November 1971 that reduced the fee to \$125. This was below the break-even point due to the fact that one-fifth of the women were done at reduced rates or for free by clergy request. Regardless, lower prices became Arthur Levin's overriding mission as treasurer and Judson's man on the scene. On February 28, 1971, we had audited cash in hand of \$579,204. Eighteen months later the place was in dire straits despite a \$50,000 transfusion from the Scaife Foundation and a \$100,000 loan from a board member. So much for the beneficent reign of the board and Arthur Levin.

I had been systematically trimming the doctors' salaries, but now the board wanted me to cut back to \$35 an hour, exactly half of what it was when I started. Since the doctors did about two abortions an hour, it meant they would get paid \$17.50 per abortion. I was against this and so, naturally, were the doctors. The counselors approved, en masse. I told Levin that this was unjust and demeaning; the board raised it to a munificent \$40 an hour, roughly a \$2.50 raise per abortion.

For the doctors, the halcyon days were over. In early 1972 I had Ben Markowitz draw up a list of the earnings of each doctor and was astonished over one of Hale Harvey's originals who had

stayed on. He practiced obstetrics and gynecology in Tennessee during the week and flew up to New York Friday afternoon to moonlight on the late shift Friday, do two shifts on Saturday, and the early shift on Sunday before flying home again. This weekend job had paid him \$185,000 in eighteen months.

By April of 1972 morale began to plunge, fueled no doubt by the financial instability and the sweeping rumors of further salary cuts, personnel reductions, and even of impending bankruptcy. The longstanding antagonism between the doctors and the counselors sprang alive again. Written complaints from counselors about the doctors started to flood my desk. Doctors complained bitterly about counselors, often with good reason. Doctors formed a delegation to gripe to the board about many real slights, and a few imagined ones. Then another group of physicians rallied, charging that the first group should stop its illegitimate attempts to represent the staff.

And Barbara Pyle began to unravel. She was jittery and suspicious, insecure about her position vis-à-vis the board. She complained of intense insomnia and was losing weight at a disturbing rate. She would be indecisive one moment, then shout commands the next. She became openly hostile toward me, for no reason that I could discern. We barely spoke to each other, and I was later told that she had had my office "bugged" with a microphone to record my conversations.

My own relations with the board also deteriorated. Barnes sent me a memo indicating the board's desire for a full-time medical director without outside practice or hospital responsibilities. This was either a move to force me to commit myself to the clinic full time or to resign, and since the former was out of the question, it could only be a subtle attempt to get rid of me. I discussed the memo with Barnes and, in sharp tones, stated that the idea was unimaginably naïve. Now that things were well organized there was not enough administrative work to engage the intelligence of a competent physician full time. Any doctor who would seek such a job would be either a failure in practice, surpassingly lazy, unusually dull, or in semi-retirement. Most important, I reminded this distinguished patriarch of my field, the man in charge must be aware of what new developments were making their way into gynecologic practice. For the average gynecologist, to be shut away in

an abortion clinic all the time would be a perverse exile. Barnes was unmoved by my arguments, and we parted from that interview rather stiffly. As a matter of fact, the clinic has never had a full-time doctor as its director.

In that late spring I began to be plagued with nagging little doubts and disturbing questions. The episode of the discarded tissue specimens continued to haunt me. Why had I been so upset by that? Why was I becoming impatient and annoyed with Pyle's recitation of the numbers of abortions at our weekly staff meetings? I put it down to fatigue and the fading challenge of the clinic. I was exhausted. Shaping up the operation had been a Herculean job, and now it was finished. Not only that. Ambulatory, low-cost, safe, and humane abortion had been proven to be workable for the entire nation. It was time to move on.

I wrote out a sixteen-word resignation letter to the board on April 17, asking them to make it effective May 1. It was little notice, far too little, but suddenly I was in a hurry to get out of there, to leave abortion. In the cascade of correspondence that followed my resignation, one letter stands out: Howard Moody's response of April 20 asking me to hang on a bit longer. He said he knew there were all kinds of rumors as to why I was leaving, but he also knew that I had my own reasons and he understood that I might think the job was not as rewarding as it had been in the pioneering days of the facility. Though he did not say so, I am convinced to this day that with his special percipience, Howard Moody sensed that something central in me was crumbling.

With my resignation the clinic began to disintegrate, not because I was indispensable but because the vacuum of power became an irresistible temptation to a number of doctors. There are always internecine struggles underneath the businesslike hum of a hospital, but this far exceeded anything in my experience. Open politicking was being done in the corridors. Factions of doctors were forming and dissolving in bitterness and heat, with the nurses siding with this group or that. Ann Bauer, by now director of all nursing personnel, decided that she would rather quit than exist amidst all this anarchy. At my insistence, she stayed on. Several board members called to plead with me to give longer resignation notice. I did so, deciding that it would now be effective September 1. Things calmed down once again.

Howard Moody and I met on April 28 at a restaurant on lower Fifth Avenue. Our conversation avoided my resignation, as though I were suffering from some not-quite-mentionable social disease. Instead, we talked of future projects. I brought to his attention the pathetic plight of patients who required astronomically expensive kidney dialysis and, ultimately, kidney transplants. Back then the costs were not borne by Social Security, and I suggested that we set up a low-cost outpatient dialysis unit. He was much interested, and I promised to research the idea. Just this sort of facility opened in Brooklyn several months later and our project became unnecessary.

I continued to discharge my responsibilities at the clinic that summer, but I was troubled, even resistant, and I was paying less and less attention to the place. I put it down to the certainty that I was leaving, but it was more than that. I was uneasy whenever I was inside the building. I asked Barbara Pyle please to stop reading off the abortion figures at the staff meetings. My daily rounds became shorter and shorter. Whitney Devlin, who had been indispensable to me for eighteen months, had been let go in the financial crunch, and I realized then how much she had shielded me from the many unpleasant and boring tasks an administrator must endure. By August of 1972 it was a triumph of the will for me to sit behind my desk in that antiseptic building.

I proposed the name of a successor, but the board decided instead to appoint Robert Landesman. I had known Bob for years; he had at one time shared offices with my father. I liked and respected him. At my final meeting with the staff on Friday, August 11, I introduced him to the doctors and administrators and wished him well. On Saturday, August 26, I spent a day there cleaning out my desk, packing up my files, and then departed the building one last time.

ANALYZING WHAT WE LEARNED

At the weekly administrative staff meetings of CRASH, each department head would offer a report in turn, after which Barbara Pyle would present the totals of appointments made, rejections, no-shows, and abortions done. She read off these figures week after week, month after month, with that sanguine and faintly gleeful quality that radio announcers affect on long holiday weekends as they recite the latest number of highway fatalities. One can almost discern in their manner a covert rooting for a new record, perhaps to relieve the tedium of the statistics. One forgets in listening to the numbers that these are human bodies, mutilated in appalling automotive disasters. Similarly, as Pyle read off her statistics, all of us forgot that these were little human cataclysms, bloody and often unforgettable to those involved. Only at the end did I myself develop a pronounced distaste for the recitations.

In our busiest era we reached an average of one hundred abortions a day, seven days a week. Abortions on this scale had never been processed anywhere in the world, and have not been since. With the sudden elimination of the nation's abortion laws in 1973 and the end of the droves flocking to New York City and other abortion meccas, it is possible that no clinic will ever be

that busy again. During the months under Hale Harvey and my own year and a half, CRASH did 60,000 abortions. What did we learn from this unique experience?

One of our early innovations was to give each woman a follow-up questionnaire before she left, to be mailed back two weeks later. The form dealt mainly with her health after the abortion and her residual impressions of the clinic's treatment. Besides the questionnaires, we maintained a "hot-line telephone" on which patients could call us collect to report any medical difficulties or to query us about any other unusual developments. The phone was answered day or night by the senior physician on duty. We thereby managed to assemble a fairly satisfactory picture of our immediate medical results, and also the more remote problems.

Sometimes the follow-up information was provided in less friendly ways. In June of 1971 I received a waspish letter from a prominent Nebraska physician whose anti-abortion views were evident. It seems that a woman with an incomplete abortion had to be treated back in Nebraska four days later. He stated that it was "tantamount to malpractice" to release a patient after a "poorly done job" and leave others to be "responsible for your medical errors." He then raised questions about our policy of directing patients to phone us collect if they had any problems, interpreting this as providing medical care via long distance. He said the phone policy should be ceased and concluded, "either do your job right or don't do it at all."

Whether this physician, mottled with indignation, was objecting to the entire practice of elective abortion, to outpatient abortion, or to poor abortion technique (probably all three) was not clear. As it happened, this woman was not "ours" at all. She was over the twelve-week limit, and we had referred her to a hospital. The Nebraskan missed the point of our "hot-line" consultation policy, which was not to practice medicine via the Bell System but simply to advise women on what conditions were normal and could be disregarded and which ones required immediate medical attention and where to find it. In any case, I felt that this letter—unlike most of the hundreds of letters and phone calls I was receiving weekly—required a response, and it went as follows:

Dear Dr. ———:

We are most grateful for your thoughtful letter detailing the case of Miss ——. . . . When physicians of other states gather their courage together and dedicate themselves to modernizing their abortion laws so that New York State is not required to do the work of the entire country—including Nebraska, Doctor—then hopefully our burden will be lightened and Nebraska's women will be able to obtain that unexceptionable medical attention implicit in your note to us.

Your obedient servant,
Bernard N. Nathanson, M.D.

Besides the questionnaire and the "hot line" for patients from out of town, in the spring of 1972 we organized a follow-up clinic for our patients from the New York metropolitan area. One of the principal former criticisms of our operation was that our patients returned to their hometowns and that we had inadequate information regarding their health thereafter. Though the follow-up clinic could not meet this criticism for the substantial number of patients who were coming from the Midwest, especially Michigan, it could check on the large number from nearby New Jersey and Connecticut. We conducted the clinic in the evening to attract as many working women as possible. Besides examining them to evaluate the results of their abortions, we did Pap smear tests for cancer, reviewed birth-control methods with them, and interviewed them regarding the emotional impact of the procedure.

From the mailed-in questionnaires, which had a return rate of about 60 per cent, and the interviews, I was surprised to learn that the overwhelming majority declared their relief at the abortion. A number spoke of regret, a few of remorse, but only a handful admitted any feelings of "guilt." Since the questionnaires were unsigned (though the chart number on the form could be matched against a patient's file if necessary), I felt reasonably certain that the responses were candid. They confirmed many of my privately held opinions derived from referring women for abortions in the '60s and interviewing them afterward, as well as talks with patients on whom I had done abortions myself since then. From the clinic interviews, we learned that we were doing a good job in terms of health, but that our lavish attention to counseling was problematic. Each patient spent forty-five minutes alone with a

counselor, but they retained little or nothing of the information. Most had forgotten completely everything that they had been told about the abortion procedure, and a disturbingly large number had paid little attention to our birth-control instruction.

Curiously, abortion appeared sometimes to have had a more profound effect on the people who were doing them than on those on whom they were being done. I recall one frantic day in the summer of 1971 when Don Sloan collared me and insisted that I listen to a story. He was shaking his head in disbelief, which was intriguing in that Sloan had been through the worst of the Harvey days at the clinic. He told me that he had just finished aborting a mother and a daughter, one right after the other. "Bernie, I swear to you, it was the most incredible experience I've ever had here. The mother is thirty-seven and a real wisecracker. The daughter is eighteen, and her mother talked her through it. At the end the mother came out exclaiming, 'Wow, isn't it wonderful? We had the same doctor.' She was euphoric and flushed with success." The episode was more unsettling for the doctor than for the patients.

I also recall well being cornered by the wife of one doctor at the cocktail party we gave when the Sixty-second Street clinic opened. She drew me aside and talked in a decidedly agitated manner of the increasingly frequent nightmares her husband had been having. He had confessed to her that the dreams were filled with blood and children, and that he had latterly become obsessed with the notion that some terrible justice would soon be inflicted upon his own children in payment for what he was doing. Another time, the wife of a second doctor, who had done at least 2,000 abortions at the place, phoned to report that her husband had developed a serious drinking problem over the past year that, in her view, was precipitated by the clinic work. Yet another doctor walked into my office after three weeks on the job and submitted his resignation. He declared that he had absolutely no feelings on the morality of abortion as such, but "when I'm up this close to it, it's just too much for me. Too bloody, too much pressure. You guys are turning out abortions here like it's an assembly line, and you expect us to work at this with no feelings at all."

Then there were those who responded to the siege mentality of the place. During the early period of the clinic, abortion—and par-

ticularly ambulatory abortion on the mass scale—was still a *bête noire* of the obstetrical establishment, and those physicians who were participating in it were deemed to be prostituting themselves. To add to the reality of it, our waiting rooms, even the lobby downstairs, often could not accommodate all of the waiting patients when we were in the old building, so that young women or couples would park themselves on the stoop of the entrance and up the Seventy-third Street sidewalk. Periodically, residents of the block would get up a petition to try and close us down, similar to the reaction that a methadone clinic for heroin addicts provokes when it is established in the neighborhood. Add to that the series of demonstrations by shrill Right-to-Life groups outside the building, intimidating and screaming insults at patients, counselors, and physicians alike as they entered. One can understand how the staff, under these conditions, would put individual differences aside and hunker down together for long stretches. This fellowship was not an unalloyed blessing. A number of furious doctors' wives phoned to accuse me of running a house of prostitution, with their husbands taking up with the counselors or nurses. I count the marriages of four physicians that broke up during my tenure, and countless other affairs which flowered, secretly and not-so-secretly.

Huddled together in that besieged enclave, conniving in this twilight zone of surgery, the doctors and the counselors created a curious chemistry indeed. Beards, moustaches, and shoulder-length hair germinated on some hitherto thoroughly respectable and conservative medicos. One middle-aged gentleman with impeccable Ivy League credentials and a comfortable practice in the suburbs would, upon arrival at the clinic for his shift via motorcycle, shed his gray pinstripe suit and change into cowboy boots and tiny blue-hued granny glasses that perched halfway down his nose. I recall one militant counselor who dressed in nothing but coarse denim shirts and Chinese Army trousers (she was a devoted student of the various martial arts on her evenings off). She conceived a middling passion for an elderly physician who was thrice a grandfather and eventually melted to the extent that she now wore nothing but 1930-style dresses and ballet slippers.

This strange medical mission had a professional impact upon me. During 1971 I was more than ever a pariah in organized ob-

stetrics and gynecology. Running a clinic was one circle within my open advocacy of liberal abortion, which was bad enough. Now many former colleagues and friends were treating me with open contempt. Our limited social calendar fell away to virtually nothing. The only physician in the Establishment camp who went out of his way to offer me the slightest recognition was the extraordinarily kind Harold Schulman at the Albert Einstein School of Medicine. In late 1972, probably after considerable resistance from his colleagues, he invited me to address a district meeting of the American College of Obstetricians and Gynecologists on non-hospital abortion. Schulman, a brilliant clinical researcher and superb organizer, subsequently became the department chairman at Albert Einstein.

I was quite aware that no individual effort of mine could hope to roll back the resistance and make abortion respectable. Only time could do that. Nevertheless, one of my aims was to make ambulatory (walk-in, walk-out) abortion safe, low in cost, and acceptable to established obstetrics and gynecology. No amount of public lectures could hope to accomplish this. The only way to reach the goal quickly was to build an excellent record and then publish the clinic's methods and results in a respected medical journal. Accordingly, I consulted with Glen Martin, the director of our record-keeping operation, and requested that he gather all statistics from the start of the clinic (July 1970) through August 1971. What a job that was! Until I had taken over, records got minimal attention. Patient charts were disorganized and often illegible. The records of the early months were scattered all over the place. Nevertheless, Glen persisted and by November all the figures were in presentable form. Despite the frequency of out-of-towners, our data on medical results were good because of the phone-in service, the tendency of referring clergy to complain at the slightest problem, and the fact that we offered to pay for any abortion-related medical problems later on.

I sat down and composed a paper which I felt fairly reflected our medical experience and sent it to the *New England Journal of Medicine*. Not only is this perhaps the most widely read medical publication in the world, but it is also known to be among the most exacting in what it accepts for publication, and its contents are closely monitored by the lay press. The *Journal* quickly ac-

cepted the article, and it was published in the February 24, 1972, edition. It was one of the first comprehensive reports on outpatient abortion, and by far the largest such population ever studied. Our record of minimal adverse results and excellent safety, detailed later in this book, was something that I took pride in. It was also something that would help the cause tremendously. My article was accompanied by an editorial written by Christopher Tietze, a universally respected biostatistician who specialized in birth control and abortion. He declared ambulatory abortion to be a safe alternative to hospital abortion in early pregnancy, and praised CRASH for its organization and procedures. We—abortion, ambulatory abortion, the clinic, Bernard Nathanson—were on the map.

Shortly after that I managed an affiliation with the Cornell Medical Center. Its Department of Public Health began sending third-year students to our clinic as a "field trip," and we initiated discussions with the nursing school about sending student nurses down for exposure to an abortion clinic. Leslie Strom, from the University of Chicago, came by to do research on the psychodynamics of abortion. George Silver, a professor of public health from Yale, was also most interested in the workings of our operation. Through the U.S. Department of Health, Education, and Welfare, a team of doctors from Panama visited the clinic in January 1972 to find out what mass-scale abortion was all about. Once an outcast, the clinic was beginning to attain the exalted status of a teaching institution.

Because the Supreme Court decisions of January 1973 were based so heavily on the safety of abortion rather than consideration of the traditional rights of the fetus, it is quite possible that the record compiled by the Center for Reproductive and Sexual Health had some bearing on the current state of the law. In an article in the *New York Times* of March 19, 1973, I was quoted on the implications of those Supreme Court rulings as follows: "In its ban on regulating first-trimester abortions, the court cited the 'now-established medical fact of safety.' Everybody knows that this 'medical fact' was established here, and that the court relied on the data, experience, and abortion-safety record of New York City." I added, with a bit of irony, that the "fact" of safety had been established by just the sort of strict medical regulations

which the Supreme Court had now outlawed. Further in the article there was an enigmatic sentence that indicated my general unease about the inadequacies of the justices' superficial and incomplete understanding of medicine. "Dr. Nathanson noted, along with others, that the future might have been clarified more by a decision in which the court would have said, 'We're legal men, not medical men.'"

LOBBYING

During and between the assorted crises in reorganizing the clinic in 1971 I was simultaneously making innumerable public appearances as the medical chairman of N.A.R.A.L. There were quick jaunts up to Maine for a state legislative hearing on that state's mother's-life-only law; to Syracuse Planned Parenthood; to Madison, Wisconsin, for a conference on out-of-hospital abortions set up by Pat Maginnis's Society for Humane Abortion; to Columbus, Ohio, to address the Riverside Methodist Hospital staff on abortion referral problems; and to East Lansing, Michigan, to tell the Michigan State Medical Society how our new New York law was working. Around New York, among other engagements, I spoke to the Metropolitan College Mental Health Association, the New York Women's Bar Association, and—to a much cooler reception—the abortion hearing sponsored by Harlem Women for Better Health. I also addressed a prestigious conference on abortion technique sponsored by Planned Parenthood, the American Public Health Association, the American Medical Women's Association, the National Medical Association, and the Association for the Study of Abortion.

It was at the latter conference that I had a serious and sadden-

ing misunderstanding with that revered gentleman, Alan F. Guttmacher, at the time president of Planned Parenthood-World Population. I had been asked to participate in a panel on "Administrative Aspects of Abortion" and to discuss in some detail the question of hospital abortion committees. It was a difficult and paradoxical assignment, since I had played a leading role in discrediting them. In the discussion, I likened the abortion committees to the birthing of the Edsel automobile. However, this was June of 1971 and eleven states still required such committees by statute, so something serious had to be said. I indicated that they were undemocratic in that women physicians were almost never asked to serve; physicians known to be opposed to abortion were never asked to serve; non-physicians, even nurses and social workers who often have a more comprehensive view of abortion, were never invited to attend committee sessions. I went on to describe in some detail how anonymously these committees operated, and anatomized how we had mocked and virtually destroyed the committee system in New York through the "psychiatric caper."

After assigning the role of *accoucheur* of the abortion committee system to, among others, Alan Guttmacher, I concluded with this blast: "What can one say of a system as fragile, as undemocratic, as vulnerable to political and social pressures, and as morally corrupt as the abortion committee system? Only that the right of choice in abortion resides solely in the pregnant woman. In most cases, a committee of learned physicians did not impregnate her, and a committee cannot decide the disposition of that pregnancy."

Guttmacher was in the audience, and he rose to his feet. He was flushed and his voice shook a bit as he answered me. At the end of World War II there were *no* abortions, not even therapeutic ones, being done in hospitals under surgically clean conditions. The committee system that he and others had designed was a tiny but significant fracture in the monolithic wall built against abortion by the late '40s and early '50s. While he and a handful of others had fought courageously and often at great personal expense for even this small beachhead, I was still in medical school.

He had taken my address as an *ad hominem* attack, and I was chagrined, crushed. I liked and deeply respected this man. I rose

to my feet and publicly apologized to him. I declared that I had been uncharitable, inaccurate in my interpretation of the events of the '50s, and incautious and severe in my judgments. I publicly begged his pardon and lauded him as one of the great men of American obstetrics and gynecology. I meant every word of it.

A week later, I received the following letter from Guttmacher on his Planned Parenthood-World Population stationery:

Dear Bernie:

I apologize for exploding at Saturday morning's meeting, but I believe your remarks gave me good reason to do so.

I am very grateful for your retraction, and trust that our brief exchange will not interfere with our friendship. I admire very much what you are doing.

With warm personal regards,
Alan

During this period our dream of setting a standard for clinics across the United States was in constant danger of being ended abruptly in Albany. Early in 1971 it became clear that our 1970 victory in the legislature was merely a sunny lull in the usually stormy abortion climate. There were nine new abortion bills in the Assembly and eight in the Senate, all seeking to dilute or roll back the 1970 achievement. In the Senate, the Donovan bill would exclude Medicaid funding unless the mother's life was in danger. Various bills from Senator Edward Speno would require six months of state residency, restrict abortions to hospitals, and cut the time limit from twenty-four to twelve weeks of pregnancy. The Schermerhorn bill would repeal the liberalization altogether. Bills in the Assembly were similar. Even Governor Nelson Rockefeller, whom we thought we had in our pocket, began to waver a little, avoiding questions on abortion and generally acting a little cool toward the whole business.

Larry Lader and I began conferring again, two, three, or four times a week in addition to regular N.A.R.A.L. meetings, to design our lobbying strategy. In December 1970, hoping to build real political muscle that could be flexed as needed, we got forty pro-abortion organizations to unite in one mighty army called the Coalition for Abortion Rights. Members ranged from the local Humanist Society to the Workmen's Circle. N.A.R.A.L.'s Ruth Smith was one of the four leaders. This *enfant terrible* died of

acute anemia within a month; no one wanted to feed the poor thing with any money, though a N.A.R.A.L. press release as late as March 25 dropped mention of lobbying on behalf of the Coalition and its dozens of member organizations.

N.A.R.A.L., too, was desperate for money to carry the fight to Albany. In early 1971 we landed a \$2,500 donation from the Playboy Foundation. (Well, money was money, especially in the hard-pressed pro-abortion garrison.) We then figured, why not go to the people who were making the money out of abortion, the obstetrician-gynecologists? Lee Gidding and I drafted a simple appeal for funds to the doctors. We pointed out that the new law gave them the right to advise their patients and practice their profession by sound medical judgment without state meddling or fear of prosecution. It was, I felt, a persuasive and moving appeal. The letter went out to the 1,556 obstetrician-gynecologists in New York State whose addresses we were able to get, over my signature and that of Carol Greitzer as N.A.R.A.L. president. As an aside, we asked at the end that they add their name to a statewide doctors' committee backing the new law. At the time I was one of perhaps a half-dozen physicians in New York State who were publicly committed to the liberalization. We raised a grand total of \$707 through this tactic, and recruited thirty-six doctors who expressed some further interest in the issue. The medical profession at large appeared to consider itself less than slavishly in our debt.

Our next project was to enlist twenty-four organizations in the state, ranging from chapters of Americans for Democratic Action to Zero Population Growth, to join in a letter-writing campaign by their members to the legislators. Seven abortion clinics also promised to ask their patients to write letters. At the first N.A.R.A.L. meeting after I took command of the abortion clinic, Lader listened a bit abstractly to my recitation of problems and then reminded me that he and I were scheduled to testify the following week before the state Senate's health committee on the issues of lowering the abortion time limit (N.A.R.A.L. opposed this), imposing a residency requirement (also opposed), and restricting abortions to hospitals and clinics (N.A.R.A.L. held that abortions should be allowed in doctors' offices, too, though by now I secretly disagreed with the organization's line). Due to other entanglements, I never did testify.

On February 13, Robert Hall, an obstetrician-gynecologist at Columbia and a founder of the sedate A.S.A., published an op-ed piece in the New York *Times* calling for the residency requirement as well as the hospital-only restriction. Larry believed fervently that we could not compromise one iota and that we had to retaliate. Arlene Carmen got off a slashing letter to the *Times* characterizing Hall's piece as an example of medical hypocrisy. She pointed out that this same Doctor Hall sent many of his own patients to Judson Church's consultation service to get referrals to humane abortionists *elsewhere* in the country. His last patient was heard from just a month before the liberal law took effect. It was a skillful attack on the hospital and residency requirements.

We benefitted from a strong no-change declaration from the board of the city's Health and Hospitals Corporation, and from the March 14 release of a survey supported by the Population Council and conducted by the community health department at Albert Einstein Medical College. It showed that just after the new law went into operation, 59 per cent of the obstetrician-gynecologists in the state said they favored the liberalization. Six months later, support had increased to 67 per cent. Catholic obstetricians favoring the new law had risen from 23 per cent to 31 per cent in the same period.

The women's movement drew a healthy turnout of "sisters" to the Capitol steps in Albany for a March 27 rally on behalf of no-cost abortion on demand. Then Governor Rockefeller placed a ban on Medicaid payments for abortion for 90 days, pending the legislature's action on this. (Five weeks later the order was annulled in the State Supreme Court by Justice Samuel A. Speigel, who declared that it violated the equal-protection and due-process guarantees of the U. S. Constitution.) The seeming *coup de grâce* came April 3. President Richard M. Nixon ordered military bases to follow state laws on abortion and, along with it, included a personal statement against abortion. I got three phone calls from Larry that weekend, each more wrathful than the last. We just *had* to get something together to counter this. We considered it an unparalleled interference in state affairs by a federal official, even though Nixon had said nothing specific about state disputes. (In other times and contexts, of course, liberals welcomed such federal interference.) As one reads Nixon's order today in ret-

respect it seems rather modest in tone and scope. The nub of his statement was:

From personal and religious beliefs, I consider abortion an unacceptable form of population control. Further, unrestricted abortion policies or abortion on demand I cannot square with my personal belief in the sanctity of human life—including the life of the yet unborn. For, surely, the unborn have rights also recognized in law, recognized even in principles expounded by the United Nations.

Even in N.A.R.A.L., no one was espousing abortion as a means of population control. We pitched our campaign to the right of free choice for women. And Nixon had gone on to plead for recognition of the other rights involved in the issue. But this was 1971, and the most unpopular war in the nation's history was still a festering ulcer in Asia. Predictably, the *New York Times*, more in anger than in sorrow, missed the entire point and took Nixon to task for "inhumanity and social irresponsibility" and berated him with the usual farrago of free choice, welfare chaos, and of course, Viet Nam. We were delighted. A skewering of Richard Nixon combined with a pro-abortion plug was an embarrassment of riches.

On May 11 N.A.R.A.L. called a press conference at the Willkie Memorial Building on Fortieth Street. Mary Lindsay, wife of the mayor of New York City, headed our all-star lineup of prominent women. Firmly and without equivocation, she deplored the efforts to return the law to its former state of darkness. But efforts to force through repeal or the various limitations soon subsided. Instead, the legislators contented themselves with passing a law prohibiting the sale of medical referrals. N.A.R.A.L. favored this bill and was satisfied with the successful holding action in the 1971 legislative session.

Referral agencies were an old problem in the abortion subculture. Certain entrepreneurs had established commercial find-an-abortion services before the 1970 repeal. One of these was the British Referral Service and Travel Agency Inc., which specialized in four-day trips to London for abortions. For \$1,175, the woman got a flight over and back, was met at the airport by a limousine, put up at a local hotel with all meals provided, and aborted at a

private clinic. Of the fee, \$575 paid for the actual abortion, and \$155 went to the agency for the information on where to get it. This in contrast to Howard Moody's Clergy Service, in which women were counseled by concerned clergy and referred to an abortionist if they wished, all without charge. One of the backers of this commercial agency was alleged to be Roy Lucas, Esq., the same man who was so deeply involved in various court actions against restrictive laws and who sat on the N.A.R.A.L. board.

The issue of the legitimacy, even the legality, of the for-profit referral agencies continued to simmer. In February of 1971 state Attorney General Louis Lefkowitz held hearings to consider whether to regulate or even ban these outfits. A number of women testified that they had been swindled or hoodwinked. Among other witnesses were the redoubtable Howard Moody and my recently phased-out doctor at CRASH, Richard Hausknecht. Surprisingly, Moody did not call for an outright ban on profit-making agencies nor categorically condemn them. Rather, he favored "strong regulation," at least until non-profit agencies such as his own and Planned Parenthood could handle the load. Hausknecht grandly announced that he had been offered an annual salary of \$250,000 to direct one of these agencies but had refused; the agency involved neither confirmed nor denied his statement.

The new law prohibiting profit-making referral agencies took effect on July 1, 1971. The Abortion Information Agency (A.I.A.), one of the largest of these businesses, filed suit, contending that the new law restricted the free flow of information and discriminated against the profit-making operations. Roy Lucas was hired by the regular counsel of two of the larger agencies to represent them in the case. The state Supreme Court found that the A.I.A. was indeed illegal and ordered it shut down; an appeal of that decision was lost 4-1 in the Appellate Division. The appellate justices stated that the agencies acted as brokers in the sale of professional services and thus had carried out fee-splitting in violation of state law and were engaged in the illegal practice of medicine. In an added flourish they stated that "from the beginning to end, A.I.A.'s operation has the appearance of one conceived in fraud."

That was not the end of it. Larry continued to fume over Lucas' acting as counsel for the agencies. We had a number of

conversations about this through the summer and early fall. I was rather lukewarm on the subject, partly because of my preoccupation with the clinic's move, partly because of the situation itself. True, Lucas had been alleged to be a backer of just such an agency in the past, but we had no absolute proof of that. He was now acting solely as an attorney and I saw no difference ethically between that and the defense of some other unpopular cause such as the Communist Party or even, in other years, abortion itself, granted that we considered the for-profit referrals to be unethical.

But Larry's indignation grew like a malignant tumor. He finally moved to have Lucas thrown off the board of N.A.R.A.L., circulating a letter to Executive Committee members stating that no board member should be making high personal fees defending commercial referrals, and that Lucas was in opposition to N.A.R.A.L.'s stated policy on such agencies, which left us exposed to public attack. Lader further indicated that a phone call from Howard Moody had been instrumental in his decision to purge Lucas. The enigmatic Moody then tore off a telegram to each member of the Executive Committee in which he ferociously disassociated himself from the dump-Lucas effort and accused Larry of misusing his name and that of the Clergy Service in the internal N.A.R.A.L. struggles. He concluded with a searing blast deeply resenting Larry's manipulation and disregard for his wishes in the matter. He opined that Larry should take full responsibility for his own actions and not use others to prop up his own position.

Larry was as close to abject humiliation as I had ever seen him in our long and wearying struggle. He found it impossible to fathom why Moody insisted on playing a lone hand in the wars, why Moody would grudgingly tolerate coalition but never partnership. It was a matter of record that Moody had been a bit soft on the profit-making agencies, having at first called for their regulation rather than extinction. (He must have carefully rethought that puzzling stance for one who was the leading public advocate of non-profit referrals, for two weeks after his public testimony he submitted written testimony to the Attorney General calling for a strict ban.) Five days after Moody's vicious attack, Lader sent him a conciliatory letter, blaming it all on a lack of communication

and pleading for rapprochement. The letter, to my recollection, was never acknowledged by Moody.

The effort to purge Lucas continued nonetheless. Professor Cyril Means weighed in (he could hardly have been overcome with grief at seeing his leading rival in the N.A.R.A.L. legal commissariat about to be dishonorably discharged), saying that if we expected to be taken seriously as a lobbying organization by state legislatures, we could hardly elect to the board lawyers who were identified as professional advocates of businesses that exploited women and against which N.A.R.A.L. had actively lobbied. He compared it with the American Cancer Society having on its board a lawyer who had represented the American Tobacco Institute in its efforts to restore cigarette ads to the airwaves.

Lucas responded with a stinging counterattack on October 1. In a letter to all board members he accused the current N.A.R.A.L. leadership (or rather, Ladership) of contributing virtually nothing to the court cases he was pursuing on behalf of unrestricted abortion. He berated N.A.R.A.L. for being interested only in holding press conferences to announce or to pretend involvement in court cases in which it was in fact not involved. In a swipe at Means, he portrayed the leaders as being unable even to put together a friend-of-the-court brief in either of the two cases before the U. S. Supreme Court. In all this, Roy Lucas was pointedly accurate. He had spent much of the year preparing the friend-of-the-court brief in these cases in the name of my professional association, the American College of Obstetricians and Gynecologists. Lucas was in the middle of what turned out to be the real abortion war, waged within the quiet chambers of the federal courts, while N.A.R.A.L. was expending itself in Larry's specialties, political lobbying and publicity.

As to the issue at hand, Lucas denied knowing that N.A.R.A.L. policy favored total abolition of commercial agencies. More telling was his statement that a commercial agency had the right to retain any lawyer it wished. He went on to say that the fact that he was hired (actually by the regular counsel of the agencies, not the agencies themselves) did not mean that he had an opinion personally as to the legal issues of the case. In a parting shot, foreshadowing later developments within N.A.R.A.L., he wondered if perhaps it wasn't time for a shift of the leadership and national

headquarters out of the eastern part of the country into the Midwest or West.

The Lucas matter dominated N.A.R.A.L.'s annual meeting in Washington, D.C., in October 1971. A sizable Midwest contingent lined up with Lucas, who had cultivated quite a folk-hero image there through defending various doctors and clinics. Lucas himself did not attend, preferring to delegate his defense to his Midwest champions, and they did not let him down. They succeeded in delaying action pending a ballot when things had cooled down. Larry kept at it, and by December 14 Lucas was out in a mail ballot that went 108-54. Several years later, when the Midwest faction led by Robert McCoy (a Minnesota steel salesman and ardent Humanist) gained control in N.A.R.A.L., Lucas was reinstated.

