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Seminar:
ABORTION

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The Institute of Criminology, Sydney University Law School

Address

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THE LAW AND PRACTICE RELATING TO ABORTION

INTRODUCTION AND SUMMARY

The British Abortion Act (formerly known as the Termination of Pregnancy Bill) was given the Royal Assent on October 27th 1967. It took effect on April 27, 1968. Thus Great Britain became the first country in what is known as the Western World to permit abortion legally and relatively freely. It may be said therefore that this Seminar on The Law and Practice Relating to Abortion held in June 1968 was timely.

Moreover it was appropriate that the first paper, presented by Professor Rupert Cross, provided a comparative critique of the legal provisions relating to abortion in England and New South Wales. It may also be regarded as appropriate that a seminar designed to consider critically the operation of the law in this area should be launched by one whose criticism was of a fundamental nature.

For Professor Cross is, as he says, an advocate of “the repeal of all prohibitions on abortions properly performed by doctors”. His paper provides not only a succinct account of the Law of Abortion in New South Wales and England, but also a clear, unequivocal statement of the case for the view that “at an appropriately early stage of the pregnancy, every woman should be able to procure an abortion (subject to proper medical advice) if she wishes to have one”.

Dr Vickery’s paper on The Psychiatric Problems of the Aborted Woman is concerned with the psychiatric sequelae to abortion. He reports the finding of the Kinsey Institute study of women who had sought abortions that “serious psychiatric sequelae to illegal abortion was rare”. He adds that his own experience “with worn out mothers and unmarried girls” is that they “tolerate illegal abortions extremely well”.

With regard to therapeutic abortion he states that whilst it is true that “psychiatric and serious neurotic depressive illness does follow therapeutic abortion . . . . the incidence is markedly less than that in pregnancy and especially after childbirth, in the so-called ‘puerperium’”. He concludes by saying that “many Australian psychiatrists would appear to support the Royal Medico-Psychological Association’s memorandum of last year [which recommended liberalization of abortion law] and the recent United Kingdom abortion law reform”.

Dr Bradfield’s paper, Medical Problems of Abortion: An Obstetrician’s View, deals with the practice of abortion from the viewpoint of an obstetrician and gynaecologist. He states that the traditional practice in New South Wales is that “the obstetrician feels reasonably free to act in what he considers to be the best interests of the patient”. The indications for the termination of pregnancy he lists as “medical, surgical, psychiatric, foetal, social and eugenic”. As for illegal abortion in Sydney, Dr Bradfield’s impression is that it has been “put on a very highly sophisticated basis”, with sound preoperative assessment, adequate hospital facilities, general anaesthesia “commonly provided”, operative expertise, post-operative follow-up and “a low complication rate”.
Nevertheless Dr Bradfield emphasized the fact that it is a mistake "to regard induction of abortion as a trivial operation free from risk". And in the latter part of his paper he deals with the operative techniques involved in abortion and some of the complications which may occur.

In conclusion he adverts to Professor Cross's suggestion that every woman should be able to procure an abortion if she wishes to have one. Dr Bradfield's view is that "the doctor must be regarded as the best judge of treatment which would be in the interest of the patient's mental and physical health ... it would be entirely contrary to all accepted surgical practice for a patient to decide when an operation should be necessary".

The final contribution to the seminar, Professor Henry Mayer's Social Attitudes to and Moral Implications of Abortion, is both the longest and the most fully documented paper presented there. Professor Mayer begins with a prophecy: "Australian abortion laws will change radically and become much more permissive within the next few years .... The laws are unlikely to sanction elective abortion but in fact we shall be moving towards this as a de facto policy".

He then proceeds to examine the abortion question "from the angle of a social scientist", and in so doing is critical of both "the dogmas of religion and of standard progressivism". It would however, be impossible to reproduce in summary form an argument as lengthy and complex as that advanced by Professor Mayer.

In the latter part of his paper he examines the structure of public opinion on the subject of abortion including in his analysis surveys conducted both overseas and in Australia. Professors Mayer's paper will be especially valuable to the reader in that he provides copious references to the available literature. Moreover in editing his paper he has added a 1970 Postscript which not only includes a selective list of the more important contributions from the current flood of material, but also briefly summarizes developments since 1968.

