

Legal Abortion:

How safe? How available? How costly?

Within the last five years, abortion has emerged from the status of a risky, expensive and illegal procedure to that of a common medical practice in nearly a dozen states. In a number of those states, a safe, legal abortion is now accessible even to the poor—traditionally the chief victims of hazardous illegal abortions. Some 500,000 legal abortions were performed in the United States last year, compared to only 6000 in 1966. And if the trend continues, legal abortion may eventually become widely available here, as it has been in many countries for years.

Meanwhile, however, few areas of medical care are so confusing to the patient. Laws differ not only from state to state, but also in their local interpretation by courts and medical societies. There may be strict residency requirements or none at all. Approval procedures may be stringent or perfunctory. Medical procedures may differ and costs may range to extremes. Consequently, if a patient is unaware of sources ready to help her, a legal abortion can be an agonizingly uncertain ordeal.

For most women, too, the decision of whether to seek an abortion is in itself a soul-searching one. While it's generally agreed that abortion is the least desirable method of birth control, convictions about it otherwise are widely contested. Whether an unwanted pregnancy is resolved by abortion, adoption, or keeping the child, the decision is made more complicated for many by moral and religious arguments that are beyond the scope of this article. This discussion will be confined to what CU learned from doctors, public health officials and abortion referral specialists across the country about the safety, availability and costs of abortion.

The reasons allowed

Only four states—New York, Washington, Alaska and Hawaii—permit abortion on request. Of those, only New York has no residency requirement. Alaska requires 30 days residency; Washington and Hawaii, 90 days. New York alone among the four serves many out-of-state residents.

Other states that have liberalized their laws since 1967 permit abortion only for specific reasons. The laws normally allow a pregnancy to be terminated if there's a danger to the woman's physical or mental health, if there's a risk of fetal deformity, or if the pregnancy was caused by rape or incest. In practice, however, most abortions—about nine out of ten—are performed to protect the woman's mental health. Medical interpretation of what constitutes a danger to mental health varies widely.

In California, for example, interpretation differs from hospital to hospital. If a person knows where to apply, permission for abortion on mental-health grounds can usually be obtained routinely on the same day. In Georgia, on the other hand, getting such permission entails a test of endurance—even though that state's abortion law is similar to California's. A Georgia applicant must amass as many as 14 signatures of approval, including those of a psychiatrist, the husband or a parent and hospital board members.

Mental-health provisions tend to be interpreted narrowly in five other states: Arkansas, Delaware, North Carolina, South Carolina and Virginia. Like Georgia, each of those states has a residency requirement.

The states where mental-health grounds are interpreted more liberally are—in addition to California—Colorado, Kansas, Maryland, New Mexico and Oregon. Florida, which liberalized its abortion law in April, is expected to be another. Except for Oregon, none of those states has a residency requirement. Approval of abortion for reasons of mental health can also be obtained readily in the District of Columbia.

Beyond the question of where to go, there are other confusing aspects of abortion services. An early abortion in New York City, for example, may cost more than \$250 or as little as \$25 (or nothing at all in some cases). It could involve an overnight stay at a hospital, or just part of a day in a special abortion clinic. It might include pre-abortion counseling and birth control services, or little more than an impersonal clinical procedure.

Length of pregnancy affects both the type of abortion required and its cost. Most clinics will treat patients only up to the 12th week of pregnancy. An existing medical problem, such as high blood pressure or a heart condition, may call for inpatient treatment at a hospital. Some agencies will treat minors without parental consent; others will not.

Whatever the obstacles, the danger is that women who desperately want abortions might be victimized by opportunists. Some women may pay exorbitant fees to physicians or commercial referral agencies. Or, if poor, they are likely to be aborted by quack practitioners in the back rooms of shops or in motels.

No one knows exactly how many illegal abortions take place in the U.S. each year. Dr. Christopher Tietze, an authority on population and abortion statistics, says the number was "possibly as high as 1.1 million before 1967," and that as many as 500 women a year may have died as a

result. He estimates that 600,000 illegal abortions may have been performed last year.