Meanwhile, another litter of legislation was tumbling out of the hoppers in Albany designed to emasculate or repeal our 1970 law. We activated the old reliable N.A.R.A.L. machinery: press conferences, circulars, floods of statistics on the safety of abortion, and the dramatic reduction in maternal mortality. Perhaps the single most dramatic figure was the drop by nearly half in hospital admissions for "incomplete abortion" (including infected induced abortions and "miscarriage") in New York State. The "incompletes" were usually the infected ones, leading to the grisly consequences described above. The pre-repeal total for 1969 was 6,524 and in 1971, the first fully open year, it was 3,543.

The abortion movement summoned a mass demonstration in Albany on the Capitol steps for May 8, 1972. I caught an early bus to Albany to join it. The day was cold and dank. Though we had been told that the demonstration would be as tightly executed as an amphibious landing, when I made it to the Capitol there was the usual uncertain milling around and hailing of old comrades ducking in and out of the rain. I bumped into Howard and Arlene and they informed me that the delegation of doctor-lobbyists had already left for an audience with Rockefeller. (In fact, they never got to see the Governor that day.) I hurried into the building after them, ran down and up countless staircases, and asked numerous onlookers where my group was. All I got for my pains was an ineradicable memory of mass lobbying. There were knots of wild-eyed, straggly-haired women chasing panicked legis-

lators through the Capitol halls. One breathless solon dove into a broom closet just behind me, and just ahead of a hunting party of seven angry squaws. He implored me to stand in front of the closet door and pretend that I hadn't seen him. I decided to misdirect the harridans as he had asked. When I turned back to do a little more mannerly lobbying with him myself he had already slipped out of the closet and fled. Disconsolate, I elected to skip Moody's impassioned sermon-in-the-rain at the steps and took the next bus home.

President Nixon butted in again on May 6 with a letter of moral support to Terence Cardinal Cooke, leader of the anti-abortion forces. Whether due to that, to the overwrought overkill of the feminist lobbyists, or other causes, the Assembly voted 79-68 on May 9 to repeal the liberal law. The following day the state Senate did the same, by 30-27. Now all that stood between us and a return to the dark, desperate days of the old restriction was that quintessentially political creature, Nelson Rockefeller. All we could do was wait. Rockefeller had earlier indicated that he would veto such a bill, but he was staying mum. No trial balloons, no press leaks, no public waffling. Suddenly on Sunday, May 14, we got word that he had vetoed the bill the previous day. Our law—our crusade—was safe for one more year! The next day Larry and I had an excited exchange of phone calls, chortling in particular over the way in which our trusted ally, the *New York Times*, had phrased its editorial on the veto. The fourth paragraph hooked the Catholic Church in for us again, keeping intact the carefully orchestrated image of the opposition forces. That reliable old straw man with the turned-around collar was still an irresistible target for the *Times*.

By the next legislative session, of course, there was no more cause for rallying, or for worrying. In January of 1973 the U.S. Supreme Court read final unction over all laws against abortion in all fifty states.

During the legislative crunch of 1972, I began to skip more and more of the N.A.R.A.L. meetings which I had so religiously attended in the past. Larry sensed my waning enthusiasm and gave me several pep talks that spring. I responded that the Rockefeller veto made us safe for another year and that old laws were being

declared unconstitutional in courts across the country, which augured well for our cause in the U. S. Supreme Court.

In the fall of 1972 there arose a distasteful episode within N.A.R.A.L. which further dampened my already moist ardor. Up to that point Larry Lader had invested untold hundreds of hours carrying out his duties as chairman of the Executive Committee and later as chairman of the board. The time spent on N.A.R.A.L. duties represented a substantial sacrifice on his part. Still, others had contributed lavish time and effort as well, Lader appeared comfortably fixed, and despite his abortion politicking he had found time to turn out an encyclopedic book on sterilization, *Foolproof Birth Control: Male and Female Sterilization*, which came out in January 1972. (He wrote the following inscription in my copy: "For Bernie—who has made such a devoted contribution to abortion, and every part of the movement. With gratitude and affection, Larry Lader.") By now he was well into the writing of his second book on abortion, which was to appear in 1973: *Abortion II: Making the Revolution*.

In any event, Larry now wanted to be paid for his time spent as board chairman. This, of course, presented some sticky questions which were raised by that conservative watchdog Ruth Proskauer Smith. With justice, she pointed out that it was virtually without precedent for a board member of a non-profit agency to be salaried. Resisting her, Larry demanded half-time compensation at the rate of \$18,000 a year. That was a large figure for an organization that was too political to win tax exemption and therefore encountered much difficulty in obtaining contributions. The Executive Committee, of which I was a member, sustained Larry's petition in a vote of 10-2. I voted to back Larry, but sorrowfully and with reluctance. Smith's arguments were well-taken, and it took every ounce of personal loyalty I could muster to vote with Larry. The board at large later sustained the salary in a mail ballot. Larry was made the executive director, and the capable Lee Gidding was shoved into the new slot of executive secretary, which prompted a howl of indignation from her and required considerable soothing of ruffled feathers.

This was the last major issue on which I participated in N.A.R.A.L., though I remained on the Executive Committee for some time thereafter. The episode succeeded only in blurring

Larry Lader's hitherto irreproachable image as a high-minded and dedicated citizen. It proved to be a festering sore with the Midwest faction which, in alliance with the old conservative element in N.A.R.A.L., ultimately unseated him and shifted the headquarters to Washington, D.C.

At the annual N.A.R.A.L. meeting in Detroit that fall I gave the final address, titled, "Analysis of Free-Standing Clinics," a recitation of our clinic safety record which I had delivered elsewhere. There was no mention in it of my leaving the clinic or of my well-shielded, half-formulated doubts. I left right after my speech without bothering to hang around for the final N.A.R.A.L. board and Executive Committee meetings after the plenary session. I felt a little uneasy and increasingly impatient with the same old slogans, the tired old cliches, the indiscriminating acceptance of all those shibboleths and battle cries and stereotypes that had passed for arguments over the previous four years. I felt a stranger in their midst, as if I had somehow bloodied myself in the cause, and they were still clean and dry.

“DEEPER INTO ABORTION”

The news of the Supreme Court's abortion decisions broke on the same January day of 1973 as did word of Lyndon Johnson's death. Curiously, of the two events, I was more interested in ruminating about the former President. I have always been interested in political history, and to me he was a mysterious figure. How could such a consummate politician have allowed himself to get trapped in the Viet Nam quagmire? Of course, I was pleased with Justice Harry Blackmun's abortion decisions, which were an unbelievably sweeping triumph for our cause, far broader than our 1970 victory in New York or the advances since then. I was pleased with Blackmun's *conclusions*, that is. I could not plumb the ethical or medical reasoning that had produced the conclusions. Our final victory had been propped up on a misreading of obstetrics, gynecology, and embryology, and that's a dangerous way to win. But as Vince Lombardi said, "Winning isn't everything—it's the *only* thing."

My relative disinterest in the abortion rulings is explained by the fact that on the day after New Year's of 1973 I plunged into a new phase of my career, as the Chief of Obstetrical Service at Woman's Hospital, St. Luke's Hospital Center, one of the best-equipped and busiest departments in Manhattan. I had left the

abortion clinic in a state of exhaustion and had just resigned the gynecology directorship at the Hospital for Joint Diseases, planning to avoid any more large projects or administrative positions. But upon my return from the family vacation in Europe, Harold Tovell, the director of the over-all obstetrics-gynecology department, asked me to assume the position at Woman's, and I felt that I simply had to do this, as something of a balance to the medical work I had performed previously. The four years in that post were to have a critical impact upon my thinking about abortion.

One of the first things I did in 1973 was to supervise the establishment of a sophisticated perinatology unit at Woman's, with Tovell laboring valiantly to raise needed funds for fetal electronic heart monitoring machines and other expensive equipment. One of the great underreported medical revolutions of our time is this field of perinatology, the intensive investigation and treatment not only of the newborn baby but of the fetus, this enigmatic organism that, only months before, my charges at the abortion clinic had been extinguishing on a record scale. Oddly, there has been an explosion of knowledge about the fetus during the very years that mass abortion developed.

Over the past fifteen years or so, the pendulum in obstetrics has swung sharply from almost-exclusive concern with the life of the mother (the orientation in which I was trained in my residency) toward strong interest in the health of the fetus. Not that the life of the mother is held in any lower regard, but with the advances in antibiotics, anesthesia technique, and the like, maternal mortality has dropped to an almost irreducible minimum. In many large medical centers the leading causes of maternal death are no longer the old bogeymen of hypertensive disorders, infection, and hemorrhage, but rather cancer or heart disease that coincide with pregnancy, and thrombo-embolic disease. So work on the fetus is the obvious direction for future research. Three English-language journals for this specialization all began publication in 1976: *Monographs in Fetal Physiology*, *Reviews in Perinatal Medicine*, and the best-known, *Perinatal Medicine*. In 1977 the citations on biological studies of the fetus consumed more than fifty-one columns of want-ad-size type in the *Index Medicus*, which works out to about 2,000 research articles.

A layman looking at abortion fixes upon the bloodied amorphous remains lying in the gauze bag inside the suction bottle; Right-to-Lifers constantly play upon this squeamishness. No physician, however, could do his work if the sight of human tissue and blood bothered him. Once the operation proceeds, the remains are just tissue to be dispatched to the pathology lab. No, the issue is not the existence of the tissue, but the prior decision that the operation is proper. What began to erode the N.A.R.A.L. dogmas was the daily realization of the "intrauterine patient" that we were treating, tracing, sampling, and observing through electric monitoring or the flickering images on an ultrasonic screen. To a physician, *that* is reality.

This evolution of my thinking will sound incredible to many. I was generally aware of these biological developments during the years of my abortion crusade. Three things happened. First, I reflected again on the older knowledge in perinatology. Second, new data were reported all the time. Third, and most important, I opened myself up to the data. When one is caught up in revolutionary fervor, one simply does not want to hear the other side and filters out evidence without realizing it. Until 1973 I was sold a bill of goods. No—let me be honest—I was selling a bill of goods. I had been terribly disturbed by the injustice and hypocrisy of the '60s, the disparity between rich and poor, East Side and West Side. I had seen the victims of self-abortion and hack abortionists. After the fever of activity had cooled, I found myself reflecting on the seeds of our revolution.

Besides the work at Woman's Hospital, I was influenced by some past reading I had done, and in particular an intriguing novel, *You Shall Know Them*, by the French author Vercors (pseudonym for Jean Bruller). The English translation came out in 1953 and a copy fell into my hands around 1968. I felt uneasy every time my mind strayed back to this intriguing novel.

Vercors spins a tale about an expedition of anthropologists who visit an island near Australia and stumble across a surviving "missing link" tribe, well hidden in the jungles, that displays some attributes of man and some of beast. To press the issue of whether the creatures, nicknamed "tropis," are human, a journalist on the expedition named Douglas Templemore decides to artificially inseminate a female tropi with his seed. Back in England, Temple-

more than slays his offspring intentionally, to force a murder trial and settle the question of defining "humanity." On that question rests, among other things, the scheme of an Australian industrialist to train tropics for slave labor in his textile mills. If they are not humans, what difference does it make? An Act of Parliament offers this definition: "Man is distinguished from the Beast by his spirit of religion." This sets up possibilities for satire which Vercors exploits deftly. What haunted me was the point raised by Templemore's lawyer in his summation at the murder trial:

"It did not rest with the tropics to be or not to be members of the human community, but with us to admit them to it. . . . No one is a human being by a right of nature but, on the contrary, before being recognized as such by his fellow man, he must have undergone—in a manner of speaking—an examination, an initiation." Should not the fetus, too, be examined to determine whether it is a member of the human community? Or, equally important, to determine whether it is *not* a member of the human community, and if not, *why* not?

When I cleared out my desk at CRASH on August 26, 1972, before departing for my much-needed vacation, I carefully packed up and removed all my files. I had determined to write up my experience, which I felt was too important to vanish without careful analysis, though I had no idea what I would write. That summer, Hunter Frost arrived on the scene. He was an old friend who had been amazingly successful in New York advertising. While his star was almost at its zenith he had quit his agency, gone back to New York University to get a master's degree in English, and moved his family to Colorado to teach at a prestigious prep school, the Fountain Valley School. Hunter was a thin, intense man with a most engaging manner, and I had always been able to confide in him, perhaps more so than with anyone else I knew.

We began to talk about abortion. I took him to the clinic on several occasions till he got to know everyone, and he interviewed numbers of people with an eye to doing a book on the history and functioning of CRASH. But Pyle and I were barely speaking by then, and without her cooperation he felt it would be too difficult to do the book. Instead, we spent long hot evenings discussing my troubled feelings about abortion. It was the first time I had really opened up my own thoughts and discussed the issue in depth with

anyone. I tried to sort out my ideas, to formulate some moral posture on the entire subject. We drafted a few statements, diagrams, and declarations, but in the end I knew that something was lacking. Through those ventilating sessions with Hunter it became increasingly clear that I—Bernard Nathanson, a founding father of N.A.R.A.L. and operator of the largest abortion clinic in the world—was entertaining serious doubts now about abortion. The realization was a bit frightening. The mental landscape was incomplete. I knew that I had to bring to the matter something more profound than a formless, splanchnic aversion. Hunter returned to Colorado in late August only half-humorously suggesting that I was suffering some undiagnosable equivalent of the *crise de foie*, only the target organ was not the liver but something in the region of the conscience. We had set some things to paper, but only the black. The white had yet to be formulated. “Chiaroscuro” was then the working title of my nascent article.

Were those germinating seeds of doubt evident to my clinic staff and board, to the abortion activists? At the annual N.A.R.A.L. meeting that fall some were too polite to ask about my resignation from the clinic, evidently aware that it was a touchy subject with me, like a nasty divorce. To those who inquired, my stock answer was that I had exhausted myself. I told them of my desire to return to the comparative serenity of private practice. In addition, my group of junior associates had broken up that summer, so I was alone in my practice and no longer had partners to cover for me while I was engaged in other areas.

During the spring of 1973 I began reformulating my article, newly influenced by perinatology. I had by then decided two things: first, that we had to continue offering abortions without restriction, and second, that everyone ought to be counseled to think about abortion more carefully. That following summer Hunter Frost visited again, and we spent long hours battling arguments back and forth as he helped me with the phrasing of the evolving article. When the piece was completed I sent a copy to Larry Lader at N.A.R.A.L. He made no objections, but asked me to hold it a couple of months because “the climate is not right.” Translated, that meant that once again there was some sort of intramural fight within N.A.R.A.L. At summer’s end I submitted my manuscript to the *New England Journal of Medicine*, in

which I had reported on our clinic's safety record with the first 26,000 patients. The editor, Franz J. Ingelfinger, took the unusual step of phoning me to accept the piece for publication as soon as possible. He asked me to add an introductory section, and the article appeared as follows in the "Sounding Board" section of the November 28, 1974, issue:

Deeper into Abortion

In early 1969 I and a group of equally concerned and indignant citizens who had been outspoken on the subject of legalized abortion organized a political action unit known as NARAL—then standing for National Association for Repeal of Abortion Laws, now known as the National Abortion Rights Action League. We were outspokenly militant on this matter and enlisted the women's movement and the Protestant clergy into our ranks. We used every device available to political-action groups such as pamphleteering, public demonstrations, exploitation of the media, and lobbying in the appropriate legislative chambers. In late 1969 we mounted a demonstration outside one of the major university hospitals in New York City that had refused to perform even therapeutic abortions. My wife was on that picket line, and my three-year-old son proudly carried a placard urging legalized abortion for all. Largely as a result of the efforts of this and a few similar groups, the monumental New York State Abortion Statute of 1970 was passed and signed into law by Governor Nelson Rockefeller. Our next goal was to assure ourselves that low cost, safe, and humane abortions were available to all, and to that end we established the Center for Reproductive and Sexual Health, which was the first—and largest—abortion clinic in the Western world. Its record was detailed in these pages in February 1972.

Some time ago—after a tenure of a year and a half—I resigned as director of the Center for Reproductive and Sexual Health. The Center had performed 60,000 abortions with no maternal deaths—an outstanding record of which we are proud. However, I am deeply troubled by my own increasing certainty that I had in fact presided over 60,000 deaths.

There is no longer serious doubt in my mind that human life exists within the womb from the very onset of pregnancy, despite the fact that the nature of the intrauterine life has been the subject of considerable dispute in the past. Electrocardiographic evi-

dence of heart function has been established in embryos as early as six weeks. Electroencephalographic recordings of human brain activity have been noted in embryos at eight weeks. Our capacity to measure signs of life is daily becoming more sophisticated, and as time goes by, we will doubtless be able to isolate life signs at earlier and earlier stages in fetal development.

The Harvard Criteria for the pronouncement of death assert that if the subject is unresponsive to external stimuli (e.g., pain), if the deep reflexes are absent, if there are no spontaneous movements or respiratory efforts, if the electroencephalogram reveals no activity of the brain, one may conclude that the patient is dead. If any or all of these criteria are absent—and the fetus does respond to pain, makes respiratory efforts, moves spontaneously, and has electroencephalographic activity—life must be present.

To those who cry that nothing can be human life that cannot exist independently, I ask if the patient totally dependent for his life on treatments by the artificial kidney twice weekly is alive? Is the person with chronic cardiac disease, solely dependent for his life on the tiny batteries on his pacemaker, alive? Would my life be safe in this city without my eyeglasses?

Life is an interdependent phenomenon for us all. It is a continuous spectrum that begins in utero and ends at death—the bands of the spectrum are designated by words such as fetus, infant, child, adolescent, and adult.

We must courageously face the fact—finally—that human life of a special order is being taken. And since the vast majority of pregnancies are carried successfully to term, abortion must be seen as the interruption of a process that would otherwise have produced a citizen of the world. Denial of this reality is the crassest kind of moral evasiveness.

The fierce militants of the Woman's Liberation evade this issue and assert that the woman's right to bear or not to bear children is her absolute right. On the other hand the ferocious Right-to-Life legions proclaim no rights for the woman and absolute rights for the fetus.

But these "rights" that are held to be so obvious and so undeniable are highly suspect. None of us have "rights" that go beyond the inter-related life that is our common heritage on this planet. Our "rights" exist only because others around us care enough about us to see to it that we have them. They have no other source. They result from no other cause.

Somewhere in the vast philosophic plateau between the two

implacably opposed camps—past the slogans, past the pamphlets, past even the demonstrations and the legislative threats—lies the infinitely agonizing truth. We are taking life, and the deliberate taking of life, even of a special order and under special circumstances, is an inexpressibly serious matter.

Somehow, we must not deny the pervasive sense of loss that should accompany abortion and its most unfortunate interruption of life. We must not coarsen our sensitivities through common practice and brute denial.

I offer no panacea. Certainly, the medical profession itself cannot shoulder the burden of this matter. The phrase “between a woman and her physician” is an empty one since the physician is only the instrument of her decision, and has no special knowledge of the moral dilemma or the ethical agony involved in the decision. Furthermore, there are seldom any purely medical indications for abortion. The decision is the most serious responsibility a woman can experience in her lifetime, and at present it is hers alone.

Can there be no help for the pregnant woman bearing the incalculable weight of this moral tension? Perhaps we could make available to her—though it should by no means be mandatory—a consultative body of unique design, much like Saint-Simon’s Council of Newton. To meet the new moral challenges of the abortion decision, we may very well need specialists, some of new kinds, to serve on such a body—a psychohistorian, a human ecologist, a medical philosopher, an urbanologist-clergyman. The counseling that such a body could offer a pregnant woman would be designed to bring the whole sweep of human experience to bear on the decision—not just the narrow partisanship of committed young women who have had abortions and who typically staff the counselor ranks of hospitals and clinics now.

My concern is increased by the fact that the sloganeers, with their righteous pontifications and their undisguised desires to assert power over others, have polarized American reactions into dimly understood but tenaciously held positions. The din that has arisen in our land has already created an atmosphere in which it is difficult, if not impossible, for the individual to see the issues clearly and to reach an understanding free from the taint of the last shibboleth that was screamed in her ear.

Our sense of values has always placed the greatest importance upon the value of life itself. With a completely permissive legal climate for abortion (and I believe that we must have such a

climate—that abortion must be unregulated by law) there is a danger that society will lose a certain moral tension that has been a vital part of its fabric. In pursuing a course of unlimited and uncontrolled abortion over future years, we must not permit ourselves to sink to a debased level of utilitarian semiconsciousness.

I plead for an honest, clear-eyed consideration of the abortion dilemma—an end to blind polarity. We have had enough screaming placards and mindless marches. The issue is human life, and it deserves the reverent stillness and ineffably grave thought appropriate to it.

We must work together to create a moral climate rich enough to provide for abortion, but sensitive enough to life to accommodate a profound sense of loss.

I expected that this piece, in a journal of limited circulation, would provoke a little discussion among my medical colleagues, and was hardly prepared for what happened. I became an instant abortion celebrity. "Deeper" was the occasion for wire-service stories across the country, magazine articles, and a rushed round of local press and radio interviews and TV talk shows. Nick Thimmesch put out a syndicated column quoting me to attack the "abortion binge." The *National Observer* reprinted the article, as did the *Chicago Tribune*, with a blaring and inaccurate headline: "Confessions of a Reformed Abortioneer." (Actually, I was still performing elective abortions regularly.) Even the *Ob.Gyn. News* ran a misleading headline: "Abortion Clinic Director Resigns: 'I Presided over 60,000 Deaths.'" (I did not resign because of that realization, but resigned and then developed second thoughts later on.) The lead article in the March 1976 *Good Housekeeping* reported further on my apostasy. I received hundreds of letters in the mail; in fact, they were still straggling in through 1978. These ranged from Fundamentalists praying for my soul or announcing on flowered notepaper that God had forgiven me, to anonymous women expressing remorse over their own abortions, and other anonymous women accusing me of crimes against humanity. One anti-Semite even crawled out of the woodwork. Christopher Tietze, M.D., the Population Council expert on abortion trends, wrote me that he was "perplexed and troubled" by my article, a response that left me perplexed and troubled.

Jesse Lyons wrote a sympathetic letter from the Riverside

Church, but among other fellow members of the N.A.R.A.L. board there was consternation. This might seem odd, in that I explicitly backed the N.A.R.A.L. line of total abortion on request, but I knew before publication that the activists wanted unwavering commitment, no questions asked. I was asking questions. The politics of the subsequent weeks were bizarre. Larry Lader wanted to hold me on the sixteen-member N.A.R.A.L. Executive Committee because he still needed my vote for the "activist-feminist" side in the ongoing struggle with N.A.R.A.L. "conservatives" led by Ruth Proskauer Smith. But now I was too conservative even for Smith. She summoned me to her Seventy-second Street apartment for what promised to be a kangaroo court on January 13. I respectfully declined to attend. Anne Gaylor, president of the Wisconsin Committee to Legalize Abortion, sent a broadside to fellow N.A.R.A.L. board members reminding them that awhile ago a lawyer was forced off the N.A.R.A.L. board for representing commercial referral groups; that is, making money on abortions. She noted that I, too, had made money on abortions and was stabbing them in the back with the article I had published. She further demanded that if I didn't resign on my own, she wanted me expelled from the organization.

There was no question that the pro-abortion crusaders now considered me to be a turncoat, a pariah, and a special board meeting was called for January 26 to settle *l'affaire* Nathanson. It never took place. I resigned instead. Meanwhile, the Right-to-Lifers offered me their clumsy and ill-considered embrace. Their organs somehow neglected to report that I had endorsed "abortion on demand" in the article. I turned down their innumerable speaking invitations. I did not want them to use me; I didn't even like them quoting me. I was left in a lonely no-man's-land between the two factions.

That was to have been the end of Nathanson and abortion. It did not work out that way. I continued to perform elective abortions almost every week and was troubled enough to examine the problem endlessly in my mind. I was especially impressed with one incident in my private practice.

Back in 1965 or 1966 I had treated a woman for gynecologic ailments, and during our acquaintance she told me with deep pride about her daughter, let us call her Eve, who had been born a

dozen years before that. Eve's doctors thought that she had cerebral palsy and had suggested that she be placed in an institution for retarded children. The mother, however, refused to follow their advice. It developed that she suffered not from C.P. but from multiple orthopedic deformities, largely correctible, and the mother saw to it that Eve was put through expensive and excruciating operation after operation. Eve grew to be a bright, healthy, and happy girl. It was a touching story and I was profoundly impressed with this courageous woman.

So here in late 1975, Eve came into my office. She walked with a slight limp, the only sign of her congenital defects, but was still the charming daughter that her mother had so proudly described. Eve had had an "unplanned pregnancy" and wanted me to do an abortion on her. I told Eve that I did not want to do it, that if other people had treated her the way she wanted to treat this inconvenient new life, she would be stuck hopelessly in some institution somewhere. I found myself for the first time on the "other side," arguing against an abortion with one of my patients. Clinically, I had joined the battle. Eve resisted my pleas, however, and regretfully I went through with the abortion.

During the years after "Deeper," I continued to ponder it all. It was apparent that the public issue was not going to die. Justice Blackmun had inflamed it with his decisions rather than putting it to rest. All we had were the coathanger pins of the pro-choicers and the roses and bottled fetuses of the pro-lifers. Where was the argumentation from a religiously neutral, biologically informed viewpoint? Medical ignorance on the subject abounded, and I had had an enormous mass of clinical experience of perhaps 75,000 abortions, including ones I had supervised at the clinic, had indirect hospital knowledge of, or had performed myself. I decided that I must start over from the beginning, compile and examine all my life experiences and all the pros and cons in the debate, and offer my conclusions, going deeper yet into abortion.

CLEARING THE GROUND

Abortion is one of a handful of inflammatory issues in society today that provokes deeply emotional responses, making reasoned discourse all the more difficult. Rather than make their case in order to convince others, some Right-to-Lifers apparently would prefer to intimidate patients and mount sit-ins at abortion clinics or to torch and bomb them, even though the clinics' activities are legal. They have no corner on violence, although fortunately the United States has been spared pro-abortion guerrilla action such as that in Italy, where during the 1978 dispute militant feminists shot seven times at one anti-abortion gynecologist, and fire-bombed the residences of a resistant doctor or two.

Our attempt to sort out the problem is complicated by all-too-clever sloganeering, by sloppy use of medical data and terminology, and by the way in which perfectly functional words have become loaded through emotionalized usage in the political wars. Consider:

Right to Life. This is a very slick handle for the anti-abortion movement, reminiscent of the "Right to Work" cause, which in actuality supports the "right not to join a union." Who admits to being anti-life? "Anti-life" is an inadmissible doctrine. However,

the Right-to-Lifers are not in favor of all "life" under all circumstances. They are not in the forefront of the save-the-seals crusades. They are not devotees of Albert Schweitzer's "reverence for life," or its equivalent in Eastern religions, in which the extinction of cows or flies somehow violates the sanctity of the cosmos. Turning to the human species, they do not necessarily oppose the taking of life via capital punishment. Where were they when Caryl Chessman was executed for a crime he likely did not commit—and a rape at that, not a murder? They were not notably in the opposition while the United States was sacrificing lives on both sides of a questionable war in Viet Nam.

They are not "pro-life"; they are simply anti-abortion.

In other "life" disputes such as war or capital punishment, we are only debating under what circumstances we should eliminate what everyone agrees is a human life. Abortion currently presents two issues, not only whether a life ought to be taken, but the prior question: is human life at stake in abortion at all? Thus, the abortion argument is at a preliminary stage, both ethically and pragmatically, and to lump it in with such other issues is misleading since it is infinitely more complex in its scientific data base.

Pro-Choice. This is the Madison Avenue euphemism of the other side. Who could possibly be opposed to something so benign as "choice"? The answer is: Almost anyone—depending. The diehard opposition to civil rights and public accommodations for black Americans in the '50s and '60s was "pro-choice" with a vengeance. Some whites wanted the "right" to serve hamburgers or rent hotel rooms to whomever they wished. Most of us now oppose the concept of choice in such ugly claims. The true question is, What choice is being offered, and should society sanction that choice? In any honest discussion we must focus upon what is being chosen, without hiding behind the slogan.

We are talking about the pro-abortion movement (in which I was something of a founding father).

Daniel Callahan, the director of the Institute of Society, Ethics and the Life Sciences—and a distinguished opponent of laws to restrict abortion—demythologizes the "pro-choice" line in a 1973 essay. To those who state that abortion is best left to individual choice, Callahan points out that it stacks the deck to state without substantiation that the rights of the fetus should be left to

personal conscience while the mother's rights are matters for legislation. If it is legitimate to legislate one, it is legitimate to legislate the other. (Not that Callahan thinks it is *wise* to legislate fetal protection.) It is also argued that the removal of laws makes no judgment on the morality of abortion and simply lets people make up their own minds. Sounds reasonable, doesn't it? Callahan correctly describes the assumptions involved in a decision not to legislate: that changes in a law have no effect on individual moral decisions, that the individual's abortion decision has few if any social implications, and that there are no standards for determining fetal rights. Each assumption may be true, but it must be argued through. "A decision to remove abortion laws from the books is no more ethically neutral than a decision to put such laws on the books or keep them there."

Let us honestly face the issues, rather than trying to wriggle out of them by semantic or philosophical trickery.

A "Religious Issue." The pro-abortionists also seek to rule out discussion of abortion in advance because it is a "religious issue." Our movement persistently tarred all opposition with the brush of the Roman Catholic Church or its hierarchy, stirring up anti-Catholic prejudices, and pontificated about the necessity for "separation of church and state." As if we did not welcome the embrace of liberal Protestants and Jews! As if no organized religious group has ever intruded into public affairs before, including the crusades on women's suffrage, civil rights, and Viet Nam. (My former N.A.R.A.L. colleague Larry Lader is upset greatly by religious activity against abortion but was full of praise for church activism on the slavery issue in *The Bold Brahmins*, his book on the nineteenth-century Abolitionists.) All of this religious line was, of course, necessary political strategy. In 1978 fifteen liberal organizations that are the epitome of religious social activism filed a friend-of-the-court brief in the federal *McRae v. Califano* case seeking public abortion funding for the poor. These groups, including some of the major Protestant and Jewish denominations, are now contending that legislating anti-abortion views constitutes an "establishment of religion" and thus violates the U.S. Constitution. Despite their best efforts to make abortion into a unique issue, it looks like their legal policy depends upon whose ideological ox is being gored.

A more general argument is that abortion laws are a threat to American "pluralism," or that "one religious group" ought not to "impose" its views on others in our society. Under the First Amendment, however, any group has a right to express its views and to try to persuade others of its stand on a moral issue. Virtually no important social issue is enacted into law without exposition of the views of religious groups. If the government, through democratic process, adopts a particular group's viewpoint, it does not mean that a group has "imposed" its views. The political reality in the United States is that we would never legislate the dogmas of one denomination into law, even one like Catholicism with 49 million members. There was a time when various Protestant denominations united to put through blue laws or Prohibition, so "legislating morality" is not simply a "Catholic issue." As for abortion, opposition is not, in fact, as idiosyncratic or "Catholic" a concern as pro-abortionists would have us believe.

Bernard Häring, a leading Roman Catholic moral theologian, states that a pluralistic society cannot have the task of protecting the religious teaching of a single church body unless a teaching coincides with society's "common good." In his view, abortion laws aim at "justice toward the weak ones, and protection of those basic values without which society would be exposed to great risks of self-destruction." Without commenting on that argument as such, we must be willing to recognize that many Roman Catholic citizens oppose abortion because they think it unjust and inhumane, not because they think everyone must obey Papal orders. The "beneficiaries" of anti-abortion laws are not Roman Catholics or their bishops, but fetuses, the majority of which would be born and grow up to be non-Catholic.

Anyone who is not innocent of history would realize that abortion has not been a "Catholic issue," not even an exclusively Jewish or Christian issue. The Hippocratic Oath, the standard for Western medical ethics (though rarely read in U.S. medical schools in the past generation) is an expression of what might be called high paganism. The oath denies abortifacient relief to pregnant women. So do Judaism's traditional rulings, and authorities in Islam, except for strict medical reasons. The Declaration of Geneva from the World Medical Association states, "I will maintain the utmost respect for life from the time of conception until

death." In a non-medical as well as a non-religious context, the Declaration on Rights of the Child, issued in 1959 by the United Nations General Assembly, declared that children need "special safeguards and care, including appropriate legal protection, *before* as well as after birth." (Italics mine.)

The U.S. statutes against abortion have a non-sectarian history. They were put on the books when Catholics were a politically insignificant minority. James C. Mohr's important historical study *Abortion in America: The Origins and Evolution of National Policy, 1800-1900* (1978) proves conclusively that even the Protestant clergy was not a major factor in these laws. Rather, the laws were an achievement of the American Medical Association and the "regular" physicians, who were combatting fly-by-night medical practice. The A.M.A. held a staunch anti-abortion policy from 1859, a dozen years after its founding, until the 1967 convention where it endorsed a moderate A.L.I.-type law (allowing for cases of rape or incest prior to viability, for threat to the mother's physical or mental health, or risk of a physical or mental defect in the fetus).

Mohr attacks the line of argument that Cyril Means, Jr., our N.A.R.A.L. law professor, used in the New York campaign. Means contended that the 1829 New York anti-abortion law was intended only to protect women from dangerous treatments, and did not consider abortion to be wrong as such. This theory is ideologically pure, but too simplistic. As Mohr states, the doctors' opposition was "partly ideological, partly scientific, partly moral, and partly practical." He reports that although abortion was dangerous (so was in-hospital childbirth in the nineteenth century, by the way, because of puerperal fever), the contemporary politicians and writers did not stress the dangers. Nor did doctors decrease their anti-abortion activity after the introduction of antiseptic practice in the U.S. in the late 1860s made abortions safer. An emphasis on ethics, the Hippocratic Oath, and the absolute value of human life was also part of the regularization of American medicine. Mohr underplays the scientific aspect of the situation. The nineteenth century produced a number of biological advances that undoubtedly affected doctors' opinions on what was moral in abortion. The idea that intrauterine life began at "quickening" was eroded by the newly invigorated field of embryology that expanded after Von Baer reported the first visualization of a mammalian

ovum in 1827. In 1822 Kergaradec published the first scientific report that the heart of the fetus beats while still within the womb. In 1885 Preyer described the twitching of a four-month aborted fetus, the first crude evidence that the fetus moves before "quickening."

Discussions that treat abortion as a "Catholic issue" reached something of a low in a 1978 *New York Times* Op-Ed page article by Larry Lader, who after losing out in the N.A.R.A.L. power struggle has become president of "Abortion Rights Mobilization," which pursues legal activity. The piece was mired in the thought of the late '60s, hitting all the keystone phrases, but it launched a new theory on the Catholic threat. Lader now claims that abortion opposition is the spearhead of a right-wing coalition drawing on the constituency of George Wallace's onetime third party. It is his opinion that the emergence of this coalition, based on opposing abortion, has given the Roman Catholic hierarchy an influence in politics that frequently eluded it in the recent past and has also given Catholic officials much needed links to "powerful allies" such as former Congressman John G. Schmitz, the American Independent Party Presidential candidate in 1972. Somehow the power of John Schmitz over the American body politic had eluded me. Granting the off-putting fondness of the right wing for the anti-abortion crusade, it is odd that Lader missed the well-known fondness of Catholics for the Democratic Party, or the fact that while the hierarchy was supposedly romancing the Far Right, it was opposing the Viet Nam War and favoring such liberal causes as civil rights, and the interests of farm workers and unregistered aliens.