In the discussion which followed the papers, Dr Vickery's point that, because it raises problems which involve religious, political, social and philosophical values, abortion tends to be a contentious issue was clearly illustrated. One of the highlights of the discussion was an exchange between Professor Cross and Dr Bradfield on the subject of what may be called "abortion on request". It was inconclusive in that Professor Cross adhered to his view that he would legalize all properly performed abortions by doctors at the request of the women, and that "doctors are the servants of the community not its paternalistic guides". Dr Bradfield on the other hand insisted that "a doctor ought, by his training and his special insights, to be in a position to best assess a women's physical and mental needs and the likely impact of any operation that she may request to have performed".

There was also an interesting exchange between Father Duffy and Professor Henry Mayer in which Father Duffy argued that in considering abortion we should not only take account of "the calculus of results", but also of "the spiritual calculus of consequences". Professor Mayer maintained that "the spiritual calculus is fair enough if you apply it to co-religionists" but not when it is applied "to other people".
In conclusion it may be mentioned that Professor Cross in the course of presenting his paper remarked the existence of "a determined obscurantist attitude on the part of the establishment, disinclining eminent lawyers and eminent doctors from getting down to this very serious problem". He greatly deplored this situation. In arranging this seminar the Institute of Criminology was able to persuade a number of eminent persons from a number of fields which overlap marginally in this area to get down to this problem.

It was not to be expected that the problem would be resolved or that any consensus would be achieved. But in so far as the seminar itself and the circulation of these papers may contribute to general knowledge and help to raise the level of public discussion of the subject of abortion they will have served a useful purpose. It remains only to thank all those who participated in the seminar and especially the distinguished authors of the papers which are contained in this volume.

GORDON HAWKINS
CHAIRMAN'S OPENING ADDRESS

Associate-Professor R. P. Roulston

There is at present a mounting campaign for either a modification or repeal of the existing laws against abortion in this State — a campaign which seems likely to become increasingly important. Also, in 1967 there was passed through the English Parliament an Abortion Act which became law in April 1968 and made very major and significant changes in the pre-existing law relating to illegal abortions. In addition, there are moves afoot in both South Australia and Western Australia to liberalize abortion laws in those States — moves which seem to have a reasonable chance of success.

In the light of these developments it was considered appropriate that the Institute of Criminology should conduct a seminar on abortion, not in order to pass resolutions or make recommendations, but in order to obtain further illumination of, and insight into, what was recognized to be a highly controversial matter.

How controversial, I did not fully realize until I began the practical task of effectively organizing the seminar. Only then did I fully realize the intense passions and sincere, but conflicting, convictions that exist in the legal and medical professions in regard to abortion. I am therefore very pleased with the wonderful response evidenced by the attendance of so many members at the seminar.

It is a well recognized fact that there are a number of legal abortions and a very much larger number of illegal abortions performed in New South Wales each year, but there is difficulty in getting accurate facts on both legal and illegal abortions. I endeavoured in a rather limited way, to obtain some information from various large hospitals in the metropolitan area, and the statistical figures that they have revealed have left me, perhaps, even more bewildered than I was before.

In one hospital, over a 5-year period there were 68 therapeutic abortions and over the same period there were 14,000 live births; at another hospital there were 10 therapeutic abortions per 1,000 live births; at another hospital, over a 4-year period there were 3 therapeutic abortions and 7,000 live births; at others, the numbers were 1 and 2. Various other hospitals assured me that over varying periods of 2, 3 and 5 years there had been no abortions at all, although at one hospital 140 persons had been admitted after what was described as "spontaneous abortion".

I was unable, quite understandably, to obtain any credible and reliable estimates as to the number of illegal abortions performed each year, but it is recognized that this is a very large number indeed, informed guesses ranging from 10,000 to 50,000.

Now, to move the proceedings along a little, I have much pleasure in introducing Professor Rupert Cross, Vinerian Professor of Law at Oxford University, who will speak to his paper, "A Critique of the Law of Abortion in New South Wales and England".

R. P. ROULSTON

* Associate-Professor of Criminal Law at Sydney University Law School.
I. A STATEMENT OF THE LAW

(a) New South Wales

The law of abortion in New South Wales is set out in Ss. 82—84 of the Crimes Act, which read as follows:

"82. Whosoever, being a woman with child,

unlawfully administers to herself any drug or noxious thing; or

unlawfully uses any instrument or other means,

with intent in any such case to procure her miscarriage, shall be liable to penal servitude for ten years.