There appears to be no question, however, about the impact of legal abortions thus far. Sharp decreases in abortion-related fatalities have been recorded in New York, California, and the District of Columbia, where legal abortion is widely available.

According to New York City health officials, illegal abortions had previously been the leading cause of maternal deaths in the city. In 1971, the first full year under its new law, the city experienced only three deaths from illegal abortions. As a result, overall maternal deaths declined 50 per cent, producing the lowest maternal death rate ever recorded in New York City.

Similarly, Los Angeles and San Francisco reported fewer injuries associated with illegal abortions. All three cities experienced declines in hospital admissions for incomplete abortions, which often involve hemorrhage or life-threatening pelvic infection. Sterility from scarring of the uterine walls or fallopian tubes may also result.

Total admissions for incomplete abortions at 10 municipal hospitals in New York City declined from 480 per month in the latter half of 1970 to 199 per month for the same period of 1971. Incomplete abortions also include miscarriages, but the number of those tends to remain fairly constant. Hence, city health officials view the decline as another significant sign that illegal abortions are on the wane.

The state of statutes: iffy

In short, available evidence shows that access to legal abortion cuts health risks substantially. But there are scores of court cases in various stages of litigation that could affect the ease of obtaining abortions. Since early 1972, for instance, restrictive abortion laws in Vermont, New Jersey and Connecticut have been struck down by Federal or state court decisions, as was Wisconsin's law in 1970. The Connecticut legislature reinstated a strict anti-abortion law in May. However, the legal situation in the other three states is not entirely clear, and many doctors there are hesitant to perform abortions until court interpretations have been further clarified.

There are, in addition, major cases pending that challenge the constitutionality of abortion laws in Georgia, Texas, Illinois, Louisiana, Missouri and North Carolina. The Georgia case, which was heard by the U.S. Supreme Court last fall, is particularly important. It calls into doubt the concept of legislating specific reasons (such as mental health or rape) for performing an abortion, contending that such statutes invade the constitutionally protected right of privacy. If that challenge is upheld, it could establish abortion on request as the law of the land. As of this writing, the Court has not announced its decision.

The first and most obvious question to be answered before seeking an abortion is sometimes overlooked: "Are you really pregnant?" For a sexually active woman with normal menstrual function, a delay of a week or two in the onset of her period is highly significant. But confirmation should be obtained. More than a few women have made a long trip to New York or California for an abortion only to find they weren't pregnant. So the first step is to consult a physician.

Some health departments or municipal hospitals will make pregnancy urine tests at little or no cost to those who have a money problem. In addition, there are 188 Planned Parenthood affiliates in 43 states and the District of Columbia; they operate some 700 medical clinics that provide low-cost pregnancy tests or information about where to get one.

The reliability of pregnancy test kits that may be sold over the counter at drugstores has not yet been established. Both the Center for Disease Control and the U.S. Food and Drug Administration are testing such kits but have not yet confirmed whether they work.

If an unwanted pregnancy is confirmed, the only way to terminate it is by abortion. No drug can be obtained that can be relied on to terminate pregnancy once a period is missed, nor will frantic exercises or douches. Sometimes a doctor will give a patient medication to bring on a period, but it only works if the woman is *not* pregnant. There is also a new class of drugs called prostaglandins that are currently being used in research centers to induce abortions. But it may be some time before their full value is known. In short, there's no abortion "pill" available once a period is missed. Furthermore, any do-it-yourself abortion method entails risk of serious injury or death. Those risks are described later.

Once the decision to seek an abortion is made, it's important to make arrangements well before the 12th week of pregnancy. An early abortion takes only a few minutes, and recovery takes a few hours. After the 12th week, the abortion procedure is more difficult and may involve a hospital stay of two days or more.

Length of pregnancy is conventionally calculated from the first day of the last menstrual period, since the precise date of conception often cannot be judged exactly. If the menstrual date was May 15, for example, the woman would be considered two months pregnant on July 15. In all cases, however, the length of pregnancy must be confirmed by a pelvic examination by a doctor.