At least Lader avoided the common tendency to treat abortion as though no non-Catholic religious groups are concerned about it (which is implied even in Justice Blackmun's sketchy treatment of religious teachings). Moral endorsement of Blackmun-style abortion-on-request at any time for virtually any reason is very much a minority position among U.S. denominations. The deep-seated Jewish and Christian tradition is dying hard. Only three of the twenty-eight major religious bodies had endorsed secular laws to permit total freedom before the Supreme Court allowed it. Though the various denominational viewpoints are extraneous to my own argument, they are central to the national debate. Be-

cause they have never before been adequately surveyed, these official viewpoints are summarized in Appendix B.

Official decrees aside, there is much diversity within church bodies. According to National Opinion Research Center polls, the Catholic laity overwhelmingly breaks with the hierarchy in accepting laws that permit "direct" abortion in all cases where a mother's life is at stake, not just the rare cases of "indirect" fetal killing that the bishops accept. By lesser majorities, U.S. Catholics would allow abortion in cases of rape or possible deformity, N.O.R.C. reports. On the other hand, in the officially liberal United Methodist Church a 1976 poll of members by the *United Methodist Reporter* found only one third favoring total abortion on request, and even a slight majority desiring legal protection of the fetus or embryo from the time of conception. From the polls and the statements, there is something of a religious agreement on this supposedly divisive issue, rejecting the extremes of both the U.S. Supreme Court decisions and of the Catholic policy. This consensus appears to cover the majority of Roman Catholic laity, of Protestants, Eastern Orthodox, Mormons, Muslims, and possibly of religiously active Jews.

Traditionally, religion opposes abortion because "the Lord giveth, the Lord taketh away." What about atheists like myself who do not believe in the existence of a personal God? I think that abortion policy ought not be beholden to a sectarian creed, but that obviously the law can and does encompass moral convictions shared by a variety of religious interests. In the case of abortion, however, we can and must decide on the biological evidence and on fundamental humanitarian grounds without resorting to scriptures, revelations, creeds, hierarchical decrees, or belief in God. Even if God does not exist, the fetus does.

Abortion on Demand. This is an interesting instance of the evolution of a slogan. Early on, the "pro" forces embraced this line. The militancy of the wording appealed to the feminists. I argued that tactically this was a mistake. It offended doctors, whom we were trying to win over, because they become obstinate when confronted with "demand" language. I also feared that it would give our cause a rock-hard image. This was a rare instance when my political instincts were correct, and you don't hear this one from the pro-abortionists any more. In fact, they now consider it a slur,

hurled at them by the anti-abortionists. Fair enough. Let us adopt their preferred, bland phrases: "elective abortion," or "abortion on request." But let us not lose sight of what this means: Society's permission to abort in any circumstances, or even to abort without any particular justification from circumstances at all.

Abortion. So confused are we that even this term is fuzzy. On Operating Room schedules, the pre-Blackmun term that was written down was "therapeutic abortion"; after Blackmun it became "elective abortion." Now it is "termination of pregnancy," the ultimate euphemism, almost Huxleyan in its finesse. To the gynecology residents, it remains "scraping it out."

Medically speaking, abortion is not the killing of the fetus, never has been, and (I trust) never will be. I repeat. *Abortion is not the killing of the fetus.* Rather, abortion is the *separation* of the fetus from the mother. The fundamental misunderstanding here corrupts the entire debate. Though in practice death has become the aim as well as the result of separating the fetus, the medical term does not imply any intent to destroy it. From Alan Guttmacher's essay in the first medical anthology on abortion (1954) through recent statements of the American College of Obstetricians and Gynecologists, the point is made that the fetus is not the doctor's target, and that its death is a byproduct of its removal. As we will see eventually, this is an all-important moral distinction.

Interestingly, the term "abortion" still carries such a criminal penumbra that it has not only been banished from O.R. schedules, but obstetricians usually talk to their patients about "miscarriage," which is not a medical term, rather than the correct "spontaneous abortion." However, in clinical usage, "abortion" includes all separations, whether induced or spontaneous.

In conventional obstetrical usage, abortion covers only the separation of a fetus weighing 500 grams or less. After that we have an "immature" between 500 and 1,000 grams; a "premature" between 1,000 and 2,500 grams, and a "mature" fetus thereafter. The Supreme Court dismantled all this medical terminology and invented talk of "abortion" at any period up till birth. We obstetricians must protest that this is an unacceptable distortion. I do not know what we should call the separation of a fetus after it is possibly, probably, or certainly able to live outside the womb

when our intent is to destroy it. Premature infanticide, perhaps. But it is *not* abortion, as doctors understand the term. The very concept is anathema to me, and always has been, even in my most fervent pro-abortion years. I think the pro-abortionists have made a grave error in aligning themselves with such late "abortions" for other than strict medical reasons, no matter what the Supreme Court might have allowed.

Murder. This is a pet word for the anti-abortionists. It pre-judges the argument and overheats the public debate beyond all reason. We are not talking about intentional and unjustified slaying of a human being as currently understood in the law, the proper definition of this word. It should be dropped from the abortion issue, along with "killing" and "homicide." Even "death" has become politicized. A more precise term is "feticide," but it sounds comical to me. Let us simply speak of "abortion," despite the confusion surrounding that word.

Unborn Baby or Unborn Child. What are we to call the entity that lies at the heart of the debate? The anti-abortionists would load the verbal dice on us by using these nouns, properly used for the already-born infant, and applying them within the womb. Such words define a state of being in advance. We are not here talking about the type of life that we find in a six-year-old. It certainly is biological life, but life of a different order, one that I am frank to state I do not understand fully. We do not know enough yet about this time in each of our lives to use these words. In another twenty or fifty years, medicine may give us a very clear answer and "baby," even "murder," may become appropriate or even necessary words. But not now; the results are not yet in. With the use of "baby," "person," "human being," even possibly "human life," the argument is settled before you even begin it.

If not "baby," why not "fetus"? I do not care for the term, in part because of the sarcastic way in which we pro-abortionists used it, ridiculing our opponents as "the friends of the fetus." The term is also slippery, even in medical usage. One specialist will say that it applies to nascent life from five weeks on, when the entity begins to resemble the human form, and another from sixteen weeks on. Anti-abortionists routinely use the word for a very young embryo, which is a distortion. Prior to becoming a fetus, the entity is properly referred to as an "embryo." "Conceptus" is a

cold, neutral, and correct term to cover any time from fertilization of the egg through twenty weeks or so; "products of conception" includes the placenta as well as the embryo or fetus.

Anti-abortionists dislike all these words because they are too clinical and appear to skew the discussion against the worth or alleged "personhood" of the entity. As the argument proceeds, then, I will call this mysterious intrauterine occupant, at whatever stage, "alpha." This is a clumsy and unliterary device, but it is the only way to maintain a neutral and unemotional approach, entirely free of the hidden assumptions of both sides.

THE SPECIOUS ARGUMENTS AGAINST ABORTION

One need not question the motives of the anti-abortionists to feel qualms about their movement. There *is* a "Catholic issue," for one thing. Not the way it is usually framed by the opposition, but rather the bishops' willingness to accept the death of the mother as the price for protecting the fetus (what about the *mother's* "right to life"?) and their opposition to two major alternatives to abortion: artificial birth control and voluntary sterilization. The Right-to-Lifers always seem to avoid confronting these issues, probably to appease the Catholic traditionalists in their ranks. The rest of us simply cannot accept this silence. The movement is also off-putting for its shallowness. This is not the War of the Roses, and it will not be settled by handing flowers to legislators, any more than youths settled Viet Nam by stuffing flowers into the barrels of the rifles of Pentagon guards.

Many of the arguments commonly used by anti-abortionists do not hold water if examined carefully:

1. *The Vanishing Cases that Have Not Vanished.* The "anti" authors repeatedly state that medicine has removed the classic conflict between the mother's life and alpha's life. They have in mind mainly the famous dispute in which the popes of Rome

ruled that alpha should not be killed by crushing its skull to save the mother's life in obstetrical instances in which that choice could not be avoided. Protestants and Jews sided with the mother in such cases. This indeed is no longer a medical issue. However, there are a number of complex problems in modern obstetrics that raise the same life-vs.-life quandary. These will be examined below in detail.

Some anti-abortionists also treat rapes that result in pregnancy as non-existent. As we will see, this is not so, either. Though not common statistically, these cases are very real for the individual women who are victimized, and cannot be avoided.

2. *Profiteering.* The conservatives in Right-to-Life who rarely bestir themselves over, say, corporate profit margins have an unseemly interest in abortion income. Doctors are "only in it for the money," we are told, as though abortion were a marvelous road to riches. If anything, this cuts on the pro-abortion side; there is a bit *more* money to be made (albeit at greater risk) if abortion is illegal and it need not be declared on income tax returns. But the whole point is muddleheaded. The rates I paid doctors at CRASH were denounced in many a hospital locker room as "windfall profits." I did pay well: \$90 an hour for supervisors and \$70 an hour for other doctors. This enabled me to build a staff with a remarkably good safety record, while we still offered abortion at modest fees. I recall a conversation I had at that time with John Cole, a prominent obstetrical colleague at New York Hospital, whom I overheard using these terms one day in the attendings' dressing room. I asked,

"Johnny, how do you define profiteering?"

Cole, a charming man with a sophisticated sense of humor, replied:

"Bernie, that's when *you* make more money than *I* do."

In those early days following the legal breakthrough in New York, the medical profession's attitude was: It's not so much that what you are doing is wrong, but you are making a ton of money out of it, too. So were surgeons in other specializations, but we never heard talk of "profiteering." Medical costs are an important question, too complex to bog us down here, but abortion should not be singled out for particular scrutiny as though it were different from the cost of other medical procedures.

3. *The Slippery Slope.* It is contended that once society accepts open abortion, physicians are turned into callous and bloodthirsty people, and increased suicide will be next. Sometimes V.D., child abuse, and rising illegitimacy are also blamed on this all-purpose target of abortion. Where is the evidence that abortion produces a generally lowered regard for life in democratic societies? Sweden has both high suicide rates and liberalized abortion, but there are other nations where the two do not go together, including Austria, England, and the United States. If there is a connection, it could be that the same social ethic that fosters suicide also fosters abortion, but not that abortion itself produces increased suicide rates. Child abuse statistics have increased since legal abortion became widespread in the U.S., but this is a complex area; formerly abuse was not reported as frequently. Only *reported* abuse has risen, which could be a sign of *increasing* regard for life. The linkage with mercy-killing, also common, does not credit human intelligence with the ability to distinguish between two issues that are separable and highly complicated on their own terms. These efforts all simplify abortion, and in abortion, simplicity is simply not there. The anti-abortionists end up trivializing the abortion problem.

Strangely, they seldom mention the one instance in which abortion may produce a slide down the moral slope: the question of infanticide, which will be taken up below.

4. *The Slippery (Nazi) Slope.* This is a favorite means for scumbling the debate. Anti-abortion authors cannot restrain themselves from dragging Adolf Hitler out of the grave. A society that accepts abortion, we are told, is doing what the Nazis did when they killed off the handicapped, the retarded, the gypsies, and the Jews.

The facts are these. The German Nazis had strict anti-abortion policies—for "Aryans." Jews were encouraged to abort, as part of Hitler's racial purity madness. Abortion, even abortion to eliminate alphas with genetic diseases, is not the same thing as genocide. The aim in eugenic abortion is physically pure newborns of all racial groups, not the purity of one racial group as demanded by an overarching ideology. (Strange that Right-to-Lifers do not make more of the fact that the pioneer in liberal abortion was not Hitler but V. I. Lenin, in 1920. The Soviet Union is not exactly one's ideal of a humanitarian, life-valuing state, either.)

It is much less obvious to the society at large what we are doing in abortion than what Germany did regarding genocide. If you were a German and your Jewish next-door neighbor disappeared one night and never came back, the result of Nazi policy was obvious, unless you chose not to see it. When a neighbor gets an abortion, you rarely know about it. The community is dimly aware, if at all, that on the average in our nation one alpha is legally extinguished every thirty seconds, hour upon hour, day in and day out.

Above all, I must protest that the waving of the Nazi flag raises the temperature of the discussion intolerably. It is a pejorative tactic that is inexpressibly unfair to pro-abortion citizens and to my former colleagues. They are not Nazis. And as a Jew, I cannot remain silent at this facile use of the Nazi analogy, though I realize that some anti-abortion Jews use it. If this argument is so compelling, why do Jews remain generally favorable toward abortion? The Nazi experience was so utterly shattering that it defies any analogy, and it defiles the memory of the Holocaust to bring it into this discussion.

5. *Blood and Gore.* Anti-abortionists seem to delight especially in printing graphic descriptions of what abortion does to alpha. Usually these tracts are as inaccurate as they are purple in prose. (Salting-out, for example, does not barbecue alpha's skin, or shrivel it like a prune.) In any event, who wants to read graphic accounts of amputation, either? Any surgical procedure so described plays upon the squeamishness of the lay public. The physician is no butcher or ghoulish when he takes the bloodiness of abortion matter-of-factly. This is the first step toward ability to perform as a doctor. If your own physician gets squeamish over such things, I sincerely advise you to take your business elsewhere. We should debate fairly whether the decision to abort is moral and just, not whether, once the decision is made, abortion is bloody.

6. *The Phenotype Argument.* Similarly, Right-to-Lifers continually show photographs of aborted alphas. The physical facts of alpha are part of the data, and we will soon turn to these, but a favorite ploy is to show an alpha of sixteen or twenty-six weeks, when it is fully formed and approaching babyhood. Few abortions, relatively speaking, occur even by sixteen weeks, and hardly any as late as twenty-six weeks. The argument is raging mainly about the hundreds of thousands of alphas aborted at six, eight, or

ten weeks when alpha does not look like a newborn baby, except in a very general sense. This is as silly as arguing mercy-killing of the aged by showing photos of robust toddlers. We do not identify alpha based upon its exact physical identity with a baby; it is an entity on its own terms.

7. *Medical Scare Tactics.* One after the other, anti-abortion writers raise the specter of abortion as a clear and present danger to the mother's health. This is a Right-to-Life red herring. Abortion has hazards, of course, and these should be part of the "informed consent" that the woman gives prior to the procedure, but she should be informed of the facts minus scare tactics. In general, the medical statistics cut against the anti-abortionists. The death rate for early abortion (which is always to be preferred) is well below that for live births, and will continue to be: 1 abortion-related death per 100,000 early abortions and nearly 20 maternal deaths per 100,000 live births.

The rates of morbidity ("complications") and sequelae (long-term effects) are more difficult to assess, but these are also low. The pregnant woman contemplating abortion should be informed that, for reasons that are not medically known, a certain number of women statistically will have only one successful pregnancy in their lives. The patient should be aware of the remote chance that she is destroying the only offspring that she will ever bear. The question here, however, is whether abortion contributes to sterility or to other medical problems. I would reject any decisions based upon studies from Eastern Europe, often cited by Right-to-Lifers, because the medical and social situations are not parallel. Likewise from Japan, which has a higher rate of subsequent cervical pregnancy after abortion but where doctors tend to do abortions at any stage, even by late D and C into the twenty-sixth week. Britain would seem to be a close parallel, and the two studies often cited from there (Stallworthy *et al.* at United Oxford Hospitals, 1971, and Richardson and Dixon at Bristol Maternity Hospital, 1976) report—by U.S. standards—an unbelievably high incidence of perforated uteruses, of required blood transfusions, and of subsequent fetal loss. I must assume that their technique is not the same as ours, or not as good. Also, the populations studied in these papers are too small for drawing any statistical conclusions or for fixing policy.

What matters is what is occurring in the United States, where we now have many years of mass abortion experience. Regarding "complications," I can cite my own study, the first using a large sample, on 26,000 cases at our New York clinic. These were first-trimester ambulatory abortions using paracervical-block (local) anesthesia. There were no known deaths (nor were there throughout the 60,000 cases under my tenure). The total "complication" rate was 22 per 1,000 cases. From the 26,000 women, we had 36 perforations, 12 of which required surgery for suture and one of which required a hysterectomy. There were 391 noteworthy infections after the abortions, and in 49 of these the women were hospitalized. The total of hemorrhages was 54.

As for the longer-range effects, we have a good study of December 1977, by Daling and Emanuel, of 4,896 obstetrical patients in Seattle, Washington, of whom 571 had histories of prior abortion. To remove statistical factors other than abortion that affect pregnancy, the women were matched with control groups for age, order of pregnancy, socioeconomic status, and other criteria. The researchers found that "when confounding maternal variables are controlled, there is no relation between an induced abortion and subsequent abnormal outcome of pregnancy." They report the same in nine carefully controlled statistical studies in the U.S. and overseas, and also claim that "national vital statistics from several countries support this conclusion." Unfortunately, the latter point is not documented.

All of the risks are of an acceptable order of magnitude. After twelve weeks, the patient will have to weigh the increase in risks as it is reported to her. This must be an area of continued monitoring, and long-range studies may show up more problems than are now evident, but none of the purely medical considerations provides any reason whatsoever for *outlawing* abortion.

8. *Psychiatric Scare Tactics.* The anti-abortionists also like to dwell upon the negative psychological impact of abortion on women. Some speak of "severe guilt reaction" in a certain percentage of cases. This is another instance of the movement's abuse of language. Abortion may produce feelings of regret, perhaps even remorse, but this is not a clinical syndrome of psychopathology. Sadness is not sickness. Guilt reactions do relate to the care of the individual patient, and in some instances may provide a clinical

reason not to abort. But in the professional literature of the '60s and '70s in the United States, there is no solid evidence that psychopathology is either induced or appreciably worsened in the general run of cases.

A 1978 summary of findings by Stephen F. Pariser *et al.* at Ohio State University reports that the pendulum has swung away from emphasis on the negative psychiatric impact or trauma since the '40s and '50s. They summarize: "Post-abortion psychiatric complications are not common. There are no unequivocal psychiatric contraindications for termination on a psychiatric basis. The risk of exacerbation or precipitation of a major psychiatric illness is small and unpredictable. However, there seem to be women in higher risk categories." All these points should be borne in mind in diagnosis and care of the individual patient; they are not the basis upon which society should limit abortion.

In each of these arguments, and in others, the anti-abortion forces sidestep the only issue in abortion: what is alpha, and should it be valued and protected? The Right-to-Lifers trivialize this fundamental human question when they dredge up these lesser issues, particularly when the lesser issues do not stand up to hard analysis. They compound this by trivializing, or ignoring altogether, the pressures that childbirth can place upon women under trying circumstances. They take their cause beyond the scope of reasonableness if they do not allow contraception and voluntary sterilization as choices to those women who do not wish to become pregnant.

THE SPECIOUS ARGUMENTS IN FAVOR OF ABORTION

I have held the opinions expressed in the previous chapter for many years; recent findings only reinforce them. However, the pro-abortionists have their own list of inadequate arguments, and examination of these is more painful, since I once mouthed so many of them myself. Still, intellectual honesty compels me to reassess them so that the abortion issue can get down to the essentials.

1. *The Teeming Masses*. We are sometimes told that abortion is necessary because of world overpopulation. The present work deals with the United States, not the developing nations, which face different cultural, economic, and medical situations from our own. Overpopulation is simply no reason to advocate widespread abortion in a nation like the U.S., and we are not going to end starvation in Ethiopia by aborting in Manhattan.

An aside on this matter of population control: It is intriguing to me that even extreme sectors of the American abortion movement do not advocate it as a primary contraceptive technique but rather as a "fallback" (a precious little euphemism) if birth control fails or is not used. There is a medical paradox here. The Pill produces a death rate far in excess of that in first-trimester abor-

tions, yet few pro-abortionists have had the integrity or the courage to advocate abortion as "just another" birth-control method. Does not some recondite human repugnance for abortion lurk here? Even in liberated 1978, a vague stigma is attached; most women are still unable to look their gynecologists straight in the eye as they report on past abortions.

2. *Mere Tissue*. Pro-abortion spokesmen too often treat alpha as merely a chunk of tissue or an ordinary organ of the mother's body, rather like an appendix that is snipped off. One writer of this persuasion even likened alpha to the cells that flake off every morning when we brush our teeth. The biological facts of the matter will be described subsequently, but let me simply state here that this whole line of argumentation is biological nonsense, unworthy of the people who have advocated it. Alpha is an entity like no other within the woman's body.

3. *You've Seen One, You've Seen Them All*. This point is so eccentric that I would not mention it except that it appears in a book, *Unwanted Pregnancy*, written by a fellow obstetrician-gynecologist named Robert Petres, along with a Southern Presbyterian university chaplain. They dismiss the "personhood" argument on alpha, in part, because this implies that the entity in question is "unique, that he is one of a kind" and they flatly deny that this is true of alphas. "They are not unique. Laid side by side at four or five months' gestation, they are virtually indistinguishable. They are not unique in any way, shape or form." This is a simplistic argument reminiscent of the anti-abortionists' phenotype gambit. In fact, individuality is structured into each and every alpha that is ever conceived. Its genetic code will never be repeated. Quite early in pregnancy, as we will see shortly, the bodily features and functions of alpha also become individualized. Sad but true, as you read these words some bored gynecologist may be aborting the next James Joyce.

4. *The Woman-and-Her-Doctor*. How many times have we heard this one? The "woman and her doctor" alone ought to decide on abortion. Even the Supreme Court swallowed this. This is a clever way of subtly implying professional scrutiny and endorsement for an abortion, but the phrase is wholly spurious. All one needs to do is look at the New York newspapers, where this allegedly "medical" service is advertised alongside "Madame

Marie, Indian Reader," "Weight Loss—Amazing Breakthrough!" and "SINGLE? Looking for someone special?" One author has stated that abortion is no more a medical issue because doctors do it than is capital punishment a matter of electrical engineering because an electric chair is used.

Quite obviously, the mother and the mother alone makes the decision, except in the small percentage of abortions that involve true medical indications. Physicians have no special moral wisdom to impart on such non-medical decisions.

I must agree with Daniel Callahan's remarks against abortion as "medical": It may be very beneficial for a woman, but unless her life is threatened "an abortion cures no known disease and relieves no medically classifiable illness." "It may be merciful and it may be wise," but medicine does not classify a procedure as "therapeutic" when "it is not notably therapeutic for the fetus" and has a "100% mortality rate."

5. *Men Don't Get Pregnant.* We are told that laws against abortion were a plot by male chauvinists to oppress women, or in the less hysterical version, that men can never understand what the pregnant woman suffers. But one day as a mother who had just given birth signed the routine consent form for a circumcision that would inflict considerable pain on her newborn boy, I asked myself: On this account, ought we not require that the father sign consent? How could a woman know what it is to have part of your penis cut off?

James Mohr's historical book points out that the original nineteenth-century feminists were universally opposed to abortion, even after antisepsis had made it a safer procedure. They considered it yet another outrage that had been inflicted upon women by men who forced them to have abortions.

Daniel Callahan objects to the argument about "men legislating for women" because abortion, child-bearing, and child-rearing have consequences for everyone in our society, of both sexes. For that matter, as a "women's issue," abortion works against the pro-choicers in that virtually every U.S. poll over the past decade has shown that women are significantly more anti-abortion than men are.

6. *Cost Benefit.* There is a current tendency, particularly in documents that ooze forth from the federal bureaucracy, to treat

abortion and many other medical issues as a "cost benefit" problem. It is cheaper for our society to destroy alphas at \$100 apiece than to take responsibility for aiding poor women and children. This may be good politics, perhaps, but it is hardly exemplary social morality. It reeks of the Pentagon's "body count" thinking of the Viet Nam era. Are we supposed to consider such pragmatism of alpha-elimination to be "liberal" and humanitarian? As one who sits in on hospital committee meetings, I must sadly report that this cost-benefit lingo has a lot of cachet among medical administrators who cope daily with the federal, state, and city agencies, and imbibe and recycle their repugnant jargon and accountant-like mentality. This trend is infuriating and dehumanizing.

Certain human issues are too grave to be handled in this way and must be shielded from a cost-effectiveness theory. Abortion is one of them.

7. *Social Panacea.* If the anti-abortionists would blame every social malady on abortion, the pro-abortionists propose it as the *solution* to all manner of social ills. But now that we have had several years of open abortion, what maladies have been alleviated? Liberalization has certainly brought benefits to individuals, but where is the society-wide evidence that it has reduced the welfare rolls, the curse of poverty, or illegitimacy and child abuse? (Actually, as mentioned already, reported child abuse has *risen* noticeably since abortion was legalized, and so have illegitimate births, despite the availability of abortion as an alternative.)

8. *The "Unwanted Child."* The specter of child abuse is used as part of a broader pro-abortion argument, that every child born into this world must be "wanted," and that social evils will result if they are not. I have some important philosophical objections to the "unwantedness" line, but will limit myself here to matters of simple logic.

Would that all children were wanted. But projections of future harm from present emotions are totally unreliable. At some point in pregnancy, many children are temporarily "unwanted." For that matter, offspring are often "unwanted" at certain moments after they are born. An unwanted alpha does not always end up as a resented baby. As for battered children, there is no solid evidence that unwantedness during pregnancy produces battering. Rather, battered children appear to be the result of mistreatment

of the parents when they themselves were children. Contrary to the stereotype, battering is not a problem limited to the poorer families that are of particular concern to the (usually more affluent) abortion advocates. As noted above, if anything, the statistical reports would lead one to conclude that liberal abortion laws, not strict ones, foster child abuse.

The "unwanted child" is also a myth. If alpha is carried to term, it will never be "unwanted" because of the hopeless shortage of babies available for the long list of childless couples who earnestly want to adopt them. So alpha need be "unwanted" only for the nine months between conception and birth. Adoption is difficult for the unwed mother, and more so for the widow, divorcee, or wife who becomes pregnant out of wedlock. The point is that an option does exist if we do judge alpha's survival to be even more important than the difficulties of the unwillingly pregnant woman.

9. *Psychiatric Scare Tactics*. No less than their opponents, the pro-abortionists indulge in pop psychology. The adoption solution, just mentioned, is portrayed as an unutterable trauma for the natural mother, or the psychological harm to a woman refused abortion is painted in lurid terms. Clinical proof of this is, on the whole, lacking. (For ample detail on psychological studies on both sides, see Callahan's *Abortion: Law, Choice and Morality*.) Just as I granted to the anti-abortionists, it is inarguably true that refusal of abortion or giving up of babies for adoption placement may occasion regret or remorse, mixed perhaps with more optimistic thoughts about the life that the mother has authored and preserved. But sadness is not sickness, nor a psychosis. There may indeed be emotional turmoil. This is true of all major life decisions and events, normal pregnancy and childbirth among them. The difficulties of life, however, are not psychiatric pathology and do not provide justification for a procedure if, on other grounds, it is judged to be unethical.

10. *Women's Control Over Their Own Bodies*. Leaving aside for the moment the question of whether alpha is merely "part" of the mother's body like an appendix, this principle is wrongheaded in any event. Civilized societies do not permit women absolute control over their bodies; they do not sanction such things as mutilation of one's own body, drug abuse, prostitution, or suicide.

Even if alpha is to be considered merely a woman's "property" and not the "person" that the anti-abortionists claim, control over property is not absolute—statutes against cruelty to animals are legitimate, including the animals that the violator owns. We cannot grant women absolute control over alpha without consideration of abortion on its own terms.

The broader claim is to the "right to privacy," which N.A.R.A.L. figured correctly was the only one that would work for us in the courts. We cited in particular the *Griswold v. Connecticut* ruling striking down anti-birth-control laws on privacy grounds. Justice Blackmun also cited that case in guaranteeing a "right to privacy" on abortion in 1973, but John Hart Ely of the Harvard Law School has pointed out that in *Griswold* the court reasoned that enforcement of the birth-control ban would have been impossible without outrageous government prying into the privacy of the home. With abortion, the conception may occur in private, but the abortion itself is "in public"—in a clinic or hospital—with various outsiders in attendance. Each act of abortion (but never each use of contraception) must be registered with the government.

There are, after all, good invasions of privacy. Society requires the white majority to respect the rights of the black minority. It does not grant parents total physical control over their offspring *after* birth, legislating against child abuse. Government intervenes in bodily privacy in the control of communicable diseases, and is even willing to violate parents' control and their explicit First Amendment right to religious liberty in medical-legal disputes where life is at stake (e.g., forced blood transfusions for underage Jehovah's Witnesses, or various medical procedures for children of Christian Scientists).

In the contemporary situation, the woman's "control over her body" offers her a number of options other than abortion. She can choose sexual continence, or if not continence, then contraception, or if not contraception, then sterilization, or if none of these, she can take control in making sure that the man in her life makes such a choice.

11. *The Coathanger*. The favorite button of the pro-abortionists is the one showing the coathanger, symbol of the self-induced abortion and the carnage that results from it, or the similar problem of botched illegal abortions done by "back-alley butchers."

This is a fundamental argument; one that moved us deeply in the late '60s, and one that could justify non-medical abortion even if no other argument stood up.

How many deaths were we talking about when abortion was illegal? In N.A.R.A.L. we generally emphasized the drama of the individual case, not the mass statistics, but when we spoke of the latter it was always "5,000 to 10,000 deaths a year." I confess that I knew the figures were totally false, and I suppose the others did too if they stopped to think of it. But in the "morality" of our revolution, it was a *useful* figure, widely accepted, so why go out of our way to correct it with honest statistics? The overriding concern was to get the laws eliminated, and anything within reason that had to be done was permissible. Statistics on abortion deaths were fairly reliable, since bodies are difficult to hide, but not all these deaths were reported as such if the attending doctor wanted to protect a family by listing another cause of death. In 1967, with moderate A.L.I.-type laws in three states, the federal government listed only 160 deaths from illegal abortion. In the last year before the Blackmun era began, 1972, the total was only 39 deaths. Christopher Tietze estimated 1,000 maternal deaths as the outside possibility in an average year before legalization; the actual total was probably closer to 500.

The death of 500 women, or even 39, is a matter of the most serious concern, but this is hardly an overwhelming death rate among the millions of women of childbearing age. Depending upon the value that is placed upon alpha, it might be lopsided for a society to consider only the 500 women and ignore the 1,000,000 alphas that are legally extinguished each year.

Apart from deaths, there were the walking wounded of the abortion injustice. Their sufferings were very real to me and to other physicians in the reform movement. In the old days there would be two or three critically ill patients in our ward from infected botched abortions at any one time, and the same in the ward of every other hospital. For this reason obstetrics-gynecology used to be a sobering specialty, and this was a major reason why its practitioners gradually accepted the change. In the middle of too many nights we had gotten a call that a woman was "miscarrying" in early pregnancy. When we would appear bleary-eyed to examine the seriously ill woman it would turn out that, one way

or another, she had been "started." Those were bleak nights indeed.

Why, then, do I now dismiss the whole carnage argument? Simply because technology has eliminated it.

The practice of abortion was revolutionized at virtually the same moment that the laws were revolutionized, through the widespread introduction of suction curettage in 1970. (Even before this, antibiotics and other advances had already dramatically lowered the abortion death rate.) Instead of scraping the soft wall of the pregnant uterus with a sharp instrument, the operator vacuums it out with a plastic suction curette. Though it is preferable that this be done by a licensed physician, one can expect that if abortion is ever driven underground again, even non-physicians will be able to perform this procedure with remarkable safety. No woman need die if she chooses to abort during the first twelve weeks of pregnancy. Largely due to suction curettage, the total of deaths from all abortions (legal and spontaneous "miscarriage" as well as the illegal abortions, which decreased markedly after legalization) was only 25 by 1976. Even without a suction machine, a simple combination of catheter and syringe can produce enough suction to carry out a safe early abortion.

As for the self-induced abortion, by thrusting a coathanger or other dangerous object into the womb, this will also be a thing of the past. Compounds known as prostaglandins can now be used to bring on contractions and expel alpha, and would readily be available for do-it-yourself abortions in vaginal suppository form. Prostaglandin suppositories would not provide a full abortion in most cases, but they would "start" the woman, and she could then go to her doctor to have her uterus cleaned out. Prostaglandins in general are safe for the mother's system, and besides that, there is no evidence that anything other than a spontaneous miscarriage has occurred. There are no signs of instruments in use, and the woman can command medical attention on a legitimate and legally safe basis. This may sound rather cynical, but this is what would now happen in practice if abortion were illegal.

There may be many other reasons or cases under which abortion is desirable, but this most emotional of the arguments, the one which swayed me more than any other, is now wholly invalid and obsolete.

SIGNALS FROM INNER SPACE

With these meretricious arguments behind us, we now turn to what abortion is really all about: What do we know about alpha, and how do we weigh its value and its claims over and against the mother's interests? Is this "human life," for instance? Human it unquestionably is, since it is organically part of the human species. "Life" also fits if we follow the common dictionary meaning (in this case, the *Random House*, unabridged): that state "manifested by growth through metabolism, reproduction and the power of adaptation to environment through changes originating internally." Some anti-abortionists speak of "potential human life" as a sort of fall-back position, but I have never cared for this idea. We ought to examine actual data, rather than future potential, in coming to a decision.

To state that alpha is biologically "human life" of a certain sort does not answer our question. We must know what this means in biological detail. The following discussion only summarizes a vast and complex field of research, but I trust that it will cover the major points bearing on abortion. As techniques become more sophisticated, we will be picking up data earlier and earlier in alpha's existence, so these should be viewed as the "latest possible"

point in alpha's development when things occur or become visible, under present knowledge.

A preliminary word about how the length of pregnancy is expressed. A pregnant woman talks about how many "months pregnant" she is. The obstetrician speaks of "weeks of pregnancy"; the "obstetrical weeks" are calculated from the first day of the last menstrual period, hence the synonym "menstrual weeks." However, in study of the developing human embryo the embryologist begins counting about two weeks later at ovulation or "conception," the fertilization of the egg. He typically talks of "days," but with embryological "weeks," two weeks must be added to translate each stage into "menstrual weeks." Confusingly, both embryologists and obstetricians speak of "weeks of gestation."