83. Whosoever —

unlawfully administers to, or causes to be taken by, any woman, whether with child or not, any drug or noxious thing; or

unlawfully uses any instrument or other means,

with intent in any such case to procure her miscarriage, shall be liable to penal servitude for ten years.

84. Whosoever unlawfully supplies or procures any drug or noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used with intent to procure the miscarriage of any woman, whether with child or not, shall be liable to penal servitude for five years."

For the time being, I am only concerned with S. 83. I will refer briefly in Section 3, to the problem of the woman who procures or attempts to procure her own miscarriage, but I will say nothing of such academic problems as the possibility of convicting a woman who mistakenly believes herself to be pregnant and of procuring the commission of an offence under S. 83. Neither do I propose to discuss the merits of the rule of law, common to England and New South Wales, according to which a doctor who performs an unlawful abortion with the utmost care is guilty of manslaughter if a tragedy ensues and the patient dies. The rule is an example of a penal policy which, though commonly accepted, I find difficult to justify, namely, the policy according to which punishment is properly increased if a greater harm than that which was intended is inflicted, albeit wholly without negligence.

This leaves me with the question of defences to a charge under S. 83. We are primarily concerned with the legality of, or the desirability of legalizing, abortions which are properly performed by doctors. If such an operation has been performed, and the doctor is charged under S. 83, the only defence generally thought to be open to him depends on the summing-up given at the English Central Criminal Court in the case of Bourne in 1939. I gather that it..."
is assumed that Bourne's case would be valid in New South Wales and my very limited study of the law of New South Wales leads me to suppose that the assumption is sound.

It will be recollected that Dr Bourne, a well-known gynaecologist who advocated reform of the law of abortion, gave himself up to the police after terminating the pregnancy, caused by rape, of a girl of fourteen. Before operating, Dr Bourne had consulted a fellow gynaecologist and each of them was satisfied that if the pregnancy has been allowed to continue the mother would have become a mental wreck, although her life would not have been in any immediate danger. Bourne was duly prosecuted, and he was acquitted after the judge had told the jury that the prosecution had to prove that the operation had not been performed for the purpose of preserving the girl's life in the sense of a normal, healthy existence.

Between 1939 and 1967, Bourne's case must have been acted on as a justification for the performance of a large number of abortions properly carried out by doctors. It is, of course, without the slightest intention of casting doubt on the bona fides of the great majority of the medical profession that I suggest that, in the case of some of these abortions, the danger to the mother's health which would have been occasioned by the continuance of the pregnancy was slight. There is, however, the inevitable drawback of any rule the administration of which is dependent on expert opinion. The practice is liable to vary considerably. I have no reason to suppose that there is any less degree of variation in the ease with which therapeutic abortions can be obtained in New South Wales than in England, where the variation is commonly believed to be considerable.

At different times between 1939 and 1968, English doctors expressed concern about the permanency of the decision in Bourne's case. Was it certain that the case would be followed by other puisne judges? Might it be condemned by an appellate court? Almost any English lawyer would have said that such fears were groundless, but they are bound to be expressed by professional men on crucial points at which the law impinges on their professional activities when the law is not clearly set out in legislation for all to behold and behove. Although I know nothing about medical opinion on the point in New South Wales, I should have thought that anxiety of the kind that I have mentioned would be all the more likely to occur in a jurisdiction in which the principle of Bourne's case has never been adopted in a reported decision. At the very least, there may be a case for casting that principle into legislative form in this State.

Taken by itself, such a step would, in the opinion of many, be a wholly inadequate measure. If the only circumstances in which a properly performed abortion is lawful are those contemplated in Bourne's case the law is too strict to be acceptable to a large body of opinion. It makes no allowance for the case in which a doctor has good ground for believing that the child will be born with a serious mental or physical incapacity; although the mother's health will not be adversely affected by the continuance of the pregnancy; it makes no allowance for cases in which the health of other children of the woman would be adversely affected by the birth of a further child; it makes no allowance for cases in which the woman's pregnancy was caused by a
sexual offence against her. I am unaware of any decision which precludes a judge in New South Wales from holding that abortions performed in any of these circumstances are lawful, but I suspect that the probability of such a holding is remote. In any event, if the circumstances in which an abortion is lawful are to be increased it must surely be common ground among the lawyers of New South Wales that the matter is one for legislation. Matters of such vital public importance cannot be left to the chance of a particular point coming before the courts. Recent English legislation on the subject of abortion should therefore be of interest in New South Wales.