The medical techniques

The type of abortion procedure employed depends largely on the length of pregnancy. During the first 12 weeks—or "first trimester"—doctors either use suction or dilation and curettage (D&C). A recent survey of 73,000 abortions for the Joint Program for the Study of Abortion (JPSA) reports that almost 93 per cent of all first trimester abortions were performed by suction; 7 per cent were performed by D&C.

Suction, also called vacuum aspiration, is currently the much preferred method for early abortion. Although general anesthesia is frequently used, some doctors may inject a local anesthetic at the cervix, the necklike opening of the uterus. The cervix is then dilated with tapered metal rods, until the opening is large enough to admit a thin tube. A vacuum pump attached to the tube is turned on, and the uterus is emptied by a gentle suction. Many doctors also scrape the inside of the uterus with a small curette—a slim, spoon-shaped instrument—to assure that all fetal and placental tissue has been removed. The patient may feel some cramps during the dilating process, but the suction and curettage (if any) are usually quick and relatively painless. The entire procedure, including preparation, takes about 15 to

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20 minutes. Ordinarily, the patient is discharged after a recovery period of a few hours.

D&C used to be the most common abortion procedure employed in the U.S. For that procedure, the doctor dilates the cervix somewhat more than for suction and then scrapes out the inside of the uterus with a curette. General anesthesia is often used with D&C, because discomfort is slightly greater than with suction. The procedure itself seldom takes more than 20 minutes, but the patient may sometimes be admitted to the hospital the night before in preparation for general anesthesia.

Suction is somewhat easier on the patient, and, according to the JPSA data, is slightly safer. Among some 54,000 first-trimester patients aborted by suction or D&C, there were no deaths attributable to the procedure. Major complications, such as a hemorrhage sufficient to require a blood transfusion or a fever of three days or more, occurred in five of each 1000 patients who were aborted by suction and in a slightly higher number of those who had D&Cs.

One surprising note in the JPSA study (which is the first extensive review of abortion safety in the U.S.) concerns very early abortions—those at six weeks or less into the pregnancy. Although still relatively safe, such abortions caused major complications about twice as often as those done at seven to 10 weeks. The latter four-week period was the safest of all.

Beyond the 12th week, the risks, the cost and the difficulty increase. Doctors often are reluctant to do abortions at 13 to 16 weeks, because they feel that there is a greater risk of hemorrhage with suction or D&C and that the uterus is still too small for the late abortion method generally used. After the first trimester, many physicians ask their patients to wait until the 17th week for saline abortion, or "salting out."

Saline is used for 95 per cent of the abortions performed after 16 weeks, according to the JPSA survey. The procedure

usually takes from one to three days. After administering a local anesthetic, the doctor inserts a long, hollow needle through the abdominal wall into the amniotic sac inside the uterus. He then withdraws some of the amniotic fluid surrounding the fetus and replaces it with a concentrated solution of salt water. Although the exchange takes several minutes, the patient usually feels little or no discomfort. The salt injection usually ends fetal life within a few hours and induces labor contractions from 12 to 48 hours later.

Once contractions begin, the process is similar to childbirth, but often not as intense. It has been described as an abbreviated form of labor. The fetus and placenta are usually expelled within one to three days after the injection.

Depending on local health codes and hospital practice, a patient may be sent home following the injection and asked to return when the contractions begin. More often, however, the procedure entails an inpatient hospital stay of one or two nights. Because of its similarity to childbirth and the expulsion of a fetus (usually in bed rather than in an operating room), the saline treatment is usually a disturbing experience. But it is the simplest and safest late abortion procedure generally available.