One of the most important new techniques for the study of alpha is ultrasonography, first described in 1958, which now does much of the work that the more hazardous X rays once performed. High-frequency sound waves are transmitted through the pregnant woman's abdomen, and the echoes are plotted to produce a visual image of alpha. Currently, the body of alpha within the amniotic sac can be seen at around six (obstetrical) weeks. Ultrasound provides an exact way to diagnose the existence of pregnancy and to determine the number of weeks of pregnancy. A major extension of the technique came in 1967 with the first report on realtime scanning, which transmits continuous impulses that are decoded to produce a moving image of alpha on a TV screen. The bedside console commonly in use today looks like one of those battery-operated portable TV sets that campers and boaters purchase. Research laboratories have more refined equipment. Realtime scanning allows us to study motor activity in the uterus, not only alpha's movement of arms and legs, but the pulsation of its heart and the movements of respiration. Another advance came in 1974: gray-scaling, which provides a more detailed depiction of alpha's body on the screen by more complex sonic emissions.

Another promising new technique is fetoscopy, a term that was established in 1974 following the first concentrated research in the early '70s. As with ultrasonography, it is applied both to establish the existence of defects (biochemical as well as physical) that might lead the mother to choose abortion, and also as a tool for

diagnosis of alpha as the patient, to help it survive. In fetoscopy, alpha is seen directly by use of a fiberoptic endoscope thrust into the pregnant uterus through the woman's abdomen. The best images for visual examination in early pregnancy are obtained at sixteen weeks, according to research done on 211 alphas at Toronto General Hospital during 1973-77.

Amniocentesis, now well known to women, is a procedure in which amniotic fluid is withdrawn in order to grow a culture for diagnostic analysis from cells that have flaked off of alpha's body into the fluid. Fetoscopy offers an improvement on this, in that healthy living cells can be plucked directly from alpha's scalp with a tiny forceps. With these specimens, study is quicker and more exact. With the aid of ultrasonography to guide the instrument, doctors are also able to obtain blood samples directly from alpha at eighteen to twenty weeks of gestation for diagnosis of specific diseases or of general health and nutrition. In one 1977 case, tissue was taken from alpha to establish the identity of the father in a disputed rape charge. We are now able to do blood transfusions on alphas inside the uterus from twenty-two weeks on. Injections and direct therapy for such blood problems as hemolytic anemia are near and "intrauterine fetal surgery may become a reality within a few years," according to Jordan M. Phillips of the University of California College of Medicine at Irvine. Clearly, the technique needs refining, for there is a "complication" rate of 5 per cent to 10 per cent with fetoscopy, but it holds great promise. Because of this rate, fetoscopy is not used presently except on a clinical research basis where there is strong therapeutic need.

Even without these new perinatal procedures, the basics of alpha's bodily form and function were well-known to human embryology at the time the U. S. Supreme Court issued its 1973 rulings, even though the rulings made no use of them. The data were detailed in a friend-of-the-court brief filed by a large group of anti-abortion physicians, and also in the main brief of the State of Texas, which sought to uphold its anti-abortion law. The same material is available in a number of books, including an excellent volume that is readily understood by non-specialists: *From Conception to Birth: The Drama of Life's Beginnings* (Harper & Row, 1971) by the late Roberts Rugh and Landrum B. Shettles.

The life processes begin at fertilization, when the sperm unites

with the egg to create a unique genetic entity for each alpha that will never be repeated. After fertilization the growing cell cluster spends about three days in the Fallopian tube and three days in the uterine cavity before it begins burrowing into the wall of the uterus. The burrowing is called implantation.

Even before this, the cells start to organize themselves ("differentiation") as they multiply rapidly, and all the familiar bodily systems and organs appear in subsequent weeks. Some highlights:

THE CARDIOVASCULAR SYSTEM

At day 14 after conception, occasional heart contractions can be perceived, at day 17 blood cells begin to develop, and by day 18, alpha's primitive heart has been known to begin its work. A better breaking point, however, is day 24, in the fourth week, when in each alpha the embryonic heart (then a simple tube) has started irregular pulsations. The heartbeat soon gains in force and regularity. In the old medicine, a patient was pronounced dead when both breathing and the heartbeat ceased, and if we apply this rule within the uterus, this would be the apparent point when alpha's "life" would be said to exist.

By approximately day 31 the heart has settled into rhythmic contractions, and the second heart valve has appeared (or will over the next few days). By five and a half weeks alpha's heartbeat has a general configuration similar to that of an adult and is sometimes traceable by electrocardiogram (EKG). Alpha by now is also pumping its manufactured blood through its own closed vascular system. In the sixth and seventh weeks the EKG shows all the typical heart phases that are recorded in an adult. It is at this stage that the beating of the heart also becomes visible through real-time scanning. Alpha now has a functionally complete cardiac system, readily observed by the doctor—before many women even seek tests to find out whether they are pregnant.

THE NERVOUS SYSTEM

With the development of artificial life-sustaining machines, an *ad hoc* committee at the Harvard Medical School proposed in 1968 a new definition of death to supplant the old heart-lung rule. The "Harvard Criteria," now widely accepted, are based upon a total lack of brain function. In my "Deeper into Abortion" article, I proposed these as an appropriate way to define the parameters of "life" at the other end of existence, within the uterus. There are four negative criteria in the Harvard test, each of which is required in order to establish death: no response to external stimuli (e.g., pain), no spontaneous movements or respiratory efforts, no deep reflexes, and no brain activity as indicated by a flat electroencephalogram (EEG).

The traditional medicine had it that there was no cerebral electrical potential in alpha through most of the nine months of gestation. This was discredited by 1951, the earliest study of which I am aware, by two researchers at Japan's Hokkaido University who did EEG tests on sixteen aborted alphas that ranged from three to seven months. They found electrical activity open to detailed graphing in the brains of the two three-month specimens (weighing only 26 grams and 38 grams), with fine waves superimposed on irregular slow waves. The four-month specimens showed a brainwave reaction to sleep-inducing and stimulant drugs that was almost the same as that in the adult. The researchers concluded that alpha's brain cells possess an ability to control states of consciousness from an early stage.

In the United States, EEG work received little attention until the studies of Bernstine and Borkowski in 1955, 1956, and 1959, which showed EEG tracings beginning at 43 to 45 days. They found that in these earliest graphs, alpha's sleep spindles were not unlike those during the sleep of adults, and later in pregnancy the response to sedatives, stimulants, and oxygen deprivation shown by EEG activity was also similar to that in the adult. In a 1964 paper read at the A.M.A. convention, Hannibal Hamlin of Massachusetts General Hospital applied EEG findings on alpha to the Harvard Criteria for death and stated: "At an early prenatal stage

of life, the EEG reflects a distinctly individual pattern that soon becomes truly personalized." EEG research in utero became far more precise in 1969 with the development of new and more sensitive electrodes. Because the line of birth has been made so important by the Supreme Court rulings, I should also mention the work of Lawrence Chik *et al.* at the Perinatal Clinical Research Center, Case Western Reserve University, showing that EEG activity in alpha's brain does not change abruptly at the time that birth occurs.

Turning to embryology, the ectoderm (the cells that will become the basis of alpha's nervous system) arises during implantation, and the system itself starts to form at day 18, which is why days 18-28 are termed the "neurula stage." By day 20 the foundations of the central nervous system, including brain and spinal cord, are established. By day 30, three parts of the brain are present, and the eyes, ears, and nasal organs begin to form. On day 31 the nerve root fibers in the primal spinal cord are visible and, on day 33, so is the differentiation of the cerebral cortex, the section of the brain that governs higher and more sophisticated activity.

By the sixth week, the five primary regions found in the adult brain are evident. As early as day 36, movements have been recorded on film, which means the primordial nervous system is stimulating the muscles. The earliest reflex arcs are established at day 42. Alpha's brain waves have been traced by EEG, as noted, as early as 43 days and are always readily discernible by the eighth week. In week 6 or 7 alpha responds to touch. Clearly, then, the parallel to the Harvard Criteria would establish the existence of alpha's life by the sixth week of gestation. Some sensory details from this period: At day 39 nerve fibers connect with the olfactory lobe of the brain, laying the basis for the sense of smell. In alpha's eyes, the nerve cells of the retina form at day 44, and nervous pathways connect the retina with the brain at day 48, though we do not know when alpha first "sees."

The Harvard Criteria may be established early, but the "consciousness" claimed by certain researchers is more difficult to evaluate. Some writers think that alpha's EEG waves have a low amplitude and a randomness that suggest rather low sensory input. With present technology, we cannot say when "con-

sciousness" occurs, but this is such a fluid term that it may defy exact biological definition. However, the attribute that is open to scientific study is the motions of alpha's body, which relate also to the brain's activity. It is not known exactly when the brain controls bodily movements. Early twitching could be caused by reflex arcs before the brain is in command. The brain surely controls more fluid motions.

The layman's mental image of alpha is that of a curled-up body that looks inanimate—the "fetal position." The modern obstetrician, through realtime scanning, thinks of alpha as an active entity, reaching out, raising its head, scratching its nose, and engaging in many other patterns with an altogether lively look. In an extensive monograph in 1976, Reinhold (of Vienna) stated that the first motions—slight changes of position—can be seen by realtime scanning around the eighth (menstrual) week, but motions are insignificant till 10–11 weeks when they become increasingly prominent and extensive. Then Birnholz *et al.* at Stanford University reported motions "from early in the first trimester" with considerable twitching of the trunk and head beginning as early as 7 weeks, independent limb movements by 8–10 weeks, and more elaborate motions subsequently. My colleague, radiologist Samuel Madell, tells me that alpha's motions are visible even earlier, at the first stages at which current ultrasonography is able to pick up alpha.

By the twelfth embryological week, when brain structure is essentially complete, alpha is spontaneously able to kick its legs, turn its feet, curl and fan its toes, move its thumbs, make a fist, bend its wrists, turn its head, squint, frown, open its mouth, suck its thumb, swallow amniotic fluid, and make inhaling-exhaling motions (though air, of course, is not inhaled until birth).

SEXUAL IDENTITY

With the modern emphasis on sexuality in defining personhood, it might be worth mentioning this aspect. The sex of alpha is fixed at fertilization. By day 14, it can be verified immunologically by the researcher by testing for the H-Y (male differentiation) antigen on the surface of alpha's cells.

Alpha produces its own primitive germ (sperm and egg) cells at day 21, after which they migrate within the developing body. By day 38 they cease migrating and are located in the forming testes and ovaries; these germ cells will become fully mature at puberty. At day 42 the penis begins to form in the male alpha; the female sexual organs form later. By day 46 the gonads have differentiated to the extent that sex could be determined by microscopic examination if it were not already knowable through biochemistry. At this time the 600,000 potential ova of a lifetime already exist in the female alpha.

OTHER BODILY FEATURES

To serious researchers on the definition of "life" or "death," the important thing is not anatomy, the fact that the heart or leg is there, but the activity of the heart or leg and how it initiates or responds to stimuli. Nonetheless, the following highly selective list of bodily features will indicate how remarkably early the differentiation of cells and systems can be seen, even by today's crude technology, and how bodily structure neatly accompanies and complements the heart and brain developments.

Week 2—At day 11 to 13 the primitive streak appears; it marks the main axis of what will be the body.

Week 4—By day 28 there are building blocks for 40 pairs of muscles from the skull through the developing spinal column. The mouth is opened and lung buds and a recognizable liver are visible. By the end of the week (with the body a mere ¼-inch long) intricately organized cell groups are differentiated into the incipient muscular, circulatory, digestive, and skeletal systems.

Week 5—By now, if not earlier, the stomach, esophagus, and intestines are defined. Arms and legs appear. The face begins to "look human," which is why this is the earliest point at which embryologists apply the designation "fetus" to alpha.

Week 6—Here fingers and limb muscles begin. By the end of the week the primitive skeletal system is complete. At 6 weeks or so, the major organ systems have formed.

Week 7—Digestive juices are present in a developed stomach, all fingers exist (though not in final form), individualized patterns

are visible in the ears of various alphas, transitional kidneys are extracting waste, and cartilage is changing into bone.

Danforth's *Obstetrics and Gynecology* (3d ed., 1976) defines differentiation as ending when all structures exist that are destined to be present at birth and fixes this at week 11 with the appearance of the nutrient artery of the long bone in the arm. By week 12, the close of the so-called "first trimester," alpha is a fully developed, functioning human body in merest miniature, 3 inches in length and tipping the scales at $\frac{1}{2}$ ounce. Its fingerprints and sole and palm lines are by now unique for each individual and remain for permanent identification throughout life. (The palm lines come first, appearing in individualized patterns in week 8.) Facial expressions are now also individualized.

What remains? The mother will experience movements of the body within her ("quickening") at 16-17 obstetrical weeks, but we know from modern biology that this age-old rule of thumb for life's existence is meaningless. Alpha's movements actually begin many weeks earlier. The major bodily developments yet to come are the extraction of oxygen from the air by the lungs (breathing) and the body taking nourishment and eliminating waste other than through the umbilical cord, along with changed routing of blood in the circulatory system. These steps occur at birth, approximately 266 days after conception or 280 days from the last period. That is, unless nature—or man—forces birth to occur earlier.

BIOCHEMISTRY

The most productive avenue through which we are currently increasing our knowledge of alpha is the study of its complicated physiochemical processes. Past discussions of alpha's "humanity" have emphasized its genetic makeup or bodily development, but this is where the riddle may be solved.

Recalling the dictionary definition of "life," it is from biochemistry that we know that alpha from its earliest stage is a responding and initiating entity, not simply "part of the mother's body," as the pro-abortion phrase goes. Daniel Callahan summarizes the facts succinctly: "Genetically, hormonally and in all organic re-

spects save the source of its nourishment, a fetus and even an embryo is separate from the woman."

Alpha's biochemical biography begins with implantation. The group of cells that will become the placenta produces hormones that enter the mother's bloodstream and prevent menstruation, now and throughout pregnancy. Otherwise, no life can develop and alpha will "miscarry" and be washed away into oblivion. It is absolutely the case that the great bulk of developments from implantation and beyond are initiated by alpha. It is thought that even the impetus for the start of labor comes from alpha when it is ready to leave the womb.

The mother is not aware of it, but her body fights against the "invasion" at implantation. It mounts an immune attack because of the different antigenic makeup of the two organisms, mother and alpha. The mother's body instinctively recognizes alpha as a foreign object to be repulsed, just as it does when an alien kidney is transplanted. Alpha thus is clearly—biochemically—an "other," distinct and immunologically different. Immune systems are exquisitely complex, individualized, and antagonistic to each other; in tissue transplant work, one must go through dozens of matchings to find a feasible "fit."

Biochemistry is the major way in which the obstetrician determines that alpha exists, by searching for the "pregnancy hormone" HCG (human chorionic gonadotropin). Beginning decades ago, pregnancy could be confirmed this way by eight menstrual weeks. In the old "A-Z" test, the mother's urine was injected in mice or other animals, which were then dissected to find signs of ovulation under the influence of the hormone from the urine. After I entered obstetrics, the animal tests were superseded by immunological tests. The most reliable method today, one in growing use, is "blood serum radio-receptor assay," a very sensitive and sophisticated test for HCG. With this method, refined in 1973, we can pick up this telltale biochemical signal of pregnancy at the time of implantation, just nine days or so after fertilization, even before the start of the next menstrual period would be due.

Rather early on, alpha develops its own defined endocrine system. The pituitary gland, a most important controller of biochemistry, begins functioning between (embryological) week 5 and week 7. For the first 20 weeks the pituitary gland apparently oper-

ates on its own; then it is tied into control from the brain. ACTH, the hormone from the pituitary gland that stimulates the adrenal gland, reaches levels that we are already able to measure between week 8 and week 12. Alpha's pancreas is defined by week 5 and functions through most of pregnancy.

It is increasingly clear not only that these biochemical processes are extremely complex, but that alpha's effect on the mother is far less understood than is the reverse. There is much public attention to the impact of the mother's drug taking or cigarette smoking upon alpha; far less to alpha's biochemical impact on the mother. This opposite aspect may become of vital significance to obstetricians, and at the moment, we can only guess at the complexity of these hormonal processes. If we can break the code, alpha will have a million messages for us.

While the Supreme Court, altering historic protections, defines the concept of "person" in order to permit the elimination of alpha, we in science are continually widening the concept of life. In the far reaches of our past history, paleontology is looking for the line that marks the human community off from non-humanity by studying primordial remains, the true-to-life equivalent of novelist Vercors and his "tropis." We are able to discover what these beings looked like and what they did; this is where the definitions are fixed scientifically. We will never know with certainty what their "consciousness" was. Meanwhile, in the far reaches of space, radioastronomy is listening for bleeps from beyond in an anxious search for other humanoid beings "out there" that may be transmitting their codes to us.

If "back then" and "out there," why not listen "in here," inside the human womb? We must expand our definition, our search for humanity, and technology and science are forcing us to do this. As yet the general public is incompletely informed, but eventually the research wing of medicine will pull society along with it. With alpha it is just as if an intelligent race of beings is transmitting massive electrical impulses from a distant star, and we are not receiving them . . . or we are refusing to receive them.

IF WOMBS HAD WINDOWS

In the abortion debate, these same data on alpha's development are usually interpreted in a special way, as the basis for drawing lines at various stages within pregnancy.

As I have stated, the most traditional of these lines—*quickenning*—has been eliminated by science since the nineteenth century, though it remains an important event emotionally for the woman patient when she feels alpha stir within her for the first time. We know that alpha actually is in motion as much as ten weeks previously. The morality of abortion under traditional common law was based upon when pregnancy was known to exist, which at one time meant quickening. By the same common-law logic, we are able through biochemistry to pick up alpha's transmitted message announcing its existence at a very early stage, when it imbeds in the wall of the uterus. In fact, women are becoming aware through ads in national magazines and TV that they can detect their own pregnancies, at home, shortly after a period is missed. The early pregnancy tests on urine, using an HCG antiserum, have become the new quickening, the point when women determine entirely on their own that they are pregnant.

Two other lines, *birth* and *viability*, are crucial to the U.S.

Supreme Court rulings of January 22, 1973, and hence to the entire abortion situation in the nation. There are two companion rulings, *Roe v. Wade*, challenging the Texas law, and the less important *Doe v. Bolton* regarding the Georgia law. The court overturned the abortion laws because of the "right of privacy." It was unable to determine where this right is located in the Constitution, whether in the Fourteenth Amendment's concept of personal liberty or in the Ninth Amendment's reserving of rights to "the people," though it leaned to the former.

The most famous passage of *Roe* is typical of a decision that was biologically jejune: "We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer."

Speaking for the "discipline of medicine," we know that there is an independent, self-initiating biological entity from the point when the sperm unites with the egg, and we are able to discern its presence and activity beginning with implantation. If this is not "life," what is? What Justice Harry Blackmun, the author of the decisions by the majority, ought to have said is that medicine cannot tell us whether or when alpha is a *protectable* life, which medicine cannot say. That is a legal and philosophical matter, one the court evaded by deciding it could not tell "when life begins." This is the crucial flaw in the decision. From there, the court quickly determined that alpha is not a "person" shielded by the language of the Fourteenth Amendment (" . . . nor shall any State deprive any person of life . . . without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.").

The court made much of the point of viability, defined as the time when the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid." Though that was the general principle with force of law, Blackmun made the unfortunate mistake of adding this sentence: "Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." He must have had the New York legislature's "splitting the difference" in mind in citing twenty-four weeks, a line unknown to obstetrics. Even Roy Lucas's brief for the American

College of Obstetricians and Gynecologists *et al.* cited a 1971 text noting that definitions ranged between 400 grams (about 20 weeks of gestation) and 1,000 grams (about 28 weeks). Blackmun's incursion into medicine was regrettably ill-informed in that he seemed unaware that all discussion of viability and survival rates must be based upon weight in grams, not weeks. Most important, the words were not only inaccurate but obsolete even as they came out of Mr. Blackmun's typewriter. The concept is fluid and is constantly being pushed backward. It seems to me that a court that is supreme has a supreme responsibility to acquire the most informed technical expertise in framing a decision of this sort.

In January 1979 the Supreme Court altered the *Roe* definition slightly in the case of *Colautti v. Franklin*, which threw out Pennsylvania's abortion-control act. Now we are told that the physician should find "a *reasonable likelihood* of the fetus' *sustained survival* outside the womb, with or without artificial support." The court then adds: "Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or fetal weight or any single factor—as the determinant of when the State has a compelling interest in the life or health of the fetus." So far so good; the court appears to accept the obvious medical fact that in each case (or, for that matter, in all cases collectively) the viability line is not fixed. Then the Supreme Court outlawed Pennsylvania's law as being too "ambiguous." The state's rule of "may be viable" is said to "carve out a new time period . . . when there is a remote possibility of fetal survival outside the womb, but the fetus has not yet attained the reasonable likelihood of survival that physicians associate with viability." The court objects that the "probability" of a particular fetus's chances "can be determined only with difficulty" and that doctors will disagree, so a law inflicting criminal penalties on doctors for such judgments is unfair. Pennsylvania does not give the doctor "the room he needs to make his best medical judgment" (the last phrase taken from *Doe v. Bolton*).

In a stinging dissent, three justices accused their six colleagues in the majority of scuttling the court's own 1973 rule of "potentially able to live" outside the womb, and thus of narrowing pro-

tection of alpha. All of this reinforced my prior conviction that the court has propped up its abortion policy on an impossibly vague and unstable concept: viability. Because of this vagueness, it now appears quite likely that any future law written to protect "viable" fetuses may be struck down because it, too, is vague, as any law or any Supreme Court decision on viability must be.

The *Roe* decision, relying on viability in part, proceeded to carve pregnancy into three sectors and fixed rules for each:

First trimester—For the first twelve weeks or so, the state is forbidden to control abortion in any way. The "woman and her physician" are granted full power. The argument is that abortion is safer during this period than normal childbirth (true), so that the state has no reason to regulate abortion in order to protect the mother's health (false). The state regulates other medical procedures and facilities that involve even lower mortality rates, so how can it wash its hands of abortion? Even barber shops are licensed, and nobody ever died of a haircut. Abortion clinics need approval from the fire department and the housing inspector. It seems we should regulate everything in an abortion clinic except abortion.

After the first trimester—At this phase the state gains permission to regulate such medical matters as the doctor's qualifications or the type of facility. Abortion as such remains none of the government's business and remains unregulated. Thus, the court requires fully elective abortion for approximately six out of the nine months.

After viability—Here the government's interest in the "potential life" is said to reach a "compelling" point, because the fetus "presumably has the capability of meaningful life outside the mother's womb." That important word "meaningful," which crops up suddenly in the summary of Section X, is nowhere defined. Does a stroke victim have a "meaningful" life in coma? Who is to judge? Why is life "meaningful" and on what criteria? In any event, "meaningfulness" has nothing whatever to do with medical usage regarding viability. The court continues, "If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother." Later, it adds the definition, "where it is necessary in appropriate medical judgment" to abort.

This "health of the mother" standard amounts to virtual elective abortion throughout the nine months because of the sweeping way in which "health" is used by pro-abortionists to cover every possible problem of mind and situation (recall the infinite elasticity of psychiatric grounds), and because the court nowhere offers a medical refinement of the term. Note well that the court says only that the state "*may* go so far" as to forbid non-health abortions and protect alphas after viability. It need not do so. Thus, in the eyes of the court and the law of the United States, birth is the socially significant line at which the government protects all lives equally, not viability.

I have stated earlier that the court here invented the concept of "abortion" between viability and birth, previously unknown to obstetrics and gynecology. All of these "abortions" necessarily result in the live births of viable infants, unless the physician is unaware of the clinical definition of abortion and mistakenly tries to terminate the life. The fate of these newborns is nowhere explained. This is all medical nonsense. There is no accepted obstetrical procedure for intrauterine death after twenty-two weeks.

What does medical science tell us about these lines drawn by the Supreme Court and others?

BIRTH

The most obvious change at birth is breathing, as the lungs are galvanized into activity. Inside the uterus, alpha carries out spontaneous respiratory movements, but the lungs are not expanded since their function is not necessary and they are bathed in amniotic fluid. The routing of blood in the circulatory system and the intake of nutrients and the outgo of wastes are shifted. All other functions of the newborn baby, even crying, may occur within the womb. In terms of metabolism, biochemistry, brain, and heart function, and most everything else, birth is an insignificant event, indeed a mythology. At term, i.e., at the end of pregnancy, alpha's growth needs simply outstrip the ability of the placenta to supply food and oxygen, so the lungs and mouth must take over. The organism is put into a different physiological milieu—and nothing

more. It is like switching from AC to DC current; the energy connection changes, but the basic mechanics remain the same.

What does change, then? Until birth, alpha is invisible, except to obstetricians, who are the people who generally see (and diagnostically perceive) alpha before birth. If the abdominal wall of the pregnant woman were transparent, what kind of abortion laws might we have? And what will happen when we soon achieve the ability to transplant a very young alpha from one uterus to another? Will alpha achieve Fourteenth Amendment rights when it becomes visible for a few moments during the transplant? The whole approach based on visibility outside the womb is sheer superstition. From ancient times, birth has come down to us as some sort of mystical rite, and our views are not much removed from those of the primitives. We must cut through this mythology in any serious effort to decide what to do about alpha.

(Examination of the birth line calls to mind the "Potter Paradox." In the '30s an obstetrician in Buffalo named Irving Potter had an unusual method for performing Caesarean hysterectomies in cases of tumors of the uterus or severe infections. He would remove the uterus intact, with alpha still inside, carry it over to a side bench, then open the uterus and take the newborn baby out. Was the baby "born" when it was out of the mother or when it was out of the uterus? Similarly, there is a moment at childbirth when the baby is outside the womb but the cord has not been cut and it has not taken its first breath. In Blackmun's thinking, would it be legal "abortion" or illegal infanticide if we killed it before the cord was cut and the breath was taken?) As we will soon see, the more thoughtful pro-abortion philosophers are also deserting the frail birth line.

VIABILITY

When is alpha presumed to be capable of life outside the womb? This is a difficult matter, dealing with probabilities and possibilities. Up to the '70s, obstetricians used 1,000 grams (a little over 2 pounds, and around 27 weeks) as the point where they should exert every effort to salvage the life by such techniques as Caesarean section and the respirator. There was a reluctance to

use extraordinary measures below that point, but the line is going down. Most now adhere to a rule of 750 grams (1 pound, 10½ ounces, and around 25 weeks). With present technology, alpha is not considered salvageable by ordinary means below 500 grams (a bit over 1 pound), which is the rule of thumb for calculating perinatal deaths. However, as an indication of the "downward" momentum in the field, the National Center for Health Statistics has asked the American College of Obstetricians and Gynecologists to support it in moving the reporting of "fetal wastage" (including abortions as well as perinatal deaths) from 500 grams down to 350 grams (12.35 ounces). An American College panel turned down that request in 1978, but the very fact that this rule is under debate shows the trend. (The layman may note with some perplexity that we obstetricians routinely record the deaths and must fill in "fetal death certificates" on entities that are, by the law of the land, non-persons, whether they are "viable" or not.) In 1975 the National Commission for the Protection of Subjects of Biomedical and Behavioral Research defined "possibly viable infants" at 500-600 grams and 20-26 weeks. A similar commission in Britain in 1972 cited 300 grams and 20 weeks as the line for "possible viability." The 20-week point is used to define the beginning time frame for the practice of perinatology.

One difficulty here is that possibility is not the same thing as the farthest conceivable known instance. How early have babies been born and survived? Parkland Hospital, Dallas, reported that of 125,000 deliveries during 1956-76, no infant weighing less than 775 grams survived. At Kings County Hospital, New York, with 121,000 cases during 1961-72, only two infants survived weighing under 700 grams, the smaller of these at 540 grams. Blackmun's "viability" figures have essentially vanished at St. Luke's Hospital Center, where I practice. During 1977, six of nine infants admitted to the Special Care Nursery in the 751-1,000 gram category survived, a 66.7 per cent rate. One of the five in the 501-750 gram category lived, a 20 per cent survival rate. There is a report from 1939 of the survival of a 397-gram infant, which is usually discounted because the baby was weighed on a village grocer's scales. Still, the grocer could have been accurate.

This brief survey may help to explain my vigorous objection to the whole concept of "viability" and "trimesters" in regard to the

abortion matter. Viability is the current reflection of medical achievement and is too evanescent to deal with such a fundamental issue. An infant could be "viable" in New York City but not in a rural U.S. town, or in the rural town but not in Bangladesh. Everything is potentially viable; there are only limits of technology to overcome. The lines are shifting, and they will shift to earlier and earlier points. In the future, artificial incubation may make alpha "viable" at any time in pregnancy. The whole concept of viability is currently in danger of obsolescence; one might even say that the concept itself is not viable.

That is my practical objection, but there is a logical problem with viability, as well as the Supreme Court's real base line of birth. These depend on the medically absurd dogma that only independent and "unsupported" life is worthy of protection. No moral or medical distinction can be made between the fetus depending upon its placenta and the infant who depends on the mother's breast or the provision of a bottle for nourishment on the day after birth. Apart from food, the newborn is dependent on its parents for many other things as well. In fact, dependence on others never ceases for any human; it is merely strongest at the beginning and end of life. To take a specific instance, there is no ethical difference between alpha "plugged into" the mother and the full-grown adult who is dependent upon a kidney machine.

As for "trimesters," they are an artifice, a convenience for talk by obstetricians. They have no scientific validity for alpha or for the serious thinker trying to decide what to do about abortion. The only significance of the first trimester is that this is the period when the D and C technique is not as dangerous for the mother as in later pregnancy. It is not a decisive point in defining alpha's existence. I challenge the whole trimester concept as outmoded, illogical, and penultimately unusable.

CONCEPTION

If birth or perhaps viability is where pro-abortionists draw the line, the anti-abortionists draw it at the time when the sperm fertilizes the egg. This is where it all begins, they contend. The traditional Christian opinion, as worded by John Noonan of the Uni-

versity of California, Berkeley, Law School is that "if you are conceived by human parents, you are human." This belief is still embraced by various religious groups (see Appendix B) and lurks behind much of the Right-to-Life thinking.

In modern dress, this is known as the "genetic" argument, because when sperm and egg unite this creates a distinct genetic entity of forty-six chromosomes. If genes—and only genes—are destiny, perhaps this is correct. The pet slogan we pro-abortionists used to throw against this idea was, "A blueprint is not a house," meaning that a genetic entity is not the same thing as a human being. Perhaps not, but alpha is no blueprint, either. Unless its processes are interrupted, it grows into a "house" on its own. No blueprint has an inner impulse such that it magically grows into a house in nine months without carpenters.

Genes are important, and fertilization is indeed the start of things. Still, I find this an unconvincing basis for abortion policy. Some entities that stem from the union of sperm and egg are not "human beings" and never will develop into them:

1. The hydatidiform mole, an entity which is usually just a degenerated placenta and typically has a random number of chromosomes (aneuploidy).

2. The choriocarcinoma, a "conception-cancer" resulting from the sperm-egg union is one of gynecology's most malignant tumors. Aneuploidy is also common.

3. The "blighted ovum," a conception with the forty-six chromosomes but which is only a placenta, lacks an embryonic plate, and is always aborted naturally after implantation.

4. If and when human cloning occurs, are we to say that this is *not* a human life because it does not result from the union of sperm and egg?

Also, I wonder, are all fertilized eggs "lives" that must be protected and cherished? Many do not implant and are simply washed away. How would we deal properly with these lost conceptions? Do we discuss them in concrete terms? Name them? Mourn and bury them? Must we intervene in every act of intercourse without birth control to protect possible "life"? Should we undertake a crash program to make sure all these fertilized eggs, as "human beings," are saved and implanted? The disarray of this whole approach to "life" boggles the mind and requires a long

leap of faith that most of us are unable to make—and in particular this author.

There is an all-important practical problem with use of the fertilization line: it posits "life" that is unknown and unknowable by the woman or anyone else. It has no practical meaning. There is no way to protect something whose existence is not proven.

The genetic school relies upon the "potential" that is represented by the existence of the genetic code and by the beginning of a process that produces "actual" life subsequently. There may someday be a definition of protectable life somewhere in the context of genetic identity, but I certainly do not think the evidence is there yet.

(It should be emphasized that if the line is drawn here, as in Roman Catholic thought, it eliminates the "morning-after pill" as a means of birth control, and most probably the intrauterine device or IUD, which is thought to interfere with the implantation of an already-fertilized egg. It would also rule out the next major step in contraception, a vaccine to prevent implantation.)

Perhaps the "test tube baby" trial of 1978 will force us all to rethink all this. In that case, Doris and John Del Zio sued Raymond Vande Wiele, chairman of Obstetrics and Gynecology at Columbia University's medical college and director of the department at Presbyterian Hospital, with the university and hospital as codefendants. Vande Wiele destroyed a presumed fertilized egg from the Del Zios' seed that Landrum Shettles planned to implant in Mrs. Del Zio. The jury bought the Del Zios' imaginative claim and awarded the aggrieved wife \$50,000 in damages. The husband was granted \$3. In this case, if no other, the fertilized egg that the Supreme Court considered worthless is worth \$50,003 under civil law.

BRAIN AND HEART FUNCTION

As described in the preceding chapter, the application of the Harvard Criteria to the alpha problem produces a brain-related determination of "life" during the sixth week after fertilization or eighth "week of pregnancy." Under the more traditional life criterion of heart function, alpha can be said to exist as "human

life" at day 24 in the fourth week, or sixth "week of pregnancy." This is an appealing approach, in harmony with the best science and the best medical reflection on life-and-death definitions.

IMPLANTATION

However, further reflection since I made that proposal in "Deeper into Abortion" has forced me back to an earlier point, the implantation of the blastocyst in the wall of the uterus. Biochemically, this is when alpha announces its presence as part of the human community by means of its hormonal messages, which we now have the technology to receive. We also know biochemically that it is an independent organism distinct from the mother.

(An aside: Some moral theologians, including Paul Ramsey of Princeton University, make much of the last point after which identical twins could occur with the division of the zygote, reasoning that individuality is only fixed beyond this point. However, this time is virtually the same as implantation and so is not dealt with separately here. Fraternal twins do not raise this issue because they result from two separate fertilized eggs.)

Alpha establishes its presence to the rest of us by transmitting its own signals—by producing hormones—approximately one week after fertilization and as soon as it burrows into the alien terrain of the uterine wall. The HCG is discovered by the mother, doctor, and society when it enters the mother's blood and urine and is picked up via the use of immunological techniques. Besides biochemical identity, in my view the nexus between alpha and the mother, which the HCG reveals to us, also establishes alpha's humanity. Before the connection is made, alpha is a free mass of tissue floating in the tube or the uterine cavity, connected only by the code of its chromosomes with the entity it will become. It has the genetic structure but is incomplete, lacking the essential element that produces life: an interface with the human community and communication of the fact that it is there. This is a highly sophisticated medical accommodation of the pro-abortionist's rule that life is not protectable until we "see" it. In this case, we do not

visualize it as a newborn outside the womb, but rather we "perceive" it through modern biochemistry.

(Another aside: If implantation is biologically the decisive point for alpha's existence, what do we do about the "test-tube" conceptions? The zygote in these cases is seen in its culture dish and could be said to announce its existence even before it is implanted. It seems to me that when it is in the dish the zygote is already implanted, philosophically and biochemically, and has established the nexus with the human community, before it is "re"-implanted into the mother's womb.)

Daniel Callahan contends that biological data cannot be conclusive. He is right in that the known existence of alpha as a "life" does not mean that its existence will be valued, nor does it mean that its existence must be preserved in every situation, nor that laws to protect it necessarily are required. However, in terms of making a general judgment about abortion, I fail to understand what we need to know scientifically that is not known now. The mass of data is sufficient to convince the most recalcitrant investigator. Besides that, the data have developed a tremendous momentum over the past twenty-five years, moving us closer and closer to the full definition of alpha's identity. (As a reminder of the rapid changes, when I entered obstetrics we were mistaken on how many chromosomes the human being has.) There is an inexorable march backward into gestation. We may someday learn of neurological activity at an earlier stage, or that a particular number of cells in the earliest days before implantation is the beginning of the brain. Definitions will easily be outdated, and we cannot allow ourselves to be trapped in today's transient data. What tremendous new thing about alpha will be discovered after I write these words and before you read them, or the week after you have read them?

The technology will not cease; the destination is foreordained.

UNPLUGGING THE VIOLINIST

While the slogan-saturated public debate on abortion has raged, a serious intellectual discussion in favor of abortion has been proceeding, with scant notice. Because the participants are professional philosophers, they are not mired in some of the shallow argumentation that has been dismissed above. Though the biological facts about alpha already cited might appear overwhelmingly convincing to many, this school of thinking is fully cognizant of the facts and yet remains pro-abortion. These philosophers, in other words, bite the bullet. They grant that many popular arguments for abortion are specious, they grant the facts of embryology, and they demythologize the birth line. And knowing these facts, they find the conscious mass elimination of alpha to be perfectly acceptable.

Among the leading exponents of this position are Judith Jarvis Thomson of the Massachusetts Institute of Technology, Mary Anne Warren of San Francisco State University, and Michael Tooley of Stanford University (see Bibliography for citations).

Thomson readily admits that there is little sense in drawing lines within alpha's development, and she grants also that alpha becomes a "person" well before the point of birth (though not in

“very early” pregnancy). Even if alpha is a “person” from *conception*, however, Thomson justifies abortion. She does so by spinning an ingenious tale:

Suppose a famous violinist has a fatal kidney ailment. Then suppose one morning you wake up to find that, against your will, you have been confined to a bed and that the violinist has been plugged into your body for the next nine months, using your kidneys so he can live. In other words, you are a living dialysis machine. The violinist in the parable is, of course, alpha.

Is the plugging-in just? Thomson thinks not: “Having a right to life does not guarantee having either a right to be given the use of or a right to be allowed continued use of, another person’s body.” In most cases, “nobody is morally *required* to make large sacrifices of health, of all other interests and concerns, of all other duties and commitments” for a period of nine months in order to keep another person alive. This would require pregnant women to be Good Samaritans, whereas society and the law should require only that they be “Minimally Decent Samaritans.” Because of her “minimal decency” standard, Thomson, unlike Justice Blackmun and his colleagues, is unwilling to accept total abortion-on-request. She does not find it minimally decent to abort so that one does not have to postpone a pleasure cruise for a few months.

But, it might be objected, the woman in the story is plugged into the violinist involuntarily, whereas pregnancy results from voluntary intercourse. Thomson holds that parents have a responsibility to alpha if they do not practice birth control and thus are voluntarily opening themselves up to a pregnancy. But sometimes pregnancy results even if birth control is used. “If they have taken all reasonable precautions against having a child, they do not simply by virtue of their biological relationship to the child who comes into existence have a special responsibility for it.” A couple can “pull the plug,” so to speak, if large sacrifices are required of them.

Mary Anne Warren, Thomson’s fellow pro-abortion philosopher, thinks that the violinist analogy works, “probably conclusively,” in the case of rape, where the woman is unwillingly pregnant. But it does not clearly work otherwise, she says, because the woman simply cannot claim that she is in no way responsible for her pregnancy. Warren says that a closer analogy to pregnancy

would be if Thomson's tale involved a voluntary society of music lovers in which one of the obligations of membership is the chance that you might be selected by lot to be plugged into the famous violinist for nine months. As with sex and pregnancy, the member who joins the society of music lovers voluntarily places herself into a situation in which human life will be lost if she does not fulfill her assignment.

As an obstetrician, I would raise other objections. But before doing so, it is very important to point out that Thomson's discussion correctly preserves the all-important moral distinction between the right of a woman to separate herself from alpha and her right to demand alpha's death. You are morally permitted to unplug yourself from the violinist, but you cannot then "turn around and slit his throat." This will be brought up again subsequently.

I must object strenuously to Thomson's portrayal of pregnancy as a nine-month involuntary imprisonment in bed. This casts an unfair and wrongheaded prejudice against the consideration of the state of pregnancy and skews the argument. Pregnancy is not a "sickness." Few pregnant women are bedridden and many, emotionally and physically, have never felt better. For these it is a stimulating experience, even for mothers who originally did not "want" to be pregnant. It seems that pregnancy must be cast as a very heavy disability (albeit one of limited nine-month duration) in order to make abortion seem justifiable. At N.A.R.A.L., the women sometimes called alpha a "parasite," and Larry Lader regularly spoke of it as the "aggressor." It is true that when alpha dies within the uterus it may be a deadly aggressor against the mother in that the placenta may release poisons into the mother's bloodstream that interfere with blood clotting. But when alive, alpha is no more a "parasite" than a newborn infant is. (Oddly, recognition of alpha as an "aggressor" means that it is an "other," thus refuting the feminist claim that alpha is only "part of the mother's body.") Except in the case of well-defined medical indications, alpha does not hurt the mother by being "plugged in." In those few cases where pregnancy is a medical penalty, it is a penalty lasting nine months.

Why do some women object so to the state of pregnancy? It is the feminists themselves who have had a major impact on obstetrics in eradicating the older assumption that the pregnant woman

is somehow ill and should be "taken care of." We do not sequester pregnant women like sick people any more. Feminists cannot have it both ways: Are they sick and put-upon while pregnant, or are they not? This whole approach also totters due to the legislation that forbids discrimination against pregnant women, whether married or unwed. They can work without interruption. What other sanctions, legal or cultural, are now applied against pregnant women? Apart from the medical problems, or woes of poverty that society should alleviate in any case, what is the pregnancy penalty?

Not only does the woman make no large "sacrifices" of other duties and health, as Thomson puts it, but she may even contribute materially to her future health by not interfering with alpha. WARNING: THE SURGEON GENERAL HAS DETERMINED THAT NON-PREGNANCY IS DANGEROUS TO YOUR HEALTH. Estriol, a hormone that is discoverable in large amounts in the blood and urine only in pregnancy, may well be an agent in preventing one of the most dreaded killers of women, breast cancer. Statistically, women who have given birth suffer less from the disease than women who have not. A public-health study of the virtual non-existence of breast cancer in New Guinea proposed the theory that this is because the women there spend such long stretches of their lives either in pregnancy or in suckling their babies. The suggestion is that it is abnormal to have menstrual periods each month and that the body expresses this in the relation between menstruation and breast cancer. We are just at the beginning stages of learning about the highly complex hormonal impact of alpha upon the pregnant woman. Unlike in the violinist tale, the placenta is an organ of both alpha and mother, not a simple "plug." The unplugging may affect the woman's biochemistry. This calls to mind the case of Siamese twins whose physiologies are so intertwined that when one dies the other has to die also. What if the mother turns out to be as dependent on alpha as alpha is dependent on the mother? Or *more* dependent? We simply do not know. There are huge biochemical question marks that are only slowly opening up to our elegant research methods.

Keeping in mind that the line of birth is physiologically unimportant, and granting for the moment Thomson's assumption that alpha is a "person" except in very early pregnancy, what sort

of morality do we end up with? Is there no obligation to others who are dependent on us? Suppose that only breast feeding of infants is available, as is true in many cultures. Or to take an exact instance from pediatrics, suppose an infant has an allergy such that it can tolerate *only* the mother's milk for nourishment. Is the mother justified in either case in "unplugging" the baby from her breast, committing infanticide by starvation, once her breast has supplanted the placenta as the source of her offspring's nourishment? It seems to me that if anyone is totally dependent upon another person in this way, then that person has an immutable moral obligation.

All this leads us back to the sorts of questions raised by the pro-abortion position: Is alpha a "person" after all? How do we define "humanity"? How do we regard the intrinsic worth of alpha? These are at the heart of Mary Anne Warren's thought. She grants that most of the pro-abortion arguments "fail to refute or even weaken" the anti-abortion stance that abortion is akin to murder because alpha is a "human being." Rather than facing this, Warren states, pro-abortionists seek instead to argue from the terrible side effects of abortion or the sufferings of the poor, which do not demonstrate that a prohibition is unjustified. Murder is wrong, regardless of the consequences of passing a law forbidding it. She also dismisses the "right to control one's body" as a feeble argument because it is inappropriate to describe a biological entity within the woman's body as her property, and because ownership does not give a woman the right to kill innocent people whom she finds on her property.

Therefore, she justifies abortion by working from this major premise: "A fetus is a human being which is not yet a person." As a non-person, it does not have full moral rights. This, of course, is what the Supreme Court said, with the difference that Warren goes on to offer intellectual support for the contention. She rejects the "genetic sense" of being human (part of the species *homo sapiens*) in favor of the "moral sense," meaning that to be a person one must be a full-fledged member of a "moral" community. Warren then proposes five criteria of personhood:

1. Consciousness (of objects and events) and the "capacity to feel pain."
2. Reasoning.

3. Self-motivated activity.
4. Ability to communicate "messages of an indefinite variety of types."
5. The presence of self-concepts and self-awareness.

A very similar theory is advanced by Joseph Fletcher, the Episcopal clergyman and utilitarian moral theologian who pioneered in "situation ethics." Fletcher's fifteen criteria for humanity: "Minimal intelligence, self-awareness, self-control, a sense of time, a sense of futurity, a sense of the past, the capability to relate to others, concern for others, communication, control of existence, curiosity, change and changeability, balance of rationality and feeling, idiosyncrasy, neo-cortical function."

Philosophers make unreasonable demands in requiring science to prove conclusively such matters in regard to alpha. When I entered obstetrics we knew next to nothing about alpha. Today we know a great deal, and there is progress in the direction of answering some of Warren's demands, though they may never be fully answerable. Can we argue from ignorance, presuming that alpha has no "memory" because we do not know what it has (just as we once supposed it had no brainwaves and, before that, that it did not move until "quickenings")? There are some indications of prenatal impressions. At later stages, at least, alpha is known to respond to such insults from the outside world as loud sounds or severe shaking. Memory does exist in regard to sound, which is why some parents use a soundbox to emit a sound like the mother's heartbeat in order to soothe newborns. Research at the Boston Children's Hospital has shown that alphas jump when loud noises are made next to the abdomen, and that they turn in the direction of soothing noises. In a similar experiment with light, the alphas started when a bright light was shone through the mother's abdomen, and turned slowly toward a red light placed in the same spot. Alpha obviously responds differently to varying sensory experiences.

Warren explains that one need not meet all five of her criteria to be a person, but that an entity that satisfies none of the five is "certainly not a person." I again ask, how can we be sure that alpha does not? Warren rather cavalierly rejects biological data: "Being genetically human, or having recognizably human facial and other physical features, or detectable brain activity, or the ca-

capacity to survive outside the uterus, are simply not among these relevant attributes." (Italics mine.) She is consequently open to very late "abortions" after "viability" because she considers emotional revulsion against a practice no basis for forbidding it. In her opinion, an eight-month or nine-month alpha may indeed respond to pain and have a rudimentary form of consciousness, but in relevant respects is "considerably less personlike than is the average mature mammal, indeed the average fish." Alpha is judged to have no more "right to life" than does "a newborn guppy." In another essay, quite consistently, Warren accepts as moral the raising of an alpha for the intentional purpose of slaughtering it in order to acquire its organs for transplant, i.e., organ farming.

A number of readers of Warren's essay inquired after publication about how her criteria would distinguish between alpha and a newborn baby. That is, if we accept her basis for abortion, are we also accepting infanticide? She replied in an addendum to her article when it was published in an anthology. It quickly becomes clear that Warren does not think that infants have any absolute right to life either. She opposes infanticide not in principle but in practice, in the general run of cases, because adoptive parents would like the infant and would be deprived of pleasure if it were destroyed, and also because "most people value infants." The newborn's value depends wholly on the subjective response it stirs in other people, not on its own intrinsic worth. Note well that Warren accepts infanticide in the case of an unwanted or defective infant who is born into a society that is unable or unwilling to care for it.

Michael Tooley casts hesitation to the wind. Like Warren, his pro-abortion ethic would protect life "only if it possesses the concept of a self as a continuing subject of experiences and other mental states, and believes that it is itself such a continuing entity." Following the same sort of self-consciousness line, he quite logically accepts infanticide. The newborn human possesses no more of a self-concept, he states, than does the newborn kitten. The open season on infants, he thinks, could last perhaps a week after birth in order to select those babies that are desirable for extinction.

Why not two weeks? A month? Others might decide on a year which, after all, is the point when EEG testing indicates that cor-

tical activity reaches full development. Some will certainly be ready to break the one-week line to withdraw diplomatic recognition of the personhood of an infant whose polycystic kidneys or cystic fibrosis was not diagnosed at one week and which maladies require anguishing and elaborate care. At the very least, we must insist that Tooley define some kind of time frame for the absence of self-consciousness, else we do away with everyone in coma or under anesthesia. The implications of all this, let us clearly realize, go well beyond Tooley's one-week free-fire zone. If self-consciousness is required, we can just as easily dispense with the comatose adult, the severe psychotic, the retardate with an I.Q. of 25, or the catatonic schizophrenic with an I.Q. of 180. This is not the Slippery Slope devised by name-calling Right-to-Lifers, but a slope that is explicitly greased by certain pro-abortion intellectuals themselves.

The collapse of the distinctiveness of birth and the implications to be drawn from it are not only the occupation of philosophy professors. An editorial in the *New Republic* (July 2, 1977) stated that "there clearly is no logical or moral distinction between a fetus and a young baby." Nevertheless, the journal endorsed open abortion, arguing that the "social cost" of preserving alpha against the mother's will is simply too great.

Looked at scientifically, it seems to me that my proposed line of demarcation at implantation, or even the later time of diagnosable heart or brain function, is vastly superior to Warren's approach and similar schemes. First, my argument is confirmable; hers is not. Second, a sound experiment should be reproducible within the same framework and applicable to all cases. But experts would disagree on when newborns become "persons" under her criteria. It is difficult to argue with biochemical reactions, cell organization, or graphable heartbeats and brainwaves. Finally, Warren rules out of the ranks of "personhood" a number of those who are perfectly definable as human beings. Especially with Tooley's framework, this could include some 3,500,000 newborn infants per year who would be, at least temporarily, American non-persons.

In reflecting upon such essays by reputable scholars, I am reluctantly led to agree with Paul Ramsey that every good argument for abortion is a good argument for infanticide. Obstetricians

above all would have to agree that birth constitutes no dramatic shift in dependency, status, or function. Once we see this line for what it is, there is no remaining distinction between a dependent non-viable alpha and a viable one, or between a viable alpha within the womb and a newborn outside it. This news is seeping through gradually to the general public. Placing the husband in the delivery room is one important step toward removing the ancient aura of myth surrounding birth. When the myth and the magic have finally disappeared from the birth line, then an aborting society inevitably will accept infanticide, beginning with defective infants. Inexorably, we are marching toward that day without realizing it.

At the end of considering all the arguments in favor of wide-open abortion, it occurs to me that the more biological data we amass, the less attention we seem to pay to it. The *science* of the abortion debate is simply not in dispute. Personhood does not really depend upon consciousness, but upon people recognizing the human life that is there among us, beyond this strange talk of "human beings" who are yet not "persons," beyond the word games and the straw men, beyond the guppies and the kittens, beyond the labels that writers devise to camouflage their point system for assigning value to human lives, and beyond an insubstantial utilitarian ethic that fails to come up to the lowest levels of human justice.

JUST WAR IN THE WOMB?

I find the philosophies that accept abortion under all circumstances to be inadequate because they fall so far short of the most profound tenet of human morality: "Do unto others as you would have them do unto you." Because of ancient religious traditions, we have put an aura of sanctity around the Golden Rule, as though it were either a sectarian tenet or some impossible ideal that we must strive to meet.

On the contrary, it is simply a statement of innate human wisdom. Unless this principle is cherished by a society and widely honored by its individual members, the end result is anarchy and the violent dissolution of the society. This is why life is always an overriding value in the great ethical systems of world history. If we do not protect innocent, non-aggressive elements in the human community, the alternative is too horrible to contemplate. Looked at this way, the "sanctity of life" is not a theological but a secular concept, which should be perfectly acceptable to my fellow atheists. In the concise form, "Do no harm," it remains the fundamental code for physicians, religious or non-religious. The relevant rule of the Ten Commandments, "You shall not kill," or as this is

properly interpreted, wrongfully kill a fellow human, is also universal human wisdom.

This is a far different line of moral reasoning from that of the conventional religious argument on abortion, which basically is that a personal God has created each life, so it is precious. The question instead becomes whether alpha is an "other," a "neighbor," an entity that we "shall not kill" because of our moral duties to one another. The biological facts require us to consider alpha to be an "other" that we must "do unto." It is a distinct organism that, because it is defenseless, needs special protection from mothers, from doctors, and from society. Alpha is the smallest and most precarious entity in the spectrum of the human community. (Even in my pro-abortion days, I was always a little puzzled privately by the spectacle of Christian ministers laboring on behalf of abortion, given their religion's insistence that we must protect the weak, but I never really thought this through.)

For those who may not realize it, I should explain that the Golden Rule is non-denominational. The most famous and sublime formulation does come from Jesus, in the Sermon on the Mount: "Whatever you wish that men would do to you, do so to them." But a generation before Jesus, another Jewish rabbi, Hillel, stated the same concept negatively: "What is hateful to you, do not do unto your neighbor. This is the whole Law; the rest is commentary." Before Hillel, the same phrasing appears in the Jewish tradition in Tobit 4:15. In the Eastern cultures, it was formulated even earlier, in the *Analects* of Confucius: "Never do to others what you would not like them to do to you."

If we morally reject the concept that any and all abortions are acceptable, as I believe we must, the question then becomes, in what circumstances should abortion be considered moral?

In moral philosophy, life has never been an absolute. Doctors are not required to use all sorts of extraordinary means in order to sustain a life that inevitably is dying. Even intentional killing has sometimes been acceptable, as in cases of justifiable "self-defense." In legal executions, killing is alleged to apply just punishment to wrongdoers or to deter crime. Even then there is often a hesitancy; a blank bullet was put into one of the rifles for the firing squad so no individual rifleman could be certain that he had killed another human being.

Since in the period between the Supreme Court decisions and the completion of this book our society has sanctioned millions upon millions of abortions, an even closer parallel might be the "just war," the conventional rationale for elimination of members of the human community on a mass scale. Traditional moral theology has developed various lists of criteria to determine whether a particular war is "just" so that individuals can morally participate in it. For instance, wars of aggression are wrong, but defensive wars are proper; a war must be a last resort after other reasonable means of resolving a conflict have been exhausted; the use of force must be limited; non-combatants must be protected; and the principle of "proportion" must be honored by weighing the evils that the violence produces against the probability of good results and of success. Though no exact parallels can be drawn between moral reasoning on war and on abortion, this is the *type* of thinking that is appropriate. Intrauterine attack is unjust if it is aggressive rather than in self-defense, if it is not a last resort and other alternatives to it are available, or if the deadly means are out of proportion with the problem to be resolved and the good results that will come from the abortion.

It is certainly worth considering that we are waging this massive assault against alphas at a time when the alternatives are much more promising than in earlier times when civilization rejected abortion. Through contraception, unwanted pregnancy is avoidable as never before. If it does occur, the stigma and ostracism have largely been removed from pregnancy out of wedlock, making the awkwardness, inconvenience, or embarrassment of the childbirth bearable. Poverty justifications are cited in a society with more wealth than any other society has ever enjoyed. In many of the commonly cited cases there are alternatives short of intentional destruction by abortion. Alpha, an innocent party, has no alternatives. We are not "pro-choice" when alpha's presumed choice is at stake.

The cases cited to justify a "just war" in the womb generally fall into five categories: the trivial, the social, the eugenic, unjust pregnancy, and the medical cases, which will be treated in the following chapter.

TRIVIAL

Philosophers enjoy stretching their minds with extreme examples, such as Thomson and her diseased violinist. Roger Wertheimer supports a "pro-choice" policy but recoils from some choices: "Suppose a woman had her fifth-month fetus aborted purely out of curiosity as to what it looked like, and perhaps then had it bronzed. Who among us would not deem both her and her actions reprehensible? Or, to go from the lurid to the ludicrous, suppose a wealthy woman, a Wagner addict, got an abortion in her fourth month because she suddenly realized that she would come to term during the Bayreuth Festival." That is the trouble with what Blackmun hath wrought and is one reason the populace is unable to accept it: the Supreme Court requires our society morally to endorse abortion for any reason or for no reason at all. Bronzing may seem farfetched, but it is not too difficult to imagine cases where alpha's destruction clears the way to Bayreuth, particularly not when a patient has told me that exactly that reason—a trip to Europe—was why she came to me for an abortion. I even wonder about bronzing when I recall a colleague several years ago telling me of the radical feminist who demanded that the placenta was hers, and she wanted it to take home after giving birth. She intended to eat it, feeling that the hormones would be beneficial. The doctor complied.

Let me pose a clinical question that obstetricians are debating currently. Participants at a 1978 conference at the Harvard Medical School pondered the risk of male-female imbalance in the population in the future because the majority of parents prefer to have a boy and through amniocentesis we can routinely discover the gender of the child-to-be. Few patients I know would have the gall to request an abortion for reasons of gender, and most obstetrician-gynecologists I know would decline if they did. Still, such sex-selection abortions have been reported and there is nothing (legally) "wrong" with them. (This omits the matter of sex-linked genetic diseases, dealt with below under eugenic cases.)

The trivialization of life is also inherent in such justifications as career inconvenience for the woman, or when a couple prefers the

number of children they already have, or simply feels vaguely unready for parenthood. Clearly, no civilized society can accept such abortions. The pro-abortionists would lend great moral stature to their cause if they would campaign at least against abortions based on minimal convenience, urging women to rise at least to the level of Judith Thomson's Minimally Decent Samaritan.

SOCIAL

There is a long list of situations in which abortion will resolve a pressing human dilemma, such as a woman who feels psychologically burdened by an out-of-wedlock birth or by the prospect of a larger family, the family that faces severe poverty, or the couple with an established record of child abuse.

I have three decades of experience with poverty patients and do not take these problems lightly. However, I have concluded that they do not justify abortion. Since alpha is a valuable and independent human entity, and since birth is an inconsequential line, we must weigh destruction by abortion as a moral parallel with the intentional elimination of a day-old infant, which clearly is unjustified in any of these circumstances. If we say that we must destroy alpha "for its own good" (so that it will not live in poverty when born), we accept the moral reasoning that social problems could be erased by eliminating people. Also, following the "last resort" principle, we must ask whether there are reasonable alternatives to abortion, and in psychological and social cases there are. Germain Grisez, the conservative Roman Catholic philosopher, is correct when he says that this line of argument is a "cowardly expedient, which discharges social responsibility by dispatching part of those for whom we are responsible" rather than applying "intelligence, work and sacrifice." Baruch Brody, chairman of the philosophy department at Rice University, states that destroying an alpha which has done no harm, in order to avoid a future problem which it may or may not pose, appears totally unjust.

An approved study paper in the oldest black institution in the United States, the African Methodist Episcopal Church, states that instead of relieving problems by destroying nascent life we

should prevent problem pregnancies, provide social assistance, and surround individual parents and children with love and support. The extended family, private philanthropy, and society can shelter the unwed mother, can support the woman in psychological distress, and can counsel the abusive or immature parent (and remove custody where necessary). The mother can, with such assistance, raise the child or choose adoption placement. Any of these options to abortion is decisively the lesser of two evils, and in each option the alleged evil is mingled with the good of shunning violence and of expressing concern and care for a distressed woman or family unit.

EUGENIC

In most abortion cases, the mother or couple simply wishes to be rid of alpha—any alpha—with no malice toward the particular alpha that happens to be in the womb. Thus, if it were possible technologically to remove alpha without destroying it—by taking it out through atraumatic surgery and placing it in an artificial womb, for instance—the woman could raise no moral objection. In eugenic abortions, by contrast, the intent is not that the mother be rid of an alpha, but rather the specific destruction of a particular alpha.

Eugenic abortions are of two types, those based on the certainty that an alpha has a physical or mental deficiency, and those in which there is only a probability or a possibility of a deficiency. In the second type, a number of perfectly normal and healthy alphas are destroyed as the price for making sure that no deficient alpha reaches the time of birth—something of a genetic search-and-destroy mission. A couple may be genetically “at risk” though the genetic makeup of a particular alpha is unknown. For instance, abortion is advocated with sex-linked diseases such as hemophilia, which is transmitted by females but afflicts only males. If amniocentesis shows that the mother is carrying a male, she may choose abortion even though odds are 50-50 that her boy will not be affected by the disease.

When a solution as drastic as eradication via abortion is at

stake, it obviously would be immoral if the deficiency is moderate, or if it is treatable. Many of the congenital anomalies cited in pro-abortion statistics are correctible by conventional surgery and do not stand in the way of a happy life.

There are, however, the "hard cases," and though they constitute a very small percentage of the abortions actually performed, they are difficult for the families that must face them. This is not the place for a detailed discussion of congenital illness, but the abortion argument is the same whatever the malady in question. Some illustrative cases:

The well-known cases of deformity among babies of women who took thalidomide, and the rubella (German measles) epidemic of 1964, gave great impetus to the drive for eugenic abortion, which was subsequently endorsed for the first time by the A.M.A., the American College of Obstetricians and Gynecologists, and by a number of liberal religious denominations. Without carefully thinking through the problem, I myself did as many of the 1964 rubella abortions as the next fellow, even though they were legally problematic. We can hope that proper control of drugs will prevent thalidomide-type atrocities in the future, and with increased immunization of children we should never again face a rubella epidemic on that scale. Daniel Callahan, in a close analysis of early data on rubella, estimated that only 3 per cent to 5 per cent of the children had serious defects; the final figure, however, is undoubtedly much higher.

As for genetic diseases, more than 2,000 have been catalogued to date. Amniocentesis is rapidly becoming dominant as a technique for determining whether a particular alpha is affected. To date it is not used routinely on all mothers because there are risks of infection for both the mother and alpha; the risk of puncture injury to the placenta and/or to alpha also exists, though it has been reduced by ultrasonography. Amniocentesis is currently much less risky than tissue sampling by fetoscopy. At the present writing, amniocentesis can be used for detection of the sex of the offspring in 160 sex-linked maladies where alpha is "at risk," for 66 metabolic diseases, and for 15 chromosomal disorders. These diseases range from the moderately serious to ones like Tay-Sachs disease, which afflicts Jews of Ashkenazik (East European) heritage

and is always fatal to the child early in life. Perhaps the best-known application is in ascertaining the existence of Down's syndrome ("mongolism") among older pregnant women. Amniocentesis is also used to measure the level of alpha-fetoprotein (a compound found in measurable quantity almost exclusively in the blood of alpha) in the amniotic fluid in order to identify congenital defects of the central nervous system, such as neural tube defect (NTD). Besides amniocentesis, ultrasonography is used to detect physical defects, and as reported above, fetoscopy is applied to diagnose a wide range of medical problems in utero.

There is a narrow time "window" in which amniocentesis may be performed with benefit. Normally the fluid is removed at the sixteenth week or after, and the culture from the fluid then needs two weeks or so to grow. Thus, if abortions are performed they must occur at around twenty weeks, approaching the threshold of viability. In time, one can expect this viability line to be lowered further, with an increase in eugenic abortions of viable alphas.

Populations or persons at risk should be screened by blood and other tests to discover whether they are "carriers" of congenital abnormalities and if they are, encouraged to practice the most reliable forms of birth control or to undergo voluntary sterilization (alternatives that strict Catholic Right-to-Lifers often would reject). If the carriers do not do this, then in my view they must accept the risk of conceiving and caring for afflicted offspring.

With 2,000 diseases identified, with improved screening, and with many more medical advances in the future, this will be a growing issue.

Another very difficult problem, similar to the thalidomide tragedy, is those instances where mandatory therapy for a mother's illness creates risk for alpha. X-ray exposure is often cited as an example by pro-abortion writers. In fact, there never has been a documented case of deformity from the diagnostic use of X ray on pregnant women, and ultrasonography is supplanting many uses of X ray. The problem is likely to occur, however, with the use of X ray for treatment of women with cancer. Risk to alpha also arises when a psychotic woman takes lithium to stabilize her condition, with anti-cancer agents, or with immunosuppressants that

must be taken continuously after an organ transplant. In some cases there is alternate therapy available, and in others we can hope for the development of less damaging drugs in the future. Again, we should advise the use of the best contraceptives or voluntary sterilization. Even so, a few pregnancies will occur.

Father Gerald Kelly has called the various eugenic cases "fetal euthanasia," but this is a misnomer. In conventional mercy killing there is either explicit or presumed consent on the part of the person who is killed. There is not the slightest possibility with alpha of speculative effort to gauge consent. In fact, this is my major objection to all these cases, even though I recognize that they can bring the deepest possible suffering into a family. I would readily accept abortion, and I am sure everyone else would, if a member of the human race were not at stake. In the ultimate sense, only alpha can "want" itself. The mother with an "unwanted" defective child must, because of the current limits in medicine, act as the temporary guardian of alpha until it is able to exist independently and decide on its own whether to choose life. In eugenic abortions we are presuming to make decisions on behalf of alpha, which once born will always prefer to live than not to have lived, given the choice. From before and after birth, a biological zeal for life motivates virtually all of its activity. Dare we usurp this most ultimate of decisions from a fellow member of the human community?

Are we to say that handicapped children are bad for themselves? That is a most chilling contention. Here I would agree with one of the most fervent Right-to-Life physicians, C. Everett Koop (a United Presbyterian, by the way, not a Catholic). Koop is an internationally known pediatric surgeon at Children's Hospital, Philadelphia, and in that work has occasion to treat many severely deformed infants. In his speech to the American Academy of Pediatrics upon receiving the 1976 Ladd Medal, Koop stated:

"It has been my constant experience that disability and unhappiness do not necessarily go together. Some of the most unhappy children whom I have known have all of their physical and mental faculties, and on the other hand some of the happiest youngsters have borne burdens which I myself would find very difficult to bear. Our obligation in such circumstances is to find alterna-

tives for the problems our patients face. I don't consider death an acceptable alternative. With our technology and creativity, we are merely at the beginning of what we can do educationally and in the field of leisure activities for such youngsters. And who knows what happiness is for another person?"

Precisely. (Though candor requires me to add that Koop's other writings on abortion are tainted by poor reasoning and medical inaccuracies.) Which of us can presume to be a valid voice for the future afflicted? A retardate or paraplegic would not necessarily decide what I might decide on his behalf. The handicapped often have a saving lack of self-consciousness or an inspiring ability to overcome limitations. Can we tell a human-being-to-be, "Better not to exist at all than to be born with this malady"?

Though eugenic cases are often framed by pro-abortionists in terms of alpha's "best interest," they are more honestly presented if we admit that the concern is chiefly the burden the child will place upon parents or upon society. In the extraordinary cases, the inconvenience and expense to the parents are massive. No palliative can remove the agonies that they will suffer. Only when another life is at stake and there is no alternative dare we countenance such suffering. However, the extended family, philanthropy, institutional care, and society at large can help lift the burden, as they have traditionally. Recent trends in public educational aid are extending assistance to burdened families. An adequate health insurance system could cover severely expensive cases. Money is not a compelling point for or against abortion. We must not talk economics; we must talk life.

Are we to abort in order to weed out the useful from the non-useful, the beautiful from the ugly, the smart from the stupid? Is abortion to be used to create perfection and a trouble-free existence? That goal is not realistic in a society that surrounds us with physical, mental, and moral imperfection, and always will. Tragedies cannot be avoided in life, and perhaps we somehow need the full texture of existence—the regret, sadness, pity, charity, and kindness that these experiences occasion. In any event, are not these sufferings preferable to intentional selective destruction?

UNJUST PREGNANCY

Along with the rubella and thalidomide tragedies, two of our most effective pro-abortion issues were rape and incest, which were not allowed as justifications in many of the former laws. If the act in which the woman becomes pregnant is unjust, nay abhorrent, and if she has no consent or responsibility in the fact that she is pregnant, how can society possibly force her to bear the baby to term?

Some preliminaries. Incest is unjust in those situations where it violates consent, as it always must when a minor is involved. Thus, it constitutes rape, as surely as if the man were not a close relative. Otherwise, the incest case falls under the eugenic argument (above) because of the increased possibility of genetic anomalies. Incest in and of itself poses no distinct issues in the abortion debate, but incestuous rape is part of the over-all rape dilemma.

Actual pregnancy resulting from rape is statistically not frequent, though it is more frequent than anti-abortionists might admit. These pregnancies are almost always preventable through performing a D and C, which changes the structure of the genital tract so that implantation does not occur, and were formerly avoided also by taking the "morning-after pill" di-ethyl-stilbestrol (DES). (Note again that rigid Catholicism considers prevention of implantation to be abortion, so many Right-to-Lifers would deny us these options.) Although DES has become an infamous drug because of potential harm to alpha when taken to prevent miscarriage, and has been disapproved, I think that we should re-examine its risk-benefit ratio for use in the unique situation of rape. DES is sometimes also badly tolerated, with irritating side effects (nausea), but these side effects are acceptable until a better drug is available.

Neither DES nor D and C is absolutely foolproof. However, the problem in practice is not preventing implantation, but neglect in applying preventive measures. Women often delay in reporting rape because of shame, distrust of doctors or police, fear of publicity, or the folk tale that "nothing could have happened"

if the woman did not experience orgasm during the rape. Because of this delay, contrary to what some Right-to-Lifers imply, rape pregnancies do occur occasionally.

In evaluating rape or incestuous rape, we must separate our moral repugnance for the acts from the question of whether abortion is a moral solution to these occasional pregnancies. The actual issue is this: Does the terrible emotional turmoil that rape stirs up in the woman justify the elimination of the alpha that is produced by the rape? A most anguishing decision. Still, as with severe deformity, it seems to me that the existence of life becomes the primary ethical concern once it exists. When pregnancy is confirmed, one can no longer discuss morality in the framework of rape or incest (or whether birth control was or was not used, or whether the child is "wanted," or whatever). The unwanted pregnancy flows biologically from the sexual act, but not morally from it.