Compared to early abortions, the risk of major complications is about three times higher with saline. Occasional complications include infection and retained placental tissue, often accompanied by fever or bleeding. A serious but rare complication is entry of the concentrated salt solution into the blood stream, which can cause convulsions and blood clotting disturbances. At 21 to 24 weeks, according to JPSA findings, saline is somewhat safer than at 17 to 20 weeks (although still riskier than early abortion). However, as of this writing, only two states permit abortion beyond 20 weeks—New York, 24, and Maryland, 26—unless it is done to preserve the woman's life. Also, many doctors prefer not to perform abortions beyond 20 weeks. At 20 weeks a fetus is incapable of sustaining life outside the uterus, and even at 24 weeks its chances for survival are considered very small. The 20-week demarcation allows a margin for error

A medication for women with Rh-negative blood

Until recently, a woman with Rh-negative blood whose husband was Rh-positive might face a serious problem after her initial pregnancy. If Rh-positive blood from her first child enters her blood stream during the delivery, the natural defense mechanism of her body produces antibodies in response. Such antibodies might then attack the blood of the fetus in a subsequent pregnancy.

According to the best estimates, some 40,000 to 50,000 women in the United States develop such antibodies each year. In turn, about 20,000 infants are affected annually—about 3000 to 4000 being stillborn and another 2000 dying soon after birth.

Fortunately, a medication has now been developed that prevents such antibodies from forming. It's called Rh immune globulin and is marketed under the trade names *RhoGAM*, *HypRhoD*, and *Gamulin Rh*. The American College of Obstetrics and Gynecology recommends that the medication be administered to Rh-negative women within 72 hours of childbirth, miscarriage or abortion.

(It's not recommended for women with Rh-positive blood or for those who have already developed antibodies from a previous pregnancy or blood transfusion. There's no evidence they would be harmed by it; they simply would obtain no benefit.) Anyone having an abortion should be checked for the Rh factor. The blood type of the fetus often cannot be determined in a miscarriage or an abortion. Consequently, under such circumstances, all Rh-negative women with no evidence of antibodies should receive the medication. Those experiencing their first pregnancy are prime candidates.

The drawback of Rh immune globulin is its cost—usually from \$35 to \$50. Clinics operated by Planned Parenthood provide the medication free to their abortion patients who need it; but elsewhere there is normally a charge for it. Despite its high cost, CU believes the medication is too important for future pregnancies to be disregarded by those who should have it. In view of the tragedy it might prevent, it warrants the expense.

in case the length of pregnancy has been underestimated.

Another method of abortion is by hysterotomy, a miniature cesarean section. The surgeon makes an incision through the lower abdomen into the uterus and removes the fetus and placenta. The operation can be performed at almost any stage of gestation but is most often done in the late period. It is considered major surgery, is usually performed under general anesthesia, and requires hospitalization of five days or more.

A hysterotomy is roughly four times more likely to cause major complications than a saline abortion. It is seldom performed nowadays except where sterilization by tying the tubes is to follow. Moreover, because of weakness in the uterine wall from the hysterotomy scar, most doctors believe that any future deliveries should be performed by cesarean section.

Some abortions are also performed by hysterectomy, surgical removal of the uterus. That is usually done when the uterus is diseased, and it is considered major surgery.

The safety factor

Among 73,000 legal abortions surveyed by JPSA, there were six deaths attributed directly or indirectly to abortion, a rate of 8.2 per 100,000 cases. New York City has recorded 14 deaths among 336,000 legal abortions, a rate of 4.2 per 100,000. In both instances, the rates were considerably lower than those in Sweden or in England and Wales (which experience a larger percentage of late abortions).

Overall, legal abortion in the U.S. is safer than childbirth. In terms of fatalities, early abortion is far safer than childbirth, and saline abortion thus far appears to be somewhat safer than a full-term delivery. However, both hysterotomy and hysterectomy are riskier than childbirth.

Time and research have helped to clarify the effect of abortions on the mental or emotional health of women who have them. So far, the fear that abortion would be a shattering psychological experience to many women has not been demonstrated. Recent research in the U.S. and Scandinavia, for example, shows that most women react to abortion only with mild feelings of depression and without serious aftereffects. While some psychiatrically ill women get worse, most seem to respond with improved mental attitudes.