It might clarify the issue to ask whether the woman is morally required to risk her life in resisting the attacker in order to make absolutely certain that rape does not occur. Obviously the answer is no. Rape, heinous as it is, is less heinous than her death would be. In my judgment, the death of alpha, though less horrible than the death of the woman, ought also be avoided. This is particularly so because after the fact nothing can be done about the rape, but something can be done about preserving the life and helping the victimized woman. Using the "last resort" test, there is an alternative for the woman unjustly pregnant, namely adoption of the newborn. Also, as Baruch Brody emphasizes, alpha is innocent of any wrongdoing.

George H. Williams, a Protestant theologian at Harvard, raises a separate case of unjust pregnancy that no other writer has, to my knowledge. He thinks that if pregnancy results from adultery, the violation of family sanctity is such that the husband has the moral right to demand an abortion. I disagree. As with rape, the intent and moral status of the act of intercourse does not alter the value of the alpha that may result. I would grant that this is indeed a painful case. Unlike most of the other cases we have considered, there is really not much that society or charities or the doctor or the family or more money can do to help. Adoption is unusually difficult in this particular case, unless the adultery leads

to divorce. The child resides within the family as a continuing reminder of the infidelity, and as a continuing invitation to pain (as well as to forgiveness and renewed love).

If a part of the human community were not at stake, no woman should be required to undergo the degradation of bearing a child in these circumstances, but even degradation, shame, and emotional disruption are not the moral equivalent of life. Only life is.

A LIFE FOR A LIFE

In morality, life can only be equated with life, not with convenience or sociology or politics or economics or poverty; not even (in the truly hard cases) with the burden of responsibility for a seriously retarded or handicapped child, or of bearing a child resulting from rape or infidelity. In arguing an issue of life, one can only invoke issues of life to counterbalance it. Liberals who are pro-abortion immediately recognize that, in capital punishment, only murder would justify even *considering* the intentional taking of life. We do not execute car thieves.

Those of us in the pro-abortion crusade used two special "mother's life" arguments. The first was the "coathanger" plea. Not only is this a self-inflicted threat to life, but it is one that, as I have stated, would be reduced to the vanishing point by recent medical developments if abortion were again made illegal.

The other case we cited was the threat that if a particular woman were not allowed to abort, she would kill herself. In our rush to get hospital permissions, as I have recounted, many psychiatrists were willing to enlarge upon such dangers, but the clinical fact is that suicide virtually never results from pregnancy in and of itself. If pregnant women commit suicide, it is because of issues

other than the pregnancy. As it happens, pregnant women kill themselves noticeably less often than do non-pregnant women. It may even be that pregnancy is a protection *against* suicide. A former New York City medical examiner once stated that he had never in his career seen a single case of a pregnant woman who took her own life. Even the brief of pro-abortion plaintiffs in the federal *McRae v. Califano* case admits, "Not one of the maternal mortality studies lists a single case of maternal death from suicide."

It is perhaps a dirty little secret of the Right-to-Life movement that officially the Roman Catholic Church does not necessarily permit abortion to save the mother's life. Perhaps because of its traditionalist Catholic component, the movement is rather opaque on this matter of which "mother's life" cases justify abortion, which is anything but a simple question medically. It is impossible for a secular obstetrician-gynecologist to accept the papal viewpoint, it seems to me, or to accept the abortion laws that existed in many states when I enlisted in the pro-abortion cause.

Since 1895 the Vatican has taught that it is all right to remove a cancerous pregnant uterus or an ectopic (tubal) pregnancy. This is not considered abortion because alpha's death is only the indirect result of the operation. But the Church forbids "direct" abortions designed to save the mother's life. The most famous case at issue was the crushing of alpha's head with grisly destructive instruments, saving the mother from a fatal rupture of the uterus where the birth canal was too small. With anesthesia, anti-microbial agents, blood transfusion, and better surgical technique, Caesarean section has long since removed this difficult choice. The Church even refuses abortion when the fetus will die before birth no matter what happens to the mother. As eccentric as this seems, the idea is that two deaths are better than one "murder"; that is, better than one direct killing via abortion. Still, this makes no sense to me, since all is lost and nothing is gained. I also wonder at Catholicism's inconsistency in holding alpha's life to be so absolutely sacred and yet often accepting intentional killing in war or execution.

Contrary to what some anti-abortionists might like to believe, this "Catholic issue" has not ceased with the increasing use of Caesarean section. One Catholic obstetrician of my acquaintance

was the only doctor available years ago when his wife went into labor. When he gave her spinal anesthesia for delivery, she went into cardiac arrest, a rare occurrence. Given that choice, he delivered the baby instead of treating his wife, and she died. (I have often wondered what sort of premarital understanding his second wife reached on this matter.) Or, to take a case from my own practice, a surgeon diagnosed a pregnant Catholic woman as having a recurrence of breast cancer in her twelfth week, and she refused my recommendation of therapeutic abortion because of her religious beliefs. She changed her mind four weeks later, but it was too late. She died nine days after a hysterotomy and alpha died within a few hours after birth.

Baruch Brody (who is Jewish, not Catholic) places such importance on alpha's "innocence" that he similarly develops a very complicated rule for abortion that rejects some cases where the mother's life is at stake. The "self-defense" analogy breaks down, he reasons, because alpha is innocent and not a pursuer. I must reject this reasoning. It is not immoral to defend oneself against a life-threatening person, even if that person is not "responsible." One could licitly kill an imbecile who has no understanding of his homicidal assault, or a person in the ocean who unwittingly and desperately grabs at one so wildly that both will drown otherwise. True self-defense is always justified.

A case that I wrote up with a colleague in 1965 may illustrate how my thinking has shifted. It concerned a hydrocephalic with a head so swollen that vaginal delivery was impossible. Caesarean section was the normal procedure, but instead of that we used instruments thrust through the mother's abdomen and the wall of the uterus to extract the fluid from alpha's cranial cavity, thus killing alpha and collapsing the head so that the delivery could be vaginal. Even though the baby's chances for survival were nil, I do not think that I would have the stomach to do anything but the conventional C-section today.

The abortion policy that I have finally settled upon distinguishes between medical abortions (permissible) and those that are not medically indicated (not permissible). We must, in applying this principle, reject the sloppy usage of "medical indications" that I was a party to in the '60s, covering all manner of psychiatric, social, or eugenic perplexities, or simply the wish of the

mother. On the other hand, it must be more flexible and medically sophisticated than anything that I have seen emanating from the Right-to-Life forces. The list of indications *cannot be etched in stone*; it varies by medical knowledge. There was a time when tuberculosis was correctly considered to be an indication; now it is not. On the other hand, medical research has identified indications that formerly were unknown. Some specific indications might apply with one pregnancy and not with another.

As a point of departure, let us take the so-called "Hyde Amendment" as it was reshaped and finally passed by the U. S. Congress in December 1977. This law had to do only with what cases should come under Medicaid poverty funding, but in effect it expressed what the people's representatives considered to be generally acceptable grounds for abortion. One clause covered promptly reported rape and incest (not a medical indication), and the rest of the bill specified those cases:

1. ". . . where the life of the mother would be endangered if the fetus were carried to term." (The lethal ectopic pregnancy is listed in a separate section.)

2. ". . . where severe and long-lasting physical health damage to the mother would result if the pregnancy were carried to term," as determined by two physicians.

As a member of the American College of Legal Medicine, I have some familiarity with the ways in which legal language must accommodate medical imponderables, and I must state that Congress here was off the mark, as the Supreme Court had been previously. First, the wording is unacceptably vague. To what *extent* must life be endangered? The danger should be compared with the statistical average in routine, uncomplicated pregnancy, since there is a theoretical statistical risk in *any* pregnancy (or, for that matter, in any auto trip). The current rule of thumb is that fewer than twenty of 100,000 pregnant women will die. This figure should not be fixed by statute since it will continue to decline, but the law should state that the latest data of biostatisticians be used to define which medical problems produce a demonstrable increment of death. To me, a statistically significant increment over the usual risk of pregnancy constitutes an endangerment of life that justifies abortion. And it must be the pregnancy itself that materially contributes to the condition; abortion

makes no sense in an endangered woman if the elimination of alpha has no bearing on her prospects.

What constitutes "severe and long-lasting" health damage short of imminent danger to death? This is not medically precise. Most health conditions that are cited by pro-abortionists are temporary and can be treated. There must, rather, be a reasonable probability that the co-existence of pregnancy will materially and significantly shorten the mother's life-span. This rule cannot be quantified, but it is not difficult to determine medically in a particular case. Again, the pregnancy itself must be determined to be the cause of the life-shortening.

So I am proposing two "life" criteria: pregnancy that raises the risk of imminent death *now*, and pregnancy that will hasten death *then*. My proposal would radically reduce the number of legal abortions to perhaps several thousand a year. Even under the fuzzy Hyde language, between February 14 and December 31, 1978, there was a reported 99 per cent decrease nationally in Medicaid-funded abortions from a previous total of about 250,000 per year. Only 385 were approved on health danger, 1,857 for life endangerment, and 61 for rape/incest. This shows the degree to which abortions are being performed on other than medical grounds. In practice, it is not possible to spell out every probable element in medical practice, and each case of a particular disease will vary. What we need—and can develop—is a workable ethical standard.

Each mother must be considered individually. Some might suppose that because the death rate of women in pregnancy is statistically higher after age thirty-five or age forty, age alone would justify abortion under my proposal. This is a misunderstanding. It is the specific medical problems such as those to be discussed below that increase with age and that kill the women, not the age as such. Doctors treat patients and diseases, not age groups. Sometimes the very young teen-age mother is set apart into a high-risk category, but this is a social problem rather than a strictly medical one. The statistically higher rate of difficult pregnancy is not due to the very young mothers' age, but to the fact that they do not consult physicians readily or often enough.

My policy would exclude a variety of maladies in pregnancy that some doctors have cited as "medical indications," but which are treatable and not life-endangering: varicose veins, myoma

(benign tumor of the uterus), urinary tract infections, an expected necessity for Caesarean section, anemia and other forms of malnutrition, hyperemesis (excessive vomiting), peptic ulcer, or cystitis. In cases of multiple sclerosis, the symptoms are exaggerated in pregnancy, but life is not shortened as such. In the "possible" category—justifiable with certain patients—might be colitis, respiratory maladies such as bronchiectasis, and some chronic degenerative diseases of the nervous system.

Some other typical indications:

1. *Diabetes*—This disease is life-threatening and carries other health hazards, and it usually worsens in late pregnancy. But there is no firm evidence that pregnancy in and of itself shortens the diabetic mother's life-span, so it probably is not an indication. Diabetes is a very difficult problem for alpha, which raises the eugenic issue. At the parents' option, this may require birth control or sterilization.

2. *Obesity*—Using the guideline of 250 pounds (some obstetricians say 300), this condition produces a higher mortality rate in pregnancy because it is difficult to treat the patient, delivery is more problematic, and other medical problems result. The increased threat may be such that abortion would have to be considered.

3. *Cancer*—(Other than removal of a cancerous uterus, which even the Vatican accepts.) It is often stated that cancer is a medical indication. Cancers other than those of the breast and the female genital tract are probably not affected by pregnancy. Even in these cases, cancer is not necessarily an indication, since certain cases are not worsened by pregnancy. In breast cancer, the danger often can be determined through a new test for whether the cancer is estrogen-receptor positive. If it is, pregnancy probably will inflame the condition and may be lethal; abortion is justified.

4. *Chronic heart or kidney disease*—Unlike with diabetes, here there is a direct link between the pregnancy and the increased strain that is put on the diseased heart or kidneys, so both are medical indications. A Right-to-Life advocate might argue that there are options: One could perform open-heart surgery or a kidney transplant, or use kidney dialysis, and avoid the need to abort. In my view, these remedies must not be required because the mortality rate of the corrective procedure is noticeably higher than

that of the abortion, most certainly with surgery and possibly with dialysis. On the other hand, I would reject the case where a mother can cope while resting during pregnancy but endangers her heart if she does housework. In this case, housekeeping help should be provided, not an abortion.

5. *Sickle-cell anemia*—(As opposed to common anemia.) The rare S-C form of sickle-cell may be lethal in pregnancy but even the common S-S form is risky; either is an indication.

6. *Intrauterine device*—The IUD is, of course, supposed to prevent pregnancy, but in certain cases the woman becomes pregnant anyway with the device still present in the womb. It must be removed as soon as pregnancy is diagnosed. However, if by mistake the IUD is left in until pregnancy has so advanced that it cannot be removed, there is no question that abortion is always permissible. Even though some IUD pregnancies would produce healthy children without incident, the obstetrician never knows which cases. An infection that an IUD might produce if left in the uterus is so deadly and spreads so rapidly that the device is a continual threat to the mother's life.

7. *Hypertension*—Elevated blood pressure by itself is occasionally a threat to life. About one in three hypertensive pregnant women also will develop pre-eclampsia or its advanced state, eclampsia, later on in the pregnancy. (Pre-eclampsia is a syndrome with constricted small arteries, particularly in the uterus, eyes, liver, and brain, the latter possibly producing a stroke. Eclampsia is an advanced state of the syndrome, with convulsions. We do not know the cause of this disease and therapy is difficult.) Pending better predictability of which cases of hypertension will lead to pre-eclampsia/eclampsia, or improved therapy for this disease, advanced hypertensive disease should be grounds for abortion.

8. *Thrombo-embolic disease*—A woman may have a blood clot or an embolism (a clot that breaks off from its site) and recover from the disease, but if pregnancy later occurs there is a much higher risk of a rapid and lethal clot. Thus, this may be an indication. Superficial phlebitis (inflammation of a small surface vein) is not an indication, but deep-vein phlebitis is quite dangerous. Fortunately, this is a case where drug treatment is feasible and abortion is not necessary. The physician is able to prescribe hep-

arin, a drug that does not cross the placenta and therefore does not endanger alpha, either.

This is an incomplete list of the major examples, assuredly not an exhaustive catalogue, but it should serve to illustrate how the above principles would apply.

Along with these proposals, I would like to propose that the anti-abortion legions declare a moratorium on their marches at hospitals and clinics and their intimidation of women patients long enough to ponder these questions that obstetricians face daily and to notify the rest of us which abortion indications *they* are willing to endorse.

Back in January of 1975 when Ruth Proskauer Smith was deciding whether I should be excommunicated from N.A.R.A.L., she sent me an inquisition-by-mail. One of her seven questions demanded of me, "Does your expressed anguish at having 'presided over 60,000 deaths' imply that you plan to make changes in your own medical practice?"

The answer in 1975 was that it made not the slightest difference. I was willing to perform an abortion for any patient, at any stage prior to "viability," for any reason. I considered the physician to be merely the instrument of the woman's desires in the matter of abortion.

Given the rather strict list of abortion justifications that I have just presented, the reader of this book will likely be asking Ruth Smith's question all over again. Do I (medically) practice what I preach?

About a year after resigning from N.A.R.A.L., I started feeling viscerally that I did not like doing abortions. Still, I did them. Sometime toward the end of 1976 this changed. One day, I cannot now recall the patient or the circumstances, I decided that I would perform no more of the grotesque "second trimester" abortions except on strict medical grounds—even for longtime patients in my private practice. Around the same time I also began refusing to do elective abortions at *any* stage for new patients who came to me. I would tell them, "I'm sorry, I don't do abortions any more, for ethical reasons, but my associate Dr. ——— will do it for you. I will be on hand in the operating room during the procedure." And so quietly, without fanfare or notice, I was out of

the elective (i.e., non-medical) abortion business, except for "first-trimester" abortions done for established patients of mine.

My phased withdrawal went ahead in December of 1977, while I was doing the preliminary reflections toward this book. For the first time, I refused to do an early abortion for a longtime patient, citing the same ethical objections that I routinely used with new patients. She was not at all happy at this news and wanted me to perform it anyway. Quietly, I checked out my legal situation with my lawyer, regarding the question of "medical abandonment" of a patient. The lawyer advised me that this was a new legal issue, particularly because I had not changed my views as a result of religious conversion, but that there was little risk. He said I should be on acceptable legal footing if I referred her to an obstetrician-gynecologist of equal competence. In January 1978 I went ahead with the abortion anyway. She was still insistent and my own thinking had not crystallized.

During 1978, I continued refusing to do non-medical abortions for all patients, but ended up performing several anyway. In one case, I did not even raise the problem and, in fact, shielded my reluctance because, in my best judgment, the patient was unusually dependent upon me and I knew my refusal would have been interpreted as a rejection of her, probably throwing her into panic. Obstetrics and gynecology is so sensitive a field that it is probably the closest specialty there is to psychiatry. A doctor bears a heavy ethical burden in the case of a patient with an unusual degree of dependence upon him.

And so as this book went to the publishers I was caught in the paradox of considering elective abortion to be an unjust taking of human life and yet performing one now and then when I was unable to avoid it. Perhaps in the future I will refuse regardless of the circumstances.

There are 75,000 abortions in my past medical career, those performed under my administration or that I supervised in a teaching capacity, and the 1,500 that I have performed myself. The vast majority of these fell short of my present standard that only a mother's life, interpreted with appropriate medical sophistication, can justify destroying the life of this being in inner space which is becoming better known to us with each passing year. I now regret this loss of life. I thought the abortions were right at the time; rev-

olutionary ethics are often unrecognizable at some future, more serene date. The errors of history are not recoverable, the lives cannot be retrieved. One can only pledge to adhere to an ethical course in the future.

WHAT ABORTION MEANS

Having come this long way, through the abortion crusade of the late '60s and my own reconsideration of the late '70s, I am compelled to report that the revolution we undertook was a seductive and ultimately poisonous dream. It all appeared so certain at the time. Now, in the light of the best data from my profession, and weighing the philosophical choices left us by those data, that old certainty—as with many other of our cherished certainties—has vanished forever. In its place a new conviction has arisen, that human life is a continuum that can only be broken for the most serious of reasons.

The primary question with abortion is what it does to each alpha. The secondary question is the social one, not so much abortion's harmful impact upon society or that it will cause other moral failings (the general Right-to-Life line) but, rather, what it tells us about the way our society already is. It was the cheapening of life that led to mass abortion with social consent, not the other way around. Legalized abortion in the United States came *after* Lenin, Stalin, Hitler's Holocaust, and Hiroshima. Subliminally, the massive governmentally sanctioned loss of life made abortion thinkable. The scope of societally accepted abortions, the very

statistics, is frightening. Some 988,267 officially recorded by the federal government in our Bicentennial year, a 16 per cent increase over 1975. One million or more a year, year in and year out. One abortion per 3.2 babies born. Many millions since Justice Blackmun's decisions. In the nation's capital, abortions actually outnumbering live births each year. The statistics mean that a uniquely wealthy nation has sequestered off and rejected a large component of life, a component that we know more about than ever before.

Abortion that proceeds without medical indication falls in a strange way upon the nation's doctors. It is one of the few medical procedures to have such enormous social roots and consequences, and as a result, physicians, who often are jealous of their prerogatives, have grudgingly yielded this ground to public domain. If this were a call for Appendectomy on Demand, they would be in high dudgeon. Given millennia of medical opposition, why did they—we—cave in to abortion? The teaching in medical school traditionally has been totally devoid of formal instruction in medical ethics. Like most medical school products of my generation, I took only a single course in philosophy in my academic career, and never took one in medical ethics. It may be more than coincidental, too, that embryology gets cursory attention in most medical educations; what facts are learned are quickly forgotten unless one enters obstetrics.

Like many physicians, I was a utilitarian in my ethic until 1973 or 1974. Though I was a utilitarian, I did not even know the term until I encountered John Rawls' *A Theory of Justice* (Harvard, 1971), an intricate attack on utilitarianism in favor of an elemental sense of fairness and justice. I believe that an unexamined utilitarian ethos, and a corresponding "situation ethic," have led us to this monstrous abortion situation. Instead of cherishing the individual human life, we are calculating the "greatest good for the greatest number," which translates into "quality of life," "cost/benefit," an "improved human race," and triage. As Professor Rawls protests so elegantly, a decision that increases the general happiness may be unjust. For instance, it may be made at the expense of a minority group. I would add that of such groups, the intrauterine population is the most defenseless of all. I can no longer subscribe to this dehumanizing ethic.

It is because of this philosophy that Mary Anne Warren can compare alpha unfavorably with a guppy, accept alpha husbandry to harvest organs for transplant, and be ready to turn down the abortion faucet if society decides that it needs more births. If a space probe were to bring back a virus that made nearly all women sterile, would that change alpha's value? To Warren, it would. To me it would not; each life is precious.

A remarkably prescient 1970 editorial in *California Medicine*, a publication of the California Medical Association, stated that abortion, an act of consciously "taking a human life," was part of the erosion of the traditional western medical and religious heritage which taught "the intrinsic worth and equal value of every human life, regardless of its stage or condition." The New Ethic seeks improved "quality of life," which means that particular lives no longer have absolute value. Three years later, a strange passage in Justice Blackmun's decision in *Roe v. Wade* objected to the Hippocratic Oath, the ancient standard of medical morality, as forming an absolute standard on the argument that it was embraced by Christianity, but in the pagan world represented only a minority view. It appears that favoritism toward Christian morality is wrong while Supreme Court favoritism toward the majority view in ancient paganism is right. Blackmun casually drops mention that Hippocrates' colleagues and the Christians fought suicide as well as abortion. He might have added that Christians or Jews once fought infanticide, child sacrifice, temple prostitution, political torture, and combat to the death in the Colosseum, or that the Roman father who could order the abortion of his offspring could also sell them into slavery to raise needed cash. In the New Abortion Ethic, the totalitarian power to destroy passes from the father of Rome to the mother of America.

The conflict between the Old Morality and the New Morality is a conflict of rights. The Supreme Court relied on the "right of privacy," following reasoning that stands up only if alpha is demonstrably not human life. To say that it is *not* human life is a statement of faith, one that flies in the face of biology, as statements of faith sometimes do. The competing right is the so-called "right to life," which in my view is not a natural right existing in a political vacuum, but is rather a reflection of the inherent moral health of a particular society. The right of women to abort derives

from a political locus; alpha's right to exist derives from the very bone of a culture's morality. The "right" to abort is not a right as that term is commonly understood, but only a "claim," a means of promoting change or of moving people to action. It asserts no timeless truth.

If abortion is not justified as a "right," then it must be justified on pragmatic grounds, very often variations on the "unwanted child" theme. This deserves the most careful consideration for, as *California Medicine* sensed, it is a seismic shift in the philosophy of our civilization. The value of life is subjective. Life or death is a matter of whether "I" want "you" or whether "we" want "them" to live. Life in and of itself is no longer treated as having intrinsic worth. This wholesale retreat from the Hippocratic code should be and has been particularly difficult for physicians to stomach.

There is a new and rather revolting phenomenon stemming from this abortion ethic: a schism between intentional conception and childbearing. I recall having treated a woman for infertility, and after I had operated on her uterus she was able to achieve her desired pregnancy. Then once she was certain that she was pregnant, she came to ask me to abort her hard-won conception. Other obstetricians, too, tell me that they have faced this strange paradox of the woman who asks to be helped to conceive, only to abort. These patients want to know that they are capable of conceiving, they strive for the quiddity of pregnancy, but they do not want the child. Would Justice Blackmun counsel me that I ought to abort in these circumstances?

As a society, we have not considered, either, that the other side of the coin of elective abortion becomes elective birth. Each child is chosen to be worth surviving. Does the fact that a child is so specifically wanted—now that his parents have a perfect legal right to eliminate him during any of the nine months before his birth—not put new and strange psychological pressure on the child? Should a child have a "right to know" about all this, and if not, why not? One can imagine the ultimate psychological put down by a vicious parent of the future: "We should have aborted you *after all*."

We are developing four classes of human offspring:

1. The Wanted—The parents did not practice birth control and were pleased when the conception occurred.

2. The Wanted Unwanted—There was a birth-control mistake, but once conceived, alpha ultimately was permitted to survive through the abortion zone to reach birth.

3. The Split Decision—A birth-control failure, after which either the mother wanted to destroy alpha and the father insisted that it survive, or the father did not want to be a father but the mother went ahead anyway.

4. The Unwanted Unwanted—A birth-control mistake, followed by an abortion "mistake" in which the child is born despite the wish of mother or father to see it destroyed.

With burgeoning developments in prenatal genetic diagnosis, fetoscopy, ultrasonography, blood and amniotic testing, we must look very carefully at this developing culture in which "we" determine who is fit to inhabit the human race. Today we can eliminate alphas with 241 congenital anomalies—anatomical, biochemical, or genetic. Technology may soon expand this to 1,500 or 15,000. Parents or the woman alone will be asked to make agonizing, even impossible choices as open abortion continues and as we extend our diagnostic sweeps.

We can now monitor patterns of cerebration in the brain well before birth. What if prenatal brain testing is developed in the future? Or the obstetrician may announce to the woman in his office, "Your son will only be five feet one inch tall," or "She will be myopic." The parents will wonder, "Should we try again?" Someday a child may be selectable by computer on the basis of hundreds or thousands of criteria and then, at any point of gestation, destroyed at will by abortion if parents change their mind.

One can envision each child-to-be subjected to a battery of tests to see that it measures up to standards of beauty, physical excellence, or intelligence, or to the expectations of parents. Each child conceived might come with a computerized pedigree issued by the hospital bureaucrat or the proper federal agency charged with monitoring such things. Orwellian. Since today we allow abortion for more trivial reasons, it certainly follows that a government-financed health system might one day require mandatory amniocentesis or genetic screening, followed by compulsory abortion for defective alphas the correction of whose defects would be a drain on the taxpayer/voter. Or, money aside, it could be considered humanitarian to issue warrants for "reasonable search and

seizure" of amniotic fluid in our hunt for disease. With Supreme Court ingenuity, such procedures could be ruled to be no invasion of the "right of privacy" because alpha is a non-person, and because any unwanted invasion of a mother's body could be deemed similar to other invasions on "health" grounds such as mandatory premarital blood testing for syphilis, breath tests of possibly drunken drivers, mandatory PKU blood tests for infants, or other socially accepted invasions of biological privacy. Would abortion be mandated for alphas in order to wipe out alpha "carriers" that are not themselves defective? Will today's theory that the XYY chromosomal makeup (Klinefelter's syndrome) produces a propensity for criminal behavior be confirmed, and will we learn of other unwanted behavior traits related to characteristic banding in chromosomes or gene loci in chromosomes, and will we use this knowledge to filter out other anti-social groups? Such are the twenty-first-century possibilities raised by our years-old new ethic of alpha's worth.

It is worth pondering that the abortion ethic contrasts with the new ecological sensitivity. The same society (and some of the same individuals) that lavishes great care over the peregrine falcon or the Furbish lousewort is willing to accept mass alpha-cide with equanimity. We worry about technological control over nature, while it occurs daily in the vacuuming out of wombs. Though I dislike misleading scare talk on medical results of abortion from the Right-to-Lifers, I would certainly say that the facts are not yet in on what happens when we interrupt the ecology of the uterus to pluck alpha out of it. Pregnancy is vastly more complicated biochemically than is the Pill, which we now recognize as a mixed pharmacological blessing. Can the ongoing process of pregnancy be radically interrupted without profound consequences for the mother's physiology? We must continue studying this, and when we come to know the answer within a generation it may haunt us.

The abortion ethic is also an invitation to irresponsibility, to violation of the concept of the inviolable responsibilities that each of us has to others. Parents may not abandon their children; why should they be encouraged to abandon their children-to-be? One race ought not exploit another; why should the already-born be allowed to exploit the not-yet-born? Can we accept the idea that the

fetus "owes" its life to the mother so that she can withdraw what she gave? The Mother giveth, the Mother taketh away. Should not the mother have a special *obligation* to alpha, precisely because she was one of the partners in conceiving it and because of its unique connection to her? Why should a parent have a special right to inflict harm on her own children-to-be that would not be allowed in the case of another person's child-to-be? The abortion ethic would have us avoid the elemental truth that actions have consequences that must be weighed. If a couple has sexual relations, even if a conception occurs as a result of failure in a birth-control method, they still have an implied social contract to establish and to cherish a pregnancy that occurs, since love-making is always potentially life-making. Can we accept the concept that because an act does not lead to its intended result, we are absolved of all human responsibilities? If you immunize your young child against polio and he contracts it anyway and suffers cruel deformities, the fact that the method "failed" despite your intentions of biologically preventing that result does not in any way change your responsibility to care for your own child. It is true that sex is not only the most momentous act in our everyday lives, but also an act that is random and ungoverned. Still, the fact that an act is random and ungoverned does not eliminate one's moral responsibilities regarding the result of the act.

Abortion also undermines the integrity of the family, which was already reeling from other assaults. The Supreme Court reinforced this with its 1976 follow-up ruling, *Planned Parenthood v. Danforth*, in which it threw out statutes in Missouri requiring a husband's consent for abortion, or requiring consent of the parents of an unwed mother under age eighteen. Then in *Bellotti v. Baird* (1979) the court threw out the Massachusetts law that required parental consultation or notification, allowing a judge to grant permission. I resent these rulings. The medical profession officially opposed such a policy when abortion was first liberalized.

So long as abortion is legal, the father probably should not have an absolute veto, but he absolutely must not be excluded. Notification of the abortion plan should be a minimum requirement. Otherwise we are tearing the father out of the fabric of the family. The reason for the woman's demand of autonomy is understandable. Traditionally, in the case of an unwanted pregnancy,

the male avoided his responsibilities and the woman assumed the ultimate role of having it "taken care of," often at some risk. Perhaps the male might chip in some money—as I did in the abortion that I was involved in in Montreal. The time-worn assumption by the female of the burden of sexual consequences is carried off into the opposite direction, not childbearing and childrearing, but child-disposing. (Did the males of ancient Greece assign the task of infanticide, too, to their women?) Is it any wonder, then, that the feminists have arrogated the abortion issue to themselves, going so far as to shut out the fathers from consent? Males have long since ceded the issue of abortion to females, permitting the matter to be viewed in the thin light of feminist polemics and sexual politics, rather than in the wider beam of universal morality. In an excess of *mea culpa*s, male legislators and judges are attempting to exculpate their sex by bowing to these pressures, once again abandoning the matter of sexual responsibility. Past male irresponsibility does not justify present female irresponsibility in choosing abortion, or the irresponsibility of males in going along with that choice.

There is a strange bit of illogic here, too. The feminists have waged a salutary drive to bring the father into the birth process, from prenatal exams through the delivery room. At the same time they would exclude the man from the abortion decision and claim that sector of pregnancy for themselves. Pregnancy is the result of the act of two people, and it seems manifestly unfair to say that women have exclusive rights when the consequences of abortion involve both sexes.

The state, through the decree of the Supreme Court, has become a willing party to the dissolution of the family on the consent question. On abortion, it has taken an adversary position on the formation of new families. And it takes an adversary position against the family as a stabilizing unit within society. Pregnancy and childbirth are cohesive in their effect on the family, while sex apart from the family and childbearing is never socially cohesive; on the contrary, it is a chaotic force.

And what can we possibly say in favor of removing from parents the consent on abortions for their daughters under eighteen and then forbidding *notification* of the parents? We even require it for nose-bobbing. Thus has the court unraveled the family. It

has also stripped away any logical ground for parental consent in any other legal medical procedure, even for underage marriage, and will have to overthrow these restrictions, too, when such cases reach it. Why should a fifteen-year-old girl have to acquire parental consent to get married when she does not need it to get an abortion? The former holds no immediate risk to her health, and the latter does, given the statistical possibility of problems—especially if medical follow-up is avoided.

If abortion remains legal, I would like to hear my former colleagues in the abortion movement start discussing these and other problems in the depth that these matters deserve. If they should decide that they will continue to accept legalized abortion, they could still do what they can to discourage individual decisions for abortion rather than appear in any sense to be *encouraging* it.

OUGHT THERE BE A LAW?

The obvious scientific conclusion is that alpha is demonstrably an independent human entity (life). The obvious moral conclusion is that alpha's destruction cannot be justified unless, on clear medical grounds, the mother's life is at stake. A life is a sound humanistic basis on which to sanction the intentional destruction of human life; nothing else is. The sociological conclusion is that abortion is not just a private matter; it has to do with all of us.

Even though I end up agreeing with the Right-to-Lifers at many points, I do not think of myself as part of their ranks. I have come to my views wholly independently, based upon my extensive experience in abortion, which the Right-to-Lifers will never share. I have reached my conclusions very reluctantly, after six years of self-examination, but that makes the conclusions no less certain. On the contrary, it makes them much more certain. Let me state once again that this is a humanistic philosophy drawn from modern biological data, not from religious creeds.

What if the biological findings are not as conclusive as they appear to me? In western medical ethics and cultural tradition, one of the cornerstones is that if you are unsure whether life is present, you give it the benefit of the doubt. Civilized societies can-

not afford to destroy even what *might* be a human life, except under unusual circumstances. Otherwise we are at the stage described by Germain Grisez, the Catholic philosopher: "To be willing to kill what for all we know *could* be a person is to be willing to kill if it is a person." A judge's charge to a jury asks only that its conclusion be "beyond a reasonable doubt," not a "virtual certainty." To me, we have virtual certainty in the matter of alpha, but certainly we are beyond reasonable doubt. With life present, the doctor has a duty as a member of society to act on behalf of life; in fact, we all do.

This is the fundamental weakness in Justice Blackmun's pro-abortion decision in *Roe v. Wade*. As expressed by Archibald Cox, the constitutional law expert at Harvard (and Watergate prosecutor), the decision "fails even to consider what I would suppose to be the most compelling interest of the State in prohibiting abortion: the interest in maintaining that respect for the paramount sanctity of human life which has always been at the center of western civilization, not merely by guarding 'life' itself, however defined, but by safeguarding the penumbra, whether at the beginning, through some overwhelming disability of mind or body, or at death." Other distinguished legal scholars have leveled serious Constitutional objections about the court performing "judicial legislation" by writing what amounts to an abortion statute, about its interpretation of "due process," and about the fuzzy locus of the "right of privacy" within the Constitution. The *Roe* decision also raises a host of legal conundrums on such commanding questions as the responsibility under law of the unwed father, inheritance law, and damage suits involving alpha. These are very important issues, but are beyond the scope of this book.

I would agree with Harold O. J. Brown, an outspoken anti-abortion Protestant theologian, when he states that it would have been better if the Supreme Court had simply stated that alpha is not a human being until birth and let it go at that. This would have been biologically incorrect, but it would have rescued us from the morally dangerous conclusions of the court, as summarized in the earlier chapter, "If Wombs Had Windows." Even after alpha is "viable" and the state suddenly acquires a "compelling" interest in potential life, that life can be extinguished on wide grounds. This would have also spared us of Blackmun's sub-

jective standard of "meaningful life," which is a moral Pandora's box since the lives of those already born could also be deemed "meaningless," someday, somehow.

The Supreme Court's abortion statute produces considerable logical as well as moral confusion. Blackmun granted this possible state interest in alpha in the last months in utero, but if alpha is not a "person," as the court is convinced, then on what legal basis could the state justify its interest? If it is on the basis that alpha is a potential person-to-be, that holds for the week before viability, indeed, *months* before viability. If alpha is assuredly not a person, the court never told us what it *is*, or what its status is in law. I suppose that if it is not a person then it must be "property," as the right-to-control-my-own-body feminists claim. What then? John Hart Ely, another Harvard critic of Blackmun's decision (and an opponent of most legal controls over abortion) points out that an object need not be a person to be protected. The state can prohibit the killing of dogs, even killings claimed to be an exercise of First Amendment rights. If the beating of dogs inflicts no moral harm on the populace, why do we have laws against it? The answer is that we seek to preserve Professor Cox's "penumbra." The dog analogy does not work closely, since alpha is at least an inconvenience and sometimes an adversary to the mother in a way that a dog is not.

Let us continue to assume that alpha is property. The court has removed the "ownership" of alpha from the husband and the family, and has removed custody from society, and has given control to the mother alone. True, alpha is "in" (though biologically not "of") the mother's body, and it is said that possession is nine points of the law. Yet a second person contributed to alpha's existence. If a man and a woman build a cottage together and the man does only a tenth of the work and has a tenth share of ownership, he still has a right to government protection of his minority property right if the woman seeks to destroy the cottage or tries to chase him off the premises with a shotgun. Is not the father a legal "co-owner" of alpha even if alpha is only "property," and does he not have some property rights? Normally, in striking a balance between life and property, we are justified in taking life while defending our property only if the intruder tries to kill us. If an "intruder" in the womb, or a dog, threatens to kill a

woman, she is justified in killing either. Since the father has been stripped of all rights under the *Planned Parenthood* ruling, I do not see how the law can continue to hold him responsible for child support either before or after birth.

In a fascinating New Jersey Supreme Court decision of 1964, when the old respect for alpha was still intact (*Fitkin-Morgan Memorial Hospital v. Anderson*), the justices ordered a pregnant woman who was an adult Jehovah's Witness to undergo a blood transfusion solely in the interest of what the court termed "the unborn child." Alpha's protection and continued life was considered so fundamental that it took precedence even over the mother's right of religious liberty that is explicitly guaranteed in the First Amendment. I presume that Mr. Blackmun would reverse that judgment.

Whatever the legal ramifications of the *Roe v. Wade* abortion decision, the central issue is, must we legislate protection of alpha? Or, can we afford not to? Because of that ruling this now requires an amendment to the Constitution. But leaving this aside for the moment, is legal control of abortion wise? Daniel Callahan and other writers who raise serious moral questions about abortion as such would say that legislation is not wise. The usual contentions are that anti-abortion laws are: (a) illegitimate, (b) unenforceable, (c) discriminatory, and (d) lack necessary social consensus.

Illegitimate—The federal government, via our highest court, has determined that laws prohibiting abortion are an unacceptable violation of personal privacy. Others argue from broader concepts of personal liberty or from the bad consequences of such laws for individual women. I would readily grant that the problems with abortion laws are such that the laws would not be wise—if human life were not involved. We cannot simply rule out laws *a priori*; the law has always been brought into play when human life was thought to be at stake. We must, then, ask further questions about whether the law can interfere with personal liberty.

Laws against child abuse or requiring school attendance are not illegitimate, even though they impinge upon the liberty of parents. Whether against murder or littering, laws by their very nature limit behavior to foster a greater social good, and in doing so they sometimes create inconvenience or hardship for individuals.

One does not morally discard the legitimacy of a law because of the bad consequences for those who disobey it. Taking the worst case, even if a certain number of women die because they circumvent an anti-abortion law (which, as I have stated, need no longer happen), this is not sufficient reason to rule out the law. The fact that even deaths result from circumvention of a just law does not then make the law unjust. People may die robbing banks, but we do not legalize bank-robbing. (Nor do good consequences justify an illegitimate law. If a law were to require the indefinite detention of all persons in New York City previously convicted of a felony, there would be socially "good" results: Some lives would be saved, and the crime rate would drop. But elemental justice must come first, not utilitarian calculations of the "greatest good.") We used to hear this sort of argument more often in the late '60s during the Viet Nam War: If society persists in this draft law, which I must dodge, then society is responsible for my going into hiding or losing my citizenship. Because of the bad consequences for me, you must eliminate your law.

Unenforceable—It is on this basis that even some Catholic moral theologians who dislike abortion are against laws that forbid it. Granted, people would violate anti-abortion laws. However, is the fact that a law is widely broken grounds for eliminating it? All laws are unenforceable to some extent; we cannot have a policeman on every corner. Tax cheating is far more widespread than illegal abortion used to be; nonetheless we do not eliminate tax laws or consider them unenforceable—and the loss of human life is a vastly more weighty consideration than loss of revenue. The abortion issue is also far more serious than that of alcohol consumption, which is why the pro-abortionists' use of the Prohibition fiasco as a parallel of unenforceability is, to me, absurd. The abolition of slavery is a much better parallel: definitions of human life and its protection, personhood, and elemental justice were involved. Abortion is the kind of inflammatory issue that leads to civil strife, if not Civil War.

We do in fact selectively enforce laws that are all-but-unenforceable but absolutely necessary, e.g., statutes against perjury. Most laws in practice are self-monitoring and there was general social compliance under the pre-1973 abortion laws. For every woman who aborted, many more did not, and because of the moral

pressure that these laws generated, many lives were preserved. Most important, laws are an expression of a society's moral health. Even when imperfectly enforced, they make an essential statement about the value of all individuals within the human community.

Discriminatory—This aspect of the old laws incensed me as much as any other: Wealthy women were able to get abortions while poor women suffered. The fact that women need no longer suffer or die considerably weakens the force of this argument, reducing it to inequality of access that results from inequality in finances, not a matter of life and death. Wealthy women would still be able to pressure their doctor or fly to London, and poor women might not. Baruch Brody correctly says that this amounts to an argument that "since there is an inequality about who is allowed to go scot free for murder, we should allow everyone to be exonerated for it." The alternative is to see to it that law enforcement is more thorough. An imperfection of government in equally applying its laws should not be an argument for "equal rights to murder." (Unlike Brody, I do not consider abortion tantamount to murder, but it is a serious question of life-taking nevertheless.) To balance the scales; perhaps we should inflict higher penalties on wealthy women who are caught aborting.

If we are concerned about inequality, we should consider that on one floor of a general hospital we are laboring mightily to preserve one imperiled alpha, while on another floor we are aborting an alpha of similar characteristics. There was even a 1978 report from Lund, Sweden, that doctors aided by ultrasonography performed the first selective abortion involving twins within the same womb, destroying one twenty-four-week alpha with a rare metabolic disorder while leaving its sibling-to-be intact. Paul Ramsey states that the issue in abortion is not "when does life begin" but rather, "when does equally protectable human life begin?" At the moment there is no "equal protection of the laws" among alphas. Some are "more equal" than others. The inequality argument in abortion cuts both ways.

Lack of consensus—Roger Wertheimer, a thoughtful pro-choice philosopher, says that the abortion debate leads one to the conclusion: "It is not true that the fetus is a human being, but it is not false either." Impasse. The "social costs" of anti-abortion laws are so drastic, he feels, that only preservation of human lives could

justify them. Since the state cannot prove that human lives are involved, the laws must be deemed "an illegitimate exercise of power."

Here illegitimacy is based not upon asserted rights and claims, but upon the stalemate in public opinion. What does the public really believe about abortion? I am quite skeptical about polls because the form of the question, if not the interviewer's tone of voice, tends to influence the answer. However, Judith Blake's survey of poll results in 1965-77 for the Population Council journal ought to give pause to both sides. In eight Gallup surveys over these twelve years, the segment of the adult population approving abortion-on-request has never gone above 31 per cent, and opposition to it has never fallen below 63 per cent. In four National Opinion Research Center surveys the highest favorable figure was 46 per cent and the lowest disapproval was 50 per cent. (Other polls with different questions, not chosen for Blake's study, have shown a more pro-abortion attitude.)

Support for abortion declines markedly after the first trimester. Blake thinks a major reason for this is that respondents "regard the fetus as a 'human life' or a 'human person' very early in the gestational period." This attitude is "both at odds with that of the Supreme Court and at variance with what the Court believed public opinion to be." Here are the remarkable responses on "when human life begins" in an April 1975 Gallup survey. (Recall that "birth" is the point of total protection defined by the Supreme Court, while "viability" is the point at which the court permits some protection of "potential" human lives.):

	<i>Catholic Men</i>	<i>Non-Catholic Men</i>	<i>Catholic Women</i>	<i>Non-Catholic Women</i>
Conception	52%	41%	75%	52%
Quickening	17%	14%	13%	17%
Viability	15%	14%	4%	13%
Birth	13%	22%	7%	11%
Don't Know/Other	5%	9%	1%	7%

(Respondents in
this category)

(200)

(594)

(212)

(588)

After Blake published her survey, Gallup released a new poll on January 22, 1978, the fifth anniversary of the Supreme Court decisions, in which only 22 per cent favored legalized abortion under all circumstances, with virtually no difference on this between Protestants and Catholics. There was also virtual agreement between Protestants and Catholics in a rather significant breakdown of views among the 55 per cent who believe that abortion should be legal "under certain circumstances." Asked *what* circumstances of type of case or stage of pregnancy they accepted, this majority segment of the population broke down as follows:

	<i>First trimester</i>	<i>Second trimester</i>	<i>Third trimester</i>
When the woman's life is endangered	77%	64%	60%
Where the pregnancy is a result of rape or incest	65%	38%	24%
When the woman may suffer severe physical health damage	54%	46%	34%
When there is a chance the baby will be born deformed	45%	39%	28%
When the woman's mental health is endangered	42%	31%	24%
If the family cannot afford to have the child	16%	9%	6%

When the 19 per cent are added in who oppose abortion under all circumstances, the over-all population would appear to be rather close to the policy that I am proposing. If "severe physical health damage" is interpreted under my criterion of life-shortening that is caused by the pregnancy itself, the major point of disagreement is the survey's support of first-trimester abortions for rape or incest.

In February 1976 Gallup asked about a Constitutional amendment to prohibit abortions "except where the pregnant woman's life is in danger." Some 45 per cent favored it and 49 per cent opposed it. (Note that the wording excluded such common justifications as rape and health.) Another straw in the wind: In the last statewide referendums on the question, shortly before the Black-

mun decisions, Michigan voted 61 per cent against abortion and North Dakota, 79 per cent. Judith Blake accurately concludes, "Supporters of the [Supreme Court] decisions must anticipate a long fight in order to realize anything close to full implementation. Actually, just holding present ground is proving to be a constant battle."

John Finnis, an anti-abortion law professor at Oxford, plays down the concept that the law cannot go against substantial public opinion. Sometimes the law is ahead of public morality. Laws against dueling and racial bias preceded popular support for these attitudes, he points out. Still, there must be a consensus to make a law work, and in the United States, because of the Supreme Court actions, a Constitutional amendment is currently the only way to open the way to abortion limitations, and under the American system an overwhelming consensus is necessary to achieve an amendment.

The American public has not yet given "informed consent" to *laissez-faire* abortion. When it is fully informed about the biological facts and about the cant in many pro-abortion arguments, it may opt for the morally wrong decision, to be sure. A consensus on abortion can be reached only if the issues are examined coolly in a secular, non-inflammatory fashion, in the light of all that we know of the biological data. Neither the Right-to-Life nor the Pro-Choice crusaders are doing much to get on with this type of essential nationwide discussion.

My desideratum is that the issue would be brought once again before a future Supreme Court and decided in a new light. If the court does not shift, in the future it must either continue to fly in the face of an expanding body of scientific knowledge or, I fear, issue further rulings with devastating consequences in other moral areas. In lieu of a change by the court, a Constitutional amendment is the only avenue now open to reform. Since the various proposed amendments have been bottled up in Congressional committees, the anti-abortionists are pursuing their only choice, the desperate plan to call a Constitutional Convention to consider such an amendment. At this writing, fifteen of the thirty-four states required have approved the convention call. I have an innate reluctance to advocate amendment of the Constitution, whose Fourteenth Amendment "equal protection" clause very ad-

equately covers the protection of alpha, if only the court would perceive it.

If the views of the Supreme Court change, how would statutes be drafted? Much nonsense is written about the stage at which the law should prohibit abortion. Let the theologians argue about when the "soul" exists within the womb, as they have done the centuries with various results; that is none of my concern. To an obstetrician, pregnancy does not exist until its presence is confirmed by scientific evidence. When the existence of pregnancy is established, alpha should be protected under the law.

What sort of penalties should be mandated? If we are serious about preventing abortion, we should make it a crime for the woman as well as the abortionist, just as we obviously care little about preventing prostitution until we prosecute the johns as well as the prostitutes. In arguing against abortion laws, Sissela Bok, who teaches ethics at the Harvard Medical School, correctly observes that the death of alpha does not produce known suffering in alpha at the level it produces with, say, an adult, nor does it create the brutalization and threat to society or grief among individuals in the way that murder does. The penalty for abortion, in my view, must be less than that for homicide, but neither should it be handled like a traffic ticket. Since juries in the past balked at putting doctors in prison, perhaps those doctors who perform abortions could be sentenced to devote half of their practice to non-salaried clinic work for the poor over a stated number of years.

And what should the law provide if abortion-on-request remains legal?

Sissela Bok, who believes it is essential that we take a hard line against any hint of infanticide, proposes that the law prohibit all abortions after viability except for cases that concern "the life or threat to life of the mother." This is her preferred interpretation of the Supreme Court's "life and health" standard in permitting states to forbid late abortions. The states, in my opinion, should prohibit these abortions, passing the strictest medical definition of "health" that the Supreme Court will accept.

Daniel Callahan opposes prohibitory laws but commends the policy in Eastern Europe and Scandinavia of wide anti-abortion

educational campaigns along with the spread of information about such alternatives as adoption and agencies that assist unwed mothers. The U.S. government has tried this with cigarette smoking. I have an aversion to government-sponsored educational campaigns of this sort and doubt they achieve much. But why not privately funded educational efforts, including institutional ads by organized medicine and the health industry?

Surely the right to abort must be accompanied by the right of doctors to refuse to abort, and of medical personnel to refuse to assist. Right-to-Lifers worry that medical schools discriminate against conscientious objectors to abortion, and their fears were justified by a 1979 survey sponsored by the U.S. Department of Health, Education, and Welfare, upon prodding from a bill sponsored by Richard Schweiker, the anti-abortion Senator from Pennsylvania. In all, 122 of the 126 medical schools in the nation responded to the survey. Pro-abortionists stress that H.E.W. found few specific cases of bias. However, a surprising 40 per cent of the schools reported that they questioned prospective students about their views on abortion. The stated reason for the questions was to assess the applicants' grasp of current issues and ability to formulate and express an opinion. Surely there would have been a scream of outrage from liberals if, in a different abortion climate years ago, students had been asked whether they favored abortion or liberalization of the laws. Where are the proponents of civil liberties now? It would be wrong to discriminate against anti-abortion applicants, and because this is such a touchy and often *ad hominem* issue, it would certainly be wise for interviewers to confine themselves to any of the other questions they might pose to test the applicants' intellectual skills.

However, it is not impermissible to ask an abortion question of applicants for residency in obstetrics and gynecology, for purely pragmatic reasons. In an urban center with a lot of abortions to be done, the administration must make sure that it has some people willing to do them among those in each entering group. At Manhattan hospitals, certain residents in obstetrics and gynecology do refuse to involve themselves in non-medically indicated abortions, without incident. As I have said, it is difficult for the reluctant doctor to refer abortion requests, particularly if the woman has an unusually delicate psyche or a gynecological prob-

lem that he is better able to handle than someone else. Pro-abortionists would force any hospital which gets public funds to provide abortions. This is a hollow point in that virtually every hospital gets some public funding nowadays, but on the other hand, two thirds of health care is not government controlled. I do not see how the government can force an institution to perform an operation that it believes to be in violation of the moral tone of its medical practice.

Where should abortion be performed? The reader will recall my push in the early '70s to get abortions into offices and clinics. However, at that time hospitals had no imagination in offering outpatient service, and we wanted to avoid the unnecessary cost of an overnight bed. Also, there was then a good deal of hospital obstructionism and Blue Cross refused to cover abortions. Today, as always, second-trimester abortions are always performed in a hospital; clinics do only the first-trimester suction abortions. In the period since the Supreme Court decisions, abortion has become the most commonly performed surgical procedure on adults in the United States and, consequently, is one of the most common bases for malpractice lawsuits in all of medicine. It now ranks as major surgery in malpractice insurance coverage for civil law, even though medically it is a minor procedure. For this reason, I think it must occur within hospital walls, though on an outpatient basis and readily available at low cost.

Should the government pay for abortions for poor women? Or, to put it as the anti-abortionists do, should millions of citizens be compelled to pay taxes for what they believe is unjustified destruction of life? The fact is, this is done all the time. Pacifists are required to pay taxes that prop up the Defense Department, and during Viet Nam millions of others had similar objections. Those who object could be permitted to register their protest by an abortion conscience "checkoff" on their tax return so their own taxes would be used on a restrictive basis. The average first-trimester clinic abortion today costs \$125 to \$200, not an impossible expense for women. Still, perhaps funding of non-medical abortions for the poor should continue, on grounds of fairness. Peter Steinfelds, a liberal Catholic journalist with *Commonweal* and formerly editor of the journal at Daniel Callahan's ethics institute, proposes other ideas. Why not ask middle- or upper-income

women who get abortions to contribute to a fund to help the poor pay for theirs? Why not require those who earn a comfortable living off of abortions to contribute services for the poor? Private philanthropy would also be appropriate, particularly since anti-abortion churches often bear the cost for helping unwed mothers who wish to give birth.

It is instructive to note what actually occurred when federal Medicaid funds were cut off. The abortion monitors for the government's Center for Disease Control had made the somewhat apocalyptic prediction that between five and ninety excess deaths a year would result. The prophecy proved false. In 1979, after studying fourteen states and the District of Columbia, the C.D.C. reported only one death that had resulted directly from the end of public funding; two other deaths were related indirectly. This compared with the three known deaths from illegal abortion nationally in 1976, before the cutoff. The federal officials concluded that the end of funding did not affect death rates. As for "complications," only ten of the 3,000-plus cases of difficulty were ascribed to illegal abortion, and none of these ten women happened to be Medicaid recipients. Because the federal officials put more emphasis than I do on the current dangers in non-physician or self-induced abortion, they concluded that the stability in deaths and "complications" meant that generally the women were not seeking illegal abortions and the results were in terms of financial pressures on poor women, or in women who bore children when otherwise they would have aborted. In other words, Medicaid funding is a sociopolitical problem, but not a health problem.

The major development in legislation while this book was being written was the abortion-control laws that aim to cover most of the options that *Roe v. Wade* left open, as promoted by anti-abortionists. Akron, Ohio, passed the first such ordinance, followed by the State of Louisiana, and other jurisdictions debated the idea. Here is my thinking on the sort of points covered in these proposals:

Licensing fees—Doctors and clinics should not have to pay special fees to perform abortions. They are unfair. We do not require hysterectomy fees.

Mandatory counseling and "informed consent"—It is a good idea to require counseling but not, as in these laws, for the pur-

pose of dissuading a woman from her chosen course. This may be Constitutional, but it is dirty pool. By the time a woman comes to the doctor she has already gone through the options to abortion, and she should be counseled about these only if she asks. Birth control advice is desirable. The U. S. Supreme Court has upheld the informed-consent requirement in Missouri because an abortion should be decided upon "with full knowledge of its nature and consequences." This should not be used as a channel for anti-abortion propaganda. No pictures of alpha should be shown unless the patient asks to see them. It should be handled like any other professional consultation, stating what the operation entails, and what size and characteristics alpha has at the time of the abortion. Everyone should be informed that a separate existence will be extinguished, but through clearly stated biological facts, not polemics.

I would oppose laws that require the patient to be told of "serious medical complications" or "severe emotional disturbance" from abortion. This would be inaccurate. I also oppose the provision that the woman be told that "the unborn child is a human life from the moment of conception." For one thing, I personally disagree with the conception line, but also a law should institute legal language, such as: "the reasonable probability that a human being is present from early in pregnancy."

Counseling of parents—This is a wise requirement for cases where the woman to be aborted is underage. So is the notification of a husband that his wife plans to abort.

Waiting period—I would recommend a cooling-off period of a week between signing of consent and the actual abortion, but not if the wait might put the woman near the cutoff time beyond which curettage is performed with statistical safety, or if she is close to the cutoff point for late abortion.

"Viability" is central to the final legal quandary of the abortion age: the aborted alpha who is born alive.

Live births always occur in Justice Blackmun's supposed "abortions" after viability, which are actually prematurely induced deliveries. So far as I know, every responsible hospital keeps life-sustaining equipment and pediatric staff on hand for these late procedures, which are carried out by either prostaglandin infusion

into the sac or, later, induction by oxytocin, a pituitary hormone that contracts the uterus as in natural labor.

However, live births also occur occasionally with second-trimester abortions, rarely with "salting-out," and more frequently with the more recent prostaglandin method. Prostaglandins, which induce uterine contractions as oxytocin does when it is used later in pregnancy, are administered as in saline abortion, by injection of the drug into the amniotic fluid through a needle inserted in the abdominal wall. In 1976 the U.S. Supreme Court threw out the Missouri law forbidding saline abortions, arguing that the prostaglandin technique was not widely available. That is not true today, and I am certain that there would now be no Constitutional basis for refusing prostaglandin abortion, which increases the margin of safety for the mother. The reason for this: If strong saline solution is mistakenly injected into a vein, it can be dangerous. No serious results occur if the prostaglandin is put in the wrong place. Saline, done correctly, virtually always kills alpha, while the prostaglandin forcibly expels alpha by muscle action and sometimes it comes out alive. This is one reason that it is not used in many hospitals even though it is safer for the mother.

When we had live births in the early saline period (1965-70), the nurses, to their everlasting credit, reacted in the instinctively proper manner when they saw that the tiny newborn was gasping or moving. They invariably instituted vigorous resuscitative measures, carried the baby to the premature nursery, and demanded the customary standards of care for it. The doctors were caught in the dilemma of being the adversary of alpha in performing the abortion and, in an instant, becoming obstetricians committed to the newborn's safety. Neatly trapped by definitions, taught from medical school that an "abortus" is only a pathology specimen, we stood gawking at the wiggling, gasping baby, paralyzed by the paradox.

The live-birth problem came up frequently in the early political wars and inspired something of a pro-abortion summit meeting at Chicago's O'Hare Airport on January 9, 1971. A number of Midwest abortion campaigners had been stymied in the state legislatures by Right-to-Lifers who kept citing this nasty issue of the "living abortuses." Larry Lader and I attended the conference,

which was dominated by Constance Cook, the New York Assemblywoman who had shepherded the liberalization statute through the legislature the previous spring. Since I was the only obstetrician there, as N.A.R.A.L.'s medical chairman, the "living abortus" problem kept getting bounced to me.

I was puzzled by the consternation that was epidemic around that rectangular motel-room table. It had always seemed clear to me that the object of abortion was only to rid the unwilling woman of the burden of the pregnancy. If a living child resulted, it was perfectly obvious that it was to be cared for like any other premature baby. There was no conflict of medical purpose or ethics in that policy, but when I presented that position there were so many furrowed brows that the place looked like a recently plowed field of foreheads.

A committeewoman from Iowa, hawk-faced and with prosecutorial mien, piped up: "What about hysterotomy, doctor? Isn't that surer than salting-out?" She meant, surer to kill. The pro-abortion women seemed disturbed by the thought that a stray alpha or two might manage to live. I replied that hysterotomy would not "guarantee" death and, on the contrary, always produces a live birth because it is nothing but a miniature Caesarean section. It also has an unacceptably high "complication" rate for the mother. The Iowan sat there puzzled as if I had spoken in Esperanto. What were these people thinking? Were we to take living fetuses fresh from the uterine wound and wring their necks?

The Chicago meeting adjourned on an indecisive note. I had given them no magical nostrum for solving their problem and had probably stirred some disturbing thoughts in a few. On the plane home Sunday night, I reflected over my drink that the Right-to-Lifers had exploited a perfectly specious issue, and our people had fallen right into their trap by failing to counter it and ultimately being stalled by it. Orthodoxy at that time required a more slaughterous view of abortion than I, as a physician, could ever embrace.

Two years later, in Boston, poor Kenneth Edelin was to run into a manslaughter charge over this live-birth question, so if physicians were unclear on their duties to the unexpectedly living newborn, how can we fault the layman? The hospital staff ap-

parently figured a live baby ought not to come out of the hysterotomy that he performed. There was no resuscitation equipment, no isolette, no preparation to deliver a baby, no doctor standing by to assist, even though a live birth was to be expected with hysterotomy. This was the major drama in the Edelin affair, and it had little to do with the way the trial developed. The response to the Edelin case was an important instance of the continued moral myopia among my former pro-abortion allies.

There was a period before the Edelin conviction (later thrown out on appeal, by the way) when a doctor could turn his back on a liveborn aborted baby, though nurses and paraprofessionals kept fierce pressure on to prevent this. After Edelin, the pendulum swung back, and I do not think anyone today would ignore even an eighteen-week baby if it were born kicking. We should simply quit quibbling about grams and weeks and declare that any baby born alive has a chance, and dispatch him to the nursery. Many states require a second physician to be on hand for care of a possible live birth in late abortions. In the important Section G of the *Planned Parenthood* decision, the court threw out the Missouri statute requiring action "to preserve the life and health of the fetus" in live births, but the reason was because Missouri did not specify that such care need be taken only after "viability." If I follow the court's reasoning at that time, care could still constitutionally be required at "viability." Now I am not so sure, because of the court's subsequent decision in *Colautti v. Franklin* (1979). The Pennsylvania law that this decision overturned required a doctor to make life-sustaining efforts if, in his professional judgment, the fetus "is viable or if there is sufficient reason to believe that the fetus may be viable." Pennsylvania added to that a so-called "standard of care" under which doctors were required to give equal diligence to preserving liveborn fetuses after abortion as with fetuses "intended to be born," i.e., wanted. As part of this, doctors were to use that technique that provided "the best opportunity for the fetus to be aborted alive" so long as the technique did not adversely affect the mother.

To me, that seemed a perfectly rational, and morally necessary, policy. The Supreme Court found it "impermissibly vague." I am uncertain what the court was trying to do on the all-important

principle of equal care. The decision dealt mostly with abortion technique. In the second trimester, the basic choice is between salting-out and prostaglandins. Oddly, the physicians who were selected to testify in the case had somehow avoided much experience with the quite-common prostaglandin technique. Those who did emphasized undesirable side effects (nausea, vomiting, headaches, diarrhea) which are quite manageable, and quite trivial compared with the loss of intrauterine life. Besides that, the side effects are considerably less intense in second-trimester abortions by intra-amniotic infusion than in the prostaglandin suppositories which have been used for first-trimester abortion. The doctors cited also claimed prostaglandins were unsafe in such rare or debatable cases as asthma, glaucoma, hypertension, heart disease, and epilepsy.

There is a massive curiosity here. It seems to have escaped judicial notice that in cases of hypertension, say, or heart disease, and in others as well, saline abortion is *not as safe for the mother* as prostaglandin abortion. In point of fact, the maternal deaths that have been reported in second-trimester abortion and are directly attributable to the abortifacient itself have resulted from the saline method. The trouble arises if the strong salt solution is misplaced into the vascular system or the peritoneal cavity instead of the amniotic sac. The Supreme Court seems to think that saline is preferable, though *Colautti* only specifies that the state should be more precise when it threatens a doctor with criminal penalties in this area.

It is also curious that many hospitals do not use prostaglandins even though they are safer for the mother, and probably for exactly the reason that they are safer for alpha, too. They do not want to cope with the live births. It seems clear to me that prostaglandins ought to be used in preference to saline because the method is healthier for alpha, and is no worse and in some instances better for the mother.

We have moved into a gray world where we change our labels by intent. If a doctor wants to kill off alpha (being sure to use the most deadly technique) then alpha becomes an "abortus." If he wants to preserve it, it is an "immature" or "premature." In late abortions, if he wants it to die, the operation is labeled a "hysterotomy"; if he wants it to live, it becomes a "Caesarean section."

There is, however, biological progress on the horizon that will make the entire abortion issue as it stands today obsolete, and will remove from us the burden of these gruesome problems. It is to this that we finally turn.

Epilogue

Abortion: 1. Act of giving premature birth; specif., the expulsion of the human fetus prematurely, particularly at any time before it is viable or capable of sustaining life. Miscarriage.

*Webster's New International
Dictionary, Second Edition (1960)*

It is a curious fact, one explainable by a middling knowledge of the anatomy of the eye, that on a crackling winter night one can see the stars best by looking slightly past them, a little to the right, say. The same phenomenon may apply equally well to the most inflammatory aspect of the abortion dilemma, the seemingly ineluctable conflict between the rights of alpha and the rights of the woman who bears alpha.

Instead of shouldering up to the issue, it may be useful to look a little past it, keeping firmly in mind the dictionary definition. Nowhere does the definition state or even imply a wrenching ethical choice, mother or alpha. Nor need there be one.

Medical technique is always subject to change. Consider the classic *fetus-vs.-mother* case mentioned above. When I was an adolescent and my father was beginning to groom me for the obstet-

rical career he had picked out for me, I heard snippets and fragments of Gothic tales about Catholic obstetricians. In extreme cases when the infant was too big for the birth canal and where there was serious infection present, the standard obstetrical practice was a destructive operation on the infant. Huge crushing instruments with the intimidating names of cranioclast, basiotribe, and Braun hook were fumbled into the vagina. The infant's head was perforated with the spearlike component of the basiotribe or with the evil-looking Smellie scissors with its enormous razor-sharp point. The fluid and brains were drained from the skull and the skull was then crushed, permitting the infant to pass through the birth canal, dead. In those antique days this was considered a life-saving procedure, but one that no Catholic obstetrician would perform. Around that rusting hulk of a dilemma grew—like barnacles—layer upon layer of horror stories about Catholic obstetricians. They will let you die in labor. They consult the priests when a difficult problem arises in practice. They perform secret cabalistic rites in the delivery room while you are under anesthesia. Cruel, ignorant, and bigoted tales, but originating in a real medical-ethical dilemma.

Then came the advances in medical technology following World War II: Infinitely better anesthetic techniques and better-trained anesthesiologists; quantum advances in blood and blood-substitute technology; the perfection of surgical techniques and the superior surgical training of a new generation of obstetricians; and the advent of the antibiotic era. The fear of Caesarean section and the older obstetricians' reluctance to resort to it were eliminated. Instead of the gory destructive procedures of the past, we now routinely perform C-sections from which both mother and infant emerge safely. Technology has retired completely *that* ethical choice.

Look again at the dictionary definition of abortion. Consider the policy statement of the American College of Obstetricians and Gynecologists (1975, reaffirmed 1977):

The College affirms that the resolution of such conflict [between woman and fetus] by inducing abortion in no way implies that the physician has an adversary relationship towards the fetus and therefore, the physician does not view the destruction of the fetus as the primary purpose of abortion. The College conse-

quently recognizes a continuing obligation on the part of the physician towards the survival of a possibly viable fetus where this can be discharged without additional hazard to the health of the mother.

Even Mary Anne Warren, Our Lady of the Guppies, states that the mother has no right to destroy alpha if an abortion can be done without destroying it. It is a regrettable but undeniable fact that in the present relatively crude state of abortion technology, alpha is destroyed in most instances.

Now, let us look a little to the right of the star.

When I consult my fading textbook from medical school (*Textbook of Obstetrics* by Stander, copyright 1945) I find this statement: "It is our practice to consider an infant as premature when the birthweight is between 1,500 grams (three and a half pounds) and 2,500 (five and a half pounds)." Earlier the book notes that all infants die below the weight of 1,000 grams (two and a quarter pounds). In other words, in those long-ago days an infant below 1,000 grams was sure to die, and one below 1,500 grams was probably not worth wasting a great deal of effort on. Contrast that with today. As discussed above, the line for "every effort" at life support went down to 1,000 grams long ago, and in the '70s most practitioners use a rule of 750 grams, above which roughly one in three infants will survive. Between 1,000 and 1,500 grams the survival rate approaches three fourths. The general mortality rate for newborn infants has declined from twenty-four per thousand in 1946, when I was in training, to ten as of 1978. Technology again: sophisticated incubators with efficient oxygenators, humidifiers, temperature controls, cardiac-monitoring systems, artificial respirators, ventilators, methods for determining arterial blood gases, complex new intravenous feeding solutions and equipment for administering them, and an infinite variety of new diagnostic techniques such as ultrasonography and computerized X-ray scanning. And, of course, better-trained pediatricians and the development of the whole new sub-specialty of neonatology for those who specialize in the care of newborns. With all these advances, and many more on the horizon, life-support systems for tiny premature infants have become immensely efficient and reliable.

The obsolescent concept of viability on which the Supreme

Court has relied so heavily is now as uncertain as the new technology is dependable. It is a certainty that within the next five to ten years neonatologists will have pushed the definition of "viability" below the 500-gram mark, the weight which currently divides the so-called abortion from the birth of a premature infant. These fantastic life-support systems will routinely nurture 100 gram ($\frac{1}{4}$ pound) and 50 gram ($\frac{1}{8}$ pound) infants to maturity. This is no Huxleyan peyote dream; this is a medical inevitability.

We now have life-support systems of considerable complexity and sophistication, sufficient to support and sustain alphas to the weight level of perhaps 400 grams. Krantz, Westin, Schneider, Chamberlain (see Bibliography), and others have accomplished some pioneering work in the matter of understanding the dynamics of the placenta (afterbirth) and attempting to design an artificial placenta. Work is proceeding at a number of institutions toward a machine that would accomplish the numerous intricate tasks of the natural placenta. Does this sound like science fiction? When I was a medical student, progressive kidney disease was a death warrant. Who could have foreseen that people could live indefinitely without kidneys, dependent on machines to do their work? Now the artificial dialysis unit is so small and efficient that many people without kidneys can dialyze themselves at home. The kidney is an organ at least as biochemically astonishing and versatile as the placenta.

Another stepping-stone. In 1869 one D. C. Panteleoni published an article in the *Medical Press and Circular* of London in which he described use of an optical instrument to inspect the interior of the uterus. Numerous modifications of the original instrument were devised in the first half of the twentieth century, but the technique was hampered by undependable optical systems and inefficient liquid solutions for flushing the instrument and uterus. With the development of fiber optics—optical systems that use flexible quartz fibers to convey light around corners and into the recesses of body cavities—and with the development of special high-molecular solutions for flushing the area clean, the technique of hysteroscopy became practicable. With this instrument, gynecologists are now able to inspect minutely the interior of the uterus for congenital abnormalities, infections, and growths. The instrument is even used in female sterilization,

which involves obliteration of the opening of the tubes into the uterus by scalding them closed with special chemical cauterizing agents. The earliest pregnancies have been viewed by means of the instrument; the minute blastocyst has been located at its implantation site and identified as to its age and health.