There is, of course, one safety warning that should never be disregarded: No one should try to abort herself. Attempting to dislodge a fetus with a knitting needle, coat hanger, or other instrument can prove fatal—and often does—when the uterus is perforated in the act. Equally dangerous would be an attempt to perform do-it-yourself suction with a vacuum cleaner and tube. Not only might it perforate the uterus, but it could suck out part of the intestines as well. Amateur introduction of saline into the cervix carries a high risk of infection and subsequent sterility. And for those unlucky enough to devise a means of injection, there is the likelihood of shooting salt into the blood stream, resulting in convulsions, coma, and death. In short, abortion is safe only in competent medical hands.

For many women, though, access to that competence may be difficult indeed. CU's consultants recommend trying locally first. If a legal abortion is possible close to home, the patient will not only save travel expenses but will be near

follow-up care if needed. Unfortunately, state laws are often unreliable guides. Pennsylvania's law, for example, dates back to 1860 and mentions no grounds for legal abortion. Yet one hospital in Philadelphia performed more abortions in 1970 than all those in Delaware and South Carolina combined—even though the latter two states had recently liberalized their laws. Local medical interpretation of the law is frequently more crucial than the law itself.

An obstetrician or family physician is the first one to consult. He may be able to help, or may know another doctor who can. If he's unable to help, there may be local agencies that can. The telephone directory may list a local Planned Parenthood office or an office of the Clergy Consultation Service on Abortion. If they're not listed, Directory Assistance (Information) may be able to supply a number in the nearest large city. As noted earlier, there are Planned Parenthood affiliates in most states, and they are good sources of information about local or nearby abortion services.

The same is true of the Clergy Consultation Service, which was founded for the specific purpose of helping women to obtain abortions. There are organized Clergy services in 34 states and individual clergymen or clergywomen (and non-clergy associates) in all other states. In 1971, some 3000 Clergy counselors handled more than 100,000 referrals for abortions.

Both Planned Parenthood and the Clergy Consultation Service are nonprofit agencies and charge no fee for referrals. While the two operate differently (Planned Parenthood covers other family planning services besides abortion), both try to secure qualified, low-cost medical care for women and to serve as consumer advocates in the abortion field. Counselors for both groups will also discuss options other than abortion, such as placing a child for adoption. If neither of those agencies is available locally, they can be reached through their information sources in New York:

FAMILY PLANNING INFORMATION SERVICE (or FPIS), 300 Park Avenue South, New York, N.Y. 10010. Telephone (212) 677-3040.

NATIONAL CLERGY CONSULTATION SERVICE, 55 Washington Square South, New York, N.Y. 10012. Telephone (212) 477-0034.

At FPIS, an interviewer will first try to obtain basic information about a caller's situation. If there's an acceptable facility in the patient's area or in a nearby state, FPIS will refer her to the Planned Parenthood affiliate that can assist with arrangements. If legal abortion isn't available nearby, the interviewer may suggest a trip to New York.

If the length of pregnancy has already been confirmed by medical examination, an appointment for abortion in New York can often be made right then. Otherwise, the caller will be asked to get an examination and call back. In either event, the interviewer will advise about costs, types of services available (hospital or clinic) and what to expect.

Those who call the Clergy headquarters hear a four-minute recorded message. It explains what the Clergy service is, gives information about abortion, and instructs on how to obtain a doctor's note confirming the length of pregnancy. The message then gives the telephone number of Clergy Con-

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sultation Services alphabetically by states. In case the caller's state isn't listed, another number is offered for information about individual Clergy counselors in the patient's state.

The Clergy number answers on a 24-hour basis. FPIS interviewers are on duty from 8:30 a.m. to 8 p.m. (Eastern Daylight or Standard Time) Monday through Friday, and from 9 to 5 on Saturdays.

Counting the costs

When state abortion laws were first liberalized, some doctors and hospitals began asking—and getting—fees that would have shamed an illegal abortionist. It was not uncommon to find quotations of \$600 for an early abortion and much more for a late one. Steep rates still exist in some areas, but reasonably priced services are becoming increasingly available.