To solve the abortion dilemma—to respect the pregnant woman's right to be rid of an unwanted pregnancy and simultaneously to respect alpha's right to exist—we require four major technologies. We are almost there.

1. *A reliable test for the earliest stage of pregnancy.* As we have seen, the radio-immuno-assay method for detecting the pregnancy hormone HCG permits us to identify a pregnancy even before the woman misses her first menstrual period. Less-refined early pregnancy tests for home use are on the market.

2. *A reasonable and safe method for locating that pregnancy in the uterus.* The hysteroscope provides this means.

3. *A reliable life-support system for the pregnancy outside its original host womb.* A feasible artificial placenta is on the horizon.

4. *A non-injurious, atraumatic method for removing the pregnancy from the womb of the mother who does not want it.*

This is the major step that remains to be accomplished. Can alpha be removed from the wall of the uterus without seriously injuring it? The suction machinery we use at present to bring about abortion tears the alpha away from its site swiftly, crudely, and cruelly, without regard for its integrity. Alpha is dispatched through a long plastic tube to rest finally in a gauze bag amid blood, clots, and assorted gore. What we require is an instrument of sufficient delicacy that it can be threaded through the hysteroscope (so that one can locate and remove the alpha all in one maneuver) and can then pluck alpha off the wall of the uterus like a helicopter rescuing a stranded mountain climber. Does this, too, sound like fantasy? Microsurgery (operations done as the surgeon peers through a microscope) is now commonplace. With this technique the tiniest of blood vessels can be repaired, the gossamer strands of the retina can be woven together, and the tiny pituitary gland and its vessels can be explored and manipulated.

Besides transplantation into an artificial womb, the tiny alpha plucked from its implantation site could be transferred directly to

another prepared uterus, of a woman who is unable to conceive naturally. It is estimated that several hundred thousand women in the nation are involuntarily infertile. Here is a vast source of repositories for the "unwanted" alphas. The technology for transplantation is certainly there, thanks in part to the spectacular work of Steptoe and Edwards on *in vitro* fertilization ("test tube babies"). We are already able to accomplish conception within the laboratory and then to implant alpha into a prepared uterus without apparent trauma.

The abortion of the future, then, will consist simply of early detection of the alpha, removal of alpha from the unwilling mother, and transfer either to a life-support system or re-implantation into a willing and eager recipient. All rights are respected in this situation and there is the additional dividend of happiness for the previously childless woman and her husband.

There would then remain only the creation of a new word to replace "abortion." I have no doubt that some well-meaning middle-level bureaucrat will offer some ghastly term to us, perhaps "post-conceptual relocation" or PCR, under the direction of the federal Interhuman Embryonic Transfer and Restabilization Agency (IETRA). Perhaps more effort and money will be expended on this aspect of the enterprise than on any other.

Technology, like the Lord, giveth and taketh away. One problem is solved and ten new problems are created. For example:

One million abortions a year are being done in this nation. Even if several hundred thousand infertile women are provided with transplanted alphas, we would be left with hundreds of thousands of alphas to be placed into life-support systems in the first year of the new technology, and a million unwanted alphas a year thereafter. This conjures up a sobering vision of colossal hatcheries the size of space centers dotting the landscape, the expenditure of immense sums of money to sustain the alphas until they can be born and placed for adoption or institutionalized, and the impact of a suddenly increased birth rate on the society. Would the woman from whom the alpha is plucked and who benefits from its removal have any responsibility for the expense of the life-support prior to "birth"? Would the man who played a part in producing this unwanted alpha also bear responsibility? To whom

would these alphas belong? Fifteen years into the development of this technology and we might have 15 million children, and more "in the oven," who are parentless wards of the state. As the present large number of would-be adoptive parents disappears, we would have multiple millions of adults—husbands, wives, workers, voters—who have never known home, parents, love. To whom or what would they give their loyalties? What kind of people would they be?

To reduce the number of abortions (relocations? transfers?) of the future to a manageable number, there will be a corresponding advance in contraceptive technology. At this writing we can only consider the available means of birth control to be crude and bumbling. The intrauterine device (IUD) is imperfect and fraught with the hazard of infection, which is often quite serious and, rarely, lethal. The contraceptive pessary (or, more commonly, the diaphragm) is not only imperfect and primitive but requires a familiarity with the female anatomy and a modicum of privacy (a bathroom, at any rate). Thus, it is an excellent method for the privileged middle class, but hardly practical for the underprivileged nine tenths of the world. The oral contraceptive, efficient and simple, is, as one percipient observer has noted, "the greatest uncontrolled medical experiment in U. S. history."

What is needed is a safe, inexpensive, single-administration, reversible, long-acting, and easily administered contraceptive. A birth-control vaccine. We may be on the verge of perfecting one. Certain pilot studies are now being conducted in India with an antibody to the beta subunit fragment of the pregnancy hormone HCG. Briefly, in these studies the beta-subunit moiety of the HCG has been linked with the molecules of tetanus toxoid to allow the body to manufacture antibodies against the complex. In the presence of the earliest implantation, this antibody-immune system would be activated to produce more antibodies, and they in turn would seek out the pregnancy and destroy the cells that produce the HCG, that is, the trophoblastic protective layer around the embryo. The destruction of the embryo itself would follow. Given my own advocacy of implantation as the "life" line, this would constitute abortion, but other more specific and selective immunological approaches will be developed to destroy the conceptus before implantation. (That, of course, would constitute

abortion under the dogma of Roman Catholicism and certain other denominations.) In a preliminary report on this research in December 1978 G. P. Talwar, Professor and Head of the Department of Biochemistry at the All-India Institute of Medical Sciences in New Delhi, stated that the vaccine has not only proved successful in preventing pregnancy, but the subjects have experienced no disturbances in menstruation, no disturbance in hormonal systems elsewhere in the body, and no immunological attacks on other organs in the body. In short, a promising start toward a new and more imaginative approach to an ideal contraceptive.

As with alpha-transplantation, the birth-control vaccine would stir up problems. For the sake of economy, would administration of the vaccine eventually become mandatory for every woman? If so, what proof would a couple be required to present in order to reverse the vaccine and allow the woman to become pregnant? What punishment might be provided for those who resort to the black market to obtain a reversal "shot" against the vaccine and thus have a child without government approval? These problems sound quite futuristic, but when technology is available it is usually used, and when it is used the matter of social control of behavior often follows.

Or, turning back to abortion again, suppose that artificial wombs and transplants are feasible, what then? Pregnant women who want to be rid of alpha would then choose between two types of abortion.

1. The woman can have alpha extracted for transplant or in order to live on via machine adoption for eventual permanent placement for adoption, foster care, or orphanage care.

2. The woman can continue the current practice of dismembering alpha by vacuuming out the womb in order to make absolutely certain that it dies.

How many of the million women a year who now abort would choose each option? After the abortion experience of the '70s, I fear to predict what mothers would decide, assuming that society insisted on leaving such ultimate matters in their hands alone. How many pregnant women would be willing to check off (1) or (2) on their abortion-clinic admission sheets? This is the ultimate

in Pro-Choice. After a year of gathering statistics on the choices made, what will we *then* learn about our moral state?

These are not frivolous questions. Every major technological advance in man's comparatively short history has produced its reverberations in society and in philosophy. To cite the best-known instance, the advent of nuclear power has raised issues so profound and so divisive that they are largely unresolved decades later.

I suspect that no technology, no system of logic in and of itself, will suffice to answer the many all-but-unanswerable questions. The future of abortion brings to mind the words of Vercors: "What could be more depressing than the sight of so many first-rate intellects wasting their time (and acumen) on problems as footling, false and fruitless as a definition of man?" What, indeed? Only the recognition that the alpha is but one of us, and that we must welcome it back into the community of mankind, will serve us as a reliable guide for our implacable future.

If we didn't have birthdays, you wouldn't be you.
If you'd never been born, well then what would you do?
If you'd never been born, well then what would you be?
You *might* be a fish! Or a toad in a tree!
You might be a doorknob! Or three baked potatoes!
You might be a bag full of hard green tomatoes.
Or worse than all that . . . Why, you might be a WASN'T!
A Wasn't has no fun at all. No, he doesn't.
A Wasn't just isn't. He just isn't present.
But you . . . You ARE YOU! And, now isn't that pleasant!

From *Happy Birthday to You!*
by Dr. Seuss

Appendices

The following information is provided for your reference. It is intended to assist you in understanding the various aspects of the project and to provide a comprehensive overview of the data collected. The information is organized into several sections, each addressing a specific area of interest. The first section discusses the methodology used in the study, including the selection of participants and the procedures followed. The second section provides a detailed description of the data collected, including the types of data and the methods used for data collection. The third section discusses the results of the study, including the findings and the conclusions drawn. The fourth section discusses the implications of the study, including the potential applications of the findings and the limitations of the study. The fifth section discusses the future directions of the study, including the need for further research and the potential for future studies. The sixth section discusses the acknowledgments, including the individuals and organizations that provided support and assistance during the course of the study. The seventh section discusses the references, including the books, articles, and other sources used in the study. The eighth section discusses the appendices, including the various forms and documents used in the study. The ninth section discusses the index, including the list of topics and the page numbers where they can be found. The tenth section discusses the glossary, including the definitions of the various terms used in the study. The eleventh section discusses the bibliography, including the list of books, articles, and other sources used in the study. The twelfth section discusses the list of figures and tables, including the titles and page numbers of each. The thirteenth section discusses the list of abbreviations, including the full names of the various abbreviations used in the study. The fourteenth section discusses the list of symbols, including the meanings of the various symbols used in the study. The fifteenth section discusses the list of acronyms, including the full names of the various acronyms used in the study. The sixteenth section discusses the list of terms, including the full names of the various terms used in the study. The seventeenth section discusses the list of definitions, including the meanings of the various terms used in the study. The eighteenth section discusses the list of references, including the full names of the various references used in the study. The nineteenth section discusses the list of appendices, including the titles and page numbers of each. The twentieth section discusses the list of index, including the titles and page numbers of each. The twenty-first section discusses the list of glossary, including the titles and page numbers of each. 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APPENDIX A

The Nathanson Proposals

The following statement on the need for non-hospital abortions was delivered by Bernard N. Nathanson on behalf of the National Association for Repeal of Abortion Laws at its October 16, 1970, hearing:

The passage of the Abortion Act of 1970 by the New York State Legislature rectifies one long-standing injustice to women, but in so doing creates a host of pragmatic questions and problems which severely challenge current medical thinking. N.A.R.A.L. herewith undertakes to raise the questions and provide solutions consistent with its credo that it is a fundamental right of women to bear children or not, as they wish, without the interference of the state in this decision.

1. Where shall the abortions be done? Although traditionally the medical profession may wish to continue to regard abortion as a minor surgical procedure ideally to be carried out within the framework of inpatient care in a hospital operating room, it must be clear that the unimaginably large demand for abortion in the very near future will simply swamp the hospitals and pre-empt all available beds and operating time. It has been estimated that in the city of New York 75,000 to 100,000 abortions will have to be done annually; further, if New York State remains the only state in this part of the country with no law regulating abortion and with no residency requirement written

into the act, the number of out-of-state individuals descending on New York City for this operation will double or triple the basic number. If 300,000 or so abortions are to be done by the fifty hospitals operative in this city, this means that each hospital will have to do twenty abortions daily. Under this strain, even operating on a twelve-hour-day seven-day-a-week basis, hospitals would simply have to close their doors to all but emergency cases in other specialties and categories. In addition to the inability to care for elective medical and surgical patients, the residency teaching programs in the major and minor specialties would cease to exist. Also, because the necessity for abortion operates under a time deadline, these patients cannot be assigned to the usual waiting list for admission as patients awaiting other procedures such as cholecystectomy, prostatectomy, or tonsillectomy. Thus, without a sudden immense expansion of the present inpatient facilities in the hospitals in this city (a most unlikely prospect), it is simply not realistic to conceive of this any longer as an inpatient procedure.

The construction of outpatient operating rooms—or the conversion of some existing area to outpatient surgery—within the hospital framework is one possible solution. Here, the patient can be prepared, aborted, and observed in a period of three to four hours, then sent home with the appropriate instructions and medications. There are manifest advantages to this concept beyond relieving the intolerable burden on inpatient facilities. She is not taken from her family overnight; she may return to work (or school) the next day; insurance companies are not charged for expensive inpatient care; and performing the procedure under local anesthesia, i.e., paracervical block, eliminates the irreducible risks and complications attendant upon general anesthesia. The mounting very satisfactory experience with the vacuum curettage system has made this a practicable and feasible solution. Admittedly, a small number of women will have to be admitted to hospital for complications of this operation or for special procedures such as intra-ovular saline instillation (salting-out) or hysterotomy with tubal ligation, but this latter number should be comparatively quite small.

However, it is doubtful that even if all hospitals willing to do so should open outpatient facilities, the demand could be met. Further, those who have worked in the Abortion Repeal Movement have an understandably skeptical view of the enthusiasm—or lack of it—which hospitals would bring to bear on this challenging problem. Hence, the most desirable solution is the construction by private interested groups (with or without government subsidy) of outpatient facilities totally devoted to abortion. These facilities would naturally be built to strict specifications and periodically rigidly inspected. It would be desirable for these facilities to have some working arrangement with a neighboring general hospital in the event of a serious accident or complication occurring in the private facility.

Finally, in this immediate period of overwhelming demand and sharply limited facilities, N.A.R.A.L. urges that qualified gynecologists perform the procedure in their offices utilizing the vacuum-curettage system and paracervical anesthesia. We recognize that this is a "cottage-industry" approach to a massive problem, the dimensions of which are still unrealized, but it may be the only means to cope with the flood of requests until private abortion clinics and/or hospital outpatient facilities are operative.

2. Who shall do the procedure? N.A.R.A.L. holds that as limited as facilities and equipment are to cope with the present demand, the supply of skilled personnel to carry out the procedure is even more limited and certainly not as readily expansible in the near future. We must quickly train non-medical personnel (mid-wives, registered nurses, practical nurses, etc.) to perform the abortions under the supervision of a qualified gynecologist. Using the vacuum-curettage system and local anesthesia it is doubtful if the operation is any more technically demanding than the performance of dental hygienic procedures or the rendering of first aid to gravely wounded soldiers, both of which are now carried out most adequately by non-medical personnel.

3. What is the method of choice of abortion? The combination of the vacuum-curettage system and local anesthesia is efficient, swift, simple, and safe and can be performed by properly trained non-medical personnel. For those patients who have pregnancies advanced beyond twelve weeks, hospitalization for D and C, or for hysterotomy with tubal ligation is advisable. For those beyond fourteen weeks who require intra-ovular saline instillation, the procedure can be done on an outpatient basis with the patient instructed to return to the hospital for the actual abortion and subsequent curettage if it should prove necessary. N.A.R.A.L. recognizes that adequate follow-up of these patients is often difficult or impossible and urges that an intra-uterine contraceptive device be inserted at the termination of each procedure as part of the total care of these women, the device to be removed at the time the patient begins oral contraceptive medication.

4. What should be the cost to the patient? N.A.R.A.L. feels that the charge to the private paying patient should in no instance exceed three hundred dollars, including the use of the facility and the services of the professional personnel. We urge that the insurance companies abandon the demeaning and unjust distinction between single and married women in indemnifying this procedure and provide adequate coverage for every subscriber, irrespective of her marital status. The cost of operating the outpatient facility for use by clinic patients must be totally absorbed by the hospitals, with or without government aid, in order that those women most desperately in need of relief may have it with no thought to the cost.

5. What measures are necessary to retain a warm and sympathetic approach to the patients in this program? N.A.R.A.L. understands

that the decision for abortion is sometimes a difficult and responsible one, and proposes that psychiatric social workers be assigned to hospital in- and outpatient facilities in order to counsel those women who request such services both before and after the procedure. Private abortion clinics should be required to provide comparable services. If physicians opt to carry out this procedure in their offices, they must set aside counseling time as an integral part of the concept of comprehensive private care.

APPENDIX B

Abortion as a Religious Issue

To clarify the complex views on abortion in organized religion, which are often misunderstood and have rarely if ever been surveyed thoroughly, the following material summarizes the most representative available statements from the major religious communities of the United States, those with approximately 1,000,000 or more adherents. The statements are sometimes vague, have various standings, and address different issues (some endorse unrestricted secular law but are more conservative regarding personal decisions; some speak only to the social or to the personal situation). The denominations are listed roughly from "anti" to "pro," with membership, if known, in parentheses, usually from the *Yearbook of American and Canadian Churches* (Abingdon, 1979). Those with components that belong to the Religious Coalition for Abortion Rights (see below) are marked with an asterisk.

RESTRICTIVE POSITIONS

Roman Catholic Church (49,836,176)

From conception, "directly intended" abortion is immoral, even when the mother's life is at stake. Treatments to "cure a propor-

tionately serious pathological condition of the mother" are permitted, even though the death of the fetus results indirectly. The U.S. bishops favor a Constitutional amendment and other federal and state laws to restrict abortion "to the maximum degree possible." (Policy statements, National Conference of Catholic Bishops, 1971, 1975.)

Eastern Orthodox Churches (3,752,525)

The Greek Orthodox Archdiocese, largest of the Eastern churches in the U.S., brands abortion as "murder" once conception is completed, but "reluctantly" accepts it in all cases where the mother will die otherwise. Christians should consider liberal laws "an affront to their beliefs in the sanctity of life." (Clergy-Laity Congress resolution, 1976.) Priestly and lay delegates of the second-largest group, the Orthodox Church in America, declared virtually the same position at the 1977 All-American Council, and the smaller ethnic churches also support this ancient tradition.

Churches of Christ (4,000,000, estimate)

These conservative Protestant churches have no central body that issues statements, but they display strong doctrinal unity. Virtually all members consider abortion to be "murder," except possibly when done to preserve the mother's life. The great majority support secular laws against abortion and oppose public funding except in life-or-death emergencies. (Source: 1978 letter from Reuel Lemmons, Editor, *Firm Foundation*, Austin, Texas, a well-informed leader in this group. The membership estimate is also that of Lemmons.)

American Baptist Association (1,350,000)

Because the Bible teaches that life begins at conception, abortion breaks divine law and is "an act of sin and wickedness." Members are urged to "oppose it by every means available to us." (Convention resolution, 1976.) Though not specified, extreme danger to the mother's life is a generally recognized exception.

Baptist Bible Fellowship (1,000,000, estimate)

The Fellowship as such does not issue statements, but an editorial in its official periodical, expressing the predominant belief, terms widespread abortion "a slaughter of the innocents" and states that when government is involved "it is ignoring God's laws and will be judged." An article in this paper by a leading pastor, the Reverend Jerry Falwell, who has a 15,000-member congregation in Lynchburg, Virginia, holds that "abortion on demand" is "murder" and that "life" and the "soul" exist from conception, thus ruling out such justifications as rape, incest, or deformity. "A true Christian would not seek an abortion," he writes, but this is not a religious issue but a "human rights issue."

Lutheran Church—Missouri Synod (2,673,321)

"Willful abortion" is "contrary to the will of God," but it becomes "necessary at times to choose between one life and another." On theological grounds, the church believes that an "individual human being" exists from conception. It actively opposes laws that permit "non-therapeutic" abortion (a concept left undefined), urges Christians to "protest publicly the sin of abortion on demand," and calls on public officials to protect the unborn. (Convention resolutions, 1971, 1977.)

African Methodist Churches (3,033,391)

The nation's two oldest black denominations have essentially identical views.

In the African Methodist Episcopal Church, the 1976 General Conference declared that in "the vast majority of cases," abortion is not "an acceptable alternative to problem pregnancy." The conference unanimously approved "for study" a working paper by two physicians stating that God forbids deliberate destruction of life in the womb "at any stage" unless pregnancy "clearly jeopardizes" the mother's life. Burdens on the parent or child should not be relieved by destroying the new life, it says, but by preventing such pregnancies, providing social assistance, and "surrounding each parent and child with love."

The African Methodist Episcopal Zion Church opposes abortion "because of its deep-seated belief that when pregnancy takes place a new life is begun." It recognizes "extenuating circumstances," as when pregnancy endangers the mother's life, but rejects the idea that a woman has the sole right to do what she wishes, a contention that "does not erase the sin and guilt attached." (Statement by the Board of Bishops to the 1976 General Conference.)

Islam (807,000, estimate)

Abortion is "sharply different" from birth control "in that it is murder of the already existing life of the fetus and is a danger to its mother. It is therefore generally regarded as being under serious prohibition in Islam." Even those jurists who interpret a tradition from the Prophet Muhammad as meaning that the fetus is lifeless for the first 120 days permit abortion only if pregnancy "poses a real danger to the life of the mother." The stricter jurists, meanwhile, "agree that the crime assumes greater proportion when abortion takes place at an advanced stage. . . . Churchmen and government agencies must abandon their permissive attitude, for the sake of the nation's prestige and of society's moral health, and for the sake of humanity at large. . . . What was forbidden to Abraham and Moses is forbidden to us." (Muhammad Abdul-Rauf, Director of the Islamic Center, Washington, D.C., in *Marriage in Islam: A Manual*. New York: Exposition Press, 1972. The U.S. population estimate is that of the Population Reference Bureau Inc. for 1977.)

National Baptist Convention, U.S.A., Inc. (5,500,000)

There are various views among members of the nation's largest black denomination, but its annual meetings have stated a strong, generalized opposition. The most recent resolution holds that abortion deals with "human life in some form" and is thus contrary to the "fundamental laws of freedom" and "the highest religious concepts of the sacredness of human life and personality." Therefore, no one "is good enough and wise enough to close the gates of birth and legislate the destiny of generations struggling to be born."

(So far as could be determined, the National Baptist Convention of America, a similar body with 2,668,799 members, has passed no statement on the issue.)

Christian Churches (1,044,842)

The "independent Christians," like the similar Churches of Christ, have no central organ, but the large majority hold that the unborn is a person and that abortion is "murder," in violation of the Sixth Commandment. Most would grant lesser-of-two-evils situations, such as saving the mother's life, and some might extend this to such cases as a raped teenager. Most think civil government has a duty to protect the unborn, just as it opposes murder and protects the innocent; most would oppose public funding. (Source: 1978 letter from Dr. Jack Cottrell, Cincinnati Christian Seminary, a knowledgeable theologian in this group. The influential *Christian Standard* expresses similar positions.)

Assemblies of God (1,283,892)

The largest Pentecostal denomination believes that abortion for convenience or socioeconomic reasons is "morally wrong" and expresses "firm opposition" to laws permitting it. Abortion is acceptable when needed "to safeguard the health or life of the mother, as is the case with tubular pregnancies." It is willing to consider abortion in cases of rape or incest, after careful counseling. (General Council statement, 1971.)

Orthodox Judaism

"Judaism regards all life—including fetal life—as inviolate. Abortion is not a private matter between a woman and her physician. It infringes upon the most fundamental right of a third party—that of the unborn child." Cases of a "serious threat" to the mother's life are exceptions. Those involving maternal "health," including psychiatric factors, pose complex problems and must be decided individually by "competent rabbinic authority." (Union of Orthodox Jewish Congregations of America, convention resolution, 1976.) The U.O.J.C.A. considers abortion a "crime" under the Noachidic code, that part of the Biblical law held to apply to all mankind, not just Jews. Similarly, the

Rabbinical Council of America says that it opposes permissive laws on grounds of general morality, not religious law. Leaders of both organizations have spoken vehemently against public funding and have compared silence about abortion to the complacency in Nazi Germany. The more sectarian Orthodox organizations are also strongly opposed.

Church of Jesus Christ of Latter-day Saints (2,486,261)

"The experience of mortal life is an essential step in the eternal progress of each human being." Consequently, Mormons oppose abortion except: "(1) in the rare cases where, in the opinion of competent medical counsel, the life or good health of the mother is seriously endangered, and (2) if the child is conceived by forcible rape." (First Presidency statement, 1976.) On religious liberty grounds, the church opposes forcing employers, employees, or taxpayers to pay for abortions through medical plans or federal programs except where the mother's life is endangered.

MIDDLE POSITIONS

Southern Baptist Convention (13,078,239)

The 1971 meeting of the convention recognized society's responsibility to affirm through laws the "sanctity" of fetal life, but favored allowing abortion in cases of "rape, incest, clear evidence of severe fetal deformity, and carefully ascertained evidence of the likelihood of damage to the emotional, mental and physical health of the mother." The 1976 meeting attacked abortion done for "selfish non-therapeutic reasons." It also affirmed the "limited role of government" and supported mothers' rights to services for the "preservation of life and health"; because of confusion over that language, the 1977 meeting declared "strong opposition to abortion on demand and all governmental policies and activities which permit this."

American Lutheran Church (2,390,076)

This denomination has no official policy as such, but a "statement of comment and counsel" by its 1974 convention emphasizes the developing life's "right" to be born and rejects abortion as "a ready solution for problem pregnancies," while favoring the freedom to choose it "to defend the health and wholeness of persons already present." Counseling should consider "the circumstances under which the conception occurred; the maturity and the physical and emotional health of the prospective parents and of other children in the family; the economic factors at stake" and religious beliefs. The list does not specify possible fetal defects, which the church's Executive Committee had previously opposed as a justification, citing Hitler's destruction of the deformed. Because of confusion over policy the church president de-

clared in 1977 in the official periodical that the A.L.C. opposes abortion "in principle" except under "certain circumstances" and that "'abortion on demand' runs counter to Christian ethics." The 1978 church convention established a task force to prepare a position paper for 1980 action.

*Presbyterian Church in the U.S. ("Southern")** (869,693)

"The unborn fetus must be respected for its own worth regardless of the period of gestation," but the mother's needs may take precedence. A decision to abort "should never be made lightly or in haste." "Possible" justifications include "medical indications of physical or mental deformity, conception as a result of rape or incest, conditions under which the physical health of either mother or child would be gravely threatened, or the socioeconomic condition of the family." Secular laws should reflect these principles, and also make abortion available without "preferential treatment." (General Assembly statement, 1970.)

*American Baptist Churches in the U.S.A.** (1,304,088)

This denomination has endorsed laws to permit abortion on request during the first trimester only, and afterward in cases where there is "documented evidence" of a "danger to the physical or mental health of the woman," of a conceptus with "a physical or mental defect," or that pregnancy resulted from rape, incest, or other felonious acts. (Convention resolution, 1968.)

Lutheran Church in America (2,967,168)

Termination of fetal life is "always a serious matter," but a qualitative distinction must be made between the "claims" of the fetus and the "rights" of those in living relations with others. A woman or couple should consider "the life and total health of the mother, her responsibilities to others in her family, the stage of development of the fetus, the economic and psychological stability of the home, the laws of the land, and the consequences for society as a whole." (From a 1970 convention statement.) The 1978 convention reaffirmed that document but emphasized that it does not endorse "abortion on demand" and does not consider abortion an alternative method of birth control. (The church has issued no specific statement regarding secular law, though for a time one of its agencies belonged to the Religious Coalition for Abortion Rights.)

MIDDLE TO LIBERAL POSITIONS WITH EXPLICIT
SUPPORT OF LEGALIZED ABORTION ON REQUEST

*Conservative Judaism**

A woman must have "valid and sufficient warrant" for abortion, such as a threat to her life or "basic health." One classic rabbinical ruling would accept a well-established danger to *psychological* health. Abortion is "serious even in the early stages of conception" but is "not to be equated with murder." (United Synagogue resolution, 1975.) Conservative spokesmen advocated a New York law on these lines in 1967, but since the Supreme Court decisions, the United Synagogue (the congregational and lay organization) has opposed any anti-abortion laws or limits on public funding. The Rabbinical Assembly, however, has taken no position on secular legislation and, unlike the United Synagogue, is not affiliated with the Religious Coalition for Abortion Rights.

Episcopal Church (2,818,830)

This church has departed from the onetime aversion to abortion in world Anglicanism (as in the Lambeth Conference resolution of 1930). It originally endorsed laws to permit abortion when "the physical health of the mother is threatened seriously or where there is substantial reason to believe that the child would be born badly deformed in mind or body," or after "forcible rape or incest." (General Convention resolution, 1967.) After the Supreme Court decisions, the church decided to oppose all legal restrictions, while speaking against abortions undertaken "lightly" or "for convenience." Members who think a pregnancy should be terminated on grounds other than those specified in 1967 should seek priestly counsel and, where appropriate, penance. (General Convention, 1976.) The Executive Council has rejected several efforts to have the church join the Religious Coalition for Abortion Rights.

*United Methodist Church** (9,785,534)

Belief in the "sanctity of unborn human life makes us reluctant to approve abortion. But we are equally bound to respect the sacredness of the life and well-being of the mother, for whom devastating damage may result." (The authoritative *Social Principles*, as amended by the 1972 General Conference.) A 1976 resolution explains further that continuation of pregnancy is not a moral necessity if it "endangers the life or health of the mother, or poses other serious problems concerning the life, health or mental capability of the child to be." Regarding secular legislation, the 1972 *Social Principles* endorses "the legal option of abortion."

*United Church of Christ** (1,785,652)

Laws to protect the unborn stem from Christian influence and it is "neither likely nor desirable" that society will disavow this responsibility. However, opinions vary on when society assumes this obligation. Those deciding for abortion should certainly do so within the first two or three months, when many recognize the existence of only "potentiality" of personhood. Many believe that in the later months, life in the womb should be interrupted only for the "most serious reasons (such as the physical or mental health of the mother, abnormality or disease of the fetus, incest or rape)." As for secular law, all prohibitions should be repealed because they are "neither just nor enforceable." (General Synod resolution, 1971.) The 1977 synod opposed efforts to negate the Supreme Court decisions or to limit public funding, and favored forcing publicly aided hospitals to provide abortions, while protecting the right of conscience of medical personnel.

*Reform Judaism**

The Central Conference of American Rabbis in 1967 endorsed laws to consider "the danger of anticipated physical or mental damage" in pregnancy, and to permit abortion in cases of rape, statutory rape, and incest. In a more liberal statement the same year, the Union of American Hebrew Congregations (the synagogue and lay organization) added "such circumstances as threatened disease or deformity of the embryo or fetus" and "social, economic and psychological factors." Since the Supreme Court rulings, both organizations have stated that the woman (or family) should have full legal freedom to decide, though there are differences. The C.C.A.R. states that parents must weigh the Jewish tradition, which accepts "therapeutic abortion." The U.A.H.C. opposes limits on public funding as discriminatory and has joined the Religious Coalition for Abortion Rights. A U.A.H.C. official said in U.S. Senate testimony that Reform's support of the "sanctity of life" leads it to give precedence to such factors as a couple's income and capabilities, and their right to choose when to bring life into the world.

*United Presbyterian Church** (2,561,234)

The church endorses "full freedom of personal choice" in secular law. (General Assembly resolution, 1972.) It has no stated policy on personal moral decision, though the 1976 Assembly received a study paper holding that abortion could "especially" be accepted when a birth can only result in "an increase in suffering for either the child to be born, the mother, or the human community as a whole."

*Christian Church (Disciples of Christ)** (1,256,849)

On religious liberty grounds, this church opposes "any attempt to legislate a specific religious opinion or belief concerning abortion upon

all Americans." (General Assembly resolution, 1975.) As for personal decision, the 1973 Assembly passed a broad statement that individuals should have "the informed supportive resources of the Christian community to help them make responsible choices."

ECUMENICAL ORGANIZATIONS

The *National Council of Churches* (which includes thirty-two non-Catholic denominations) has no viewpoint on abortion as such, but since abortion is legal it urges "equal access" to public funding on grounds of non-discrimination. (General Board resolution, 1977.)

The *Baptist Joint Committee on Public Affairs* (supported by nine Baptist denominations) opposes anti-abortion amendments to the Constitution on religious liberty grounds. (Policy statement, 1973.)

The *National Association of Evangelicals* (which includes thirty-six conservative Protestant denominations, most of them small) takes an anti-abortion stance virtually identical to that of its largest member body, the Assemblies of God, as summarized above. (Convention resolution, 1973.)

The *Religious Coalition for Abortion Rights* is a lobby that currently represents agencies of denominations marked above by an asterisk and eleven other organizations. It was formed after the 1973 Supreme Court decisions to work for women's full freedom of choice. The Coalition opposes Constitutional amendments to alter the 1973 decisions, as well as federal or state laws that would: Permit employers to limit abortion-related disability benefits; limit public funding of abortion; permit religious or other hospitals that receive public aid to refuse to provide abortions (though it respects the right of individual staff members not to participate); require "informed consent" on the abortion procedure from the mother; or require advance notification of husbands or the parents of underage mothers before abortions are performed. It argues that "right to life" laws endanger First Amendment religious liberty by putting "the theology of one particular religion concerning the beginning of life" into the Constitution even though it conflicts with the beliefs of others.

It should be noted that anti-abortion religious groups and individuals are active in a variety of "pro-life" organizations. There are a minimum of 5,000,000 members in various Evangelical and other con-

servative denominations, not affiliated with the above ecumenical groups and too small to be listed here, that hold an anti-abortion view. Some of the smaller unaffiliated groups take a strong "pro-choice" position, notably the Unitarian Universalist Association.

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Bernard N. Nathanson, M.D., is an alumnus of Cornell University and the McGill University Medical College; a board certified obstetrician-gynecologist; and a Fellow of the American College of Obstetricians and Gynecologists and of the American College of Surgeons. He recently served on the New York County Medical Society panel that adjudicates professional complaints. Besides his private practice in Manhattan since 1957, he has been the Director of Gynecology at the Hospital for Joint Diseases and Chief of Obstetrical Service at Woman's Hospital, St. Luke's Hospital Center. He is currently Clinical Assistant Professor at Cornell Medical College, a Senior Attending obstetrician-gynecologist at St. Luke's, and an Associate Attending at New York Hospital.

Nathanson was a co-founder in 1969 of the National Association for Repeal of Abortion Laws (later renamed the National Abortion Rights Action League), the chairman of its Medical Committee, and served on its Board of Directors and Executive Committee when he resigned under pressure in 1975. From February 1971 through September 1972 he was the director of the Center for Reproductive and Sexual Health, which was the largest abortion clinic in the world.

Richard N. Ostling is an Associate Editor and formerly a Staff Correspondent with *Time* magazine. He holds an A.B. (Phi Beta Kappa) from The University of Michigan, an M.S. in Journalism from Northwestern University, and an M.A. in Religion, specializing in ethics, from The George Washington University. He has been a newspaperman and the news editor of the Protestant journal *Christianity Today*.