Abortions up to 12 weeks are available through Clergy referrals for \$125 in New York City, and the level of care is generally as fine as the city has to offer. At the discretion of individual Clergy counselors, the fee may be reduced to \$25 in cases of obvious need. Women with no money at all will have a problem, but both the Clergy and Planned Parenthood try to locate doctors and facilities that treat an occasional patient without charge.

Planned Parenthood of New York City operates two excellent clinics for patients up to 10 weeks pregnant; the maximum fee is \$145, an all-inclusive rate that covers pregnancy detection and follow-up examination as well as other related services. Rates are adjusted on a sliding scale based on need, and in obvious emergencies the fee has been waived. For those with no money problem, early abortions are widely available in New York for \$125 to \$200; lower fees usually apply to abortion clinics, higher ones to regular hospitals.

Late abortions usually include a hospital stay, so the price is higher. A saline abortion costs about \$350, although some doctors may charge \$300. Neither Planned Parenthood nor Clergy services refer patients to facilities that charge more than \$350 for a saline abortion in New York. Hysterotomies cost at least \$800 and can go considerably higher. Women without money who need a late abortion have the most difficulty obtaining care.

Nationally, the abortion services that the Clergy deal with charge from \$125 to "no more than \$300" for early abortions. Saline abortions normally cost from \$325 to \$375 in states where the Clergy refers patients, but they can cost as much as \$425 in some areas. Abortions obtained through Planned Parenthood referrals have approximately the same price structure.

Note that many abortion clinics and hospitals offer birth control services as part of their overall care. CU urges patients to take advantage of those services. While its effect on future childbearing is still in question, there is evidence that abortion might increase the chances of a premature birth in subsequent pregnancies. Birth control avoids that risk—as well as other possible complications of abortion. Again, no matter how safe legal abortion may be, it's still the least desirable method of birth control.

FTC compromises on cigarette ads

Most people know by now that cigarette smoking is dangerous to health. It is the chief cause of lung cancer, according to the American Cancer Society, and a factor in other cancers, heart disease, pulmonary emphysema and other ailments. Yet cigarette sales continue to increase, and more youngsters take up the habit every day. Encouraging them is hundreds of millions of dollars worth of cigarette advertising issued each year, representing cigarette smoking as a desirable practice with no harmful effects.

The Federal Trade Commission has recognized that the potentially false and misleading advertising constitutes an unfair trade practice. Its response has been to elicit a consent order from the six major manufacturers of cigarettes under which all print advertisements will carry the legend:

Warning: The Surgeon General Has Determined That
Cigarette Smoking Is Dangerous to Your Health

The warning must be printed black-on-white in a type size scaled to the size of the advertisement. (The warning printed above complies with the formula for a full-page advertisement in a magazine of this page size.)

CU filed comments against the acceptance of the consent order by the FTC because we believe that it constitutes tacit approval by the FTC of the misrepresentations in cigarette advertising.

If past history is any guide, the warnings printed in the ads will, within a short time, carry no more force than the ones now printed on the side of cigarette packages; people may know that the message is there, but it won't communicate in competition with the alluring invitation to smoke embodied in the ads. In short, they will not stop the unfair trade practices perpetrated by the cigarette advertisers.

If cigarette sales reach new records next year, as they very probably will, perhaps the FTC will stop introducing delaying actions and try, directly or through Congress, to prohibit all advertisements for cigarettes, an action CU would support.

Under the terms of a separate voluntary agreement between the FTC and the major cigarette companies, all ads for major brands have been disclosing the advertised cigarette's tar and nicotine content. The figures used are to be those obtained by the FTC in its periodic testing. The results of the latest tests, released last April, are on the facing page.

CU doesn't endorse the smoking of any brand, no matter what its tar and nicotine content may be; none have been shown to be harmless. All are addictive. And even through accepted medical theory holds that a substantial reduction in tar intake may delay the onset of deleterious effects, studies suggest that addicted smokers who switch to low-nicotine cigarettes may compensate by smoking more.