(b) England

Sections 58—59 of the Offences Against the Person Act, 1861, contain prohibitions on abortions and the supply of instruments or drugs for the purpose of abortion substantially the same as those of Ss. 82—84 of the New South Wales Crimes Act; but these English provisions must now be read in the light of the Abortion Act 1967. The relevant portions of that Act read as follows:

"1. (1) Subject to the provisions of this section, a person shall not be guilty of an offence under the law relating to abortion when a pregnancy is terminated by a registered medical practitioner if two registered medical practitioners are of the opinion, formed in good faith —

(a) that the continuance of the pregnancy would involve risk to the life of the pregnant woman, or of injury to the physical or mental health of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated; or

(b) that there is a substantial risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped.

(2) In determining whether the continuance of a pregnancy would involve such risk of injury to health as is mentioned in paragraph (a) of subsection (1) of this section, account may be taken of the pregnant woman's actual or reasonably foreseeable environment.

(3) Except as provided by subsection (4) of this section, any treatment for the termination of pregnancy must be carried out in a hospital vested in the Minister of Health or the Secretary of State under the National Health Service Acts, or in a place for the time being approved for the purposes of this section by the said Minister or the Secretary of State.

(4) Subsection (3) of this section, and so much of subsection (1) as relates to the opinion of two registered medical practitioners, shall not apply to the termination of a pregnancy by a registered medical practitioner in a case where he is of the opinion, formed in good faith, that the termination is immediately necessary to save the life or to prevent grave permanent injury to the physical or mental health of the pregnant woman.

"4. (1) Subject to subsection (2) of this section, no person shall be under any duty, whether by contract or by any statutory or other legal requirement, to participate in any treatment authorized by this Act to which he has a conscientious objection:

Provided that in any legal proceedings the burden of proof of conscientious objection shall rest on the person claiming to rely on it.
(2) Nothing in subsection (1) of this section shall affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury to the physical or mental health of a pregnant woman.

(3) In any proceedings before a court in Scotland, a statement on oath by any person to the effect that he has a conscientious objection to participating in any treatment authorized by this Act shall be sufficient evidence for the purpose of discharging the burden of proof imposed upon him by subsection (1) of this section.”

Legislative effect has thus been given in England to the principle of R. v. Bourne; but far more important is the fact that the Act declares that abortions are lawful if performed to prevent the birth of a seriously handicapped child or injury to the health of another child in the woman’s family. The omission of the case in which the woman has been the victim of a sexual offence and pregnancy resulted is, from the theoretical point of view, little short of breathtaking as the plain intention was to liberalize the law. Intercourse with girls under sixteen is stringently prohibited and yet the law prohibits the termination of the worst effects of such intercourse – the girl’s pregnancy; a law which prohibits a woman who has been the victim of one of the grossest wrongs known to the law, rape, taking steps to have the pregnancy for which she is in no way responsible terminated is Draconian in its severity. The objection that the doctor asked to perform the abortion would not know whether the girl or woman had been the victim of a sexual offence is quite unconvincing. Abortions of all girls under sixteen at the time of conception could be made lawful if requested by the girl’s parents or guardians. The fact that the police were prepared to treat the case as one of rape could easily be made sufficient to render the abortion lawful. The reason I have described the omission as breathtaking only from the theoretical point of view is that I strongly suspect that, in most cases in which a girl or woman has been made pregnant in consequence of a sexual offence, a doctor would come to the conclusion that the continuance of the pregnancy would be seriously detrimental to her health; but this raises the important question of the role of the medical profession in relation to abortion, a question best considered after a further proposal for reform has been considered.

II. A DRASTIC SUGGESTION

I wish to be numbered among the by no means insignificant quantity of persons who advocate the repeal of all prohibition on abortions properly performed by doctors. I give below three reasons which impel me to the conclusion that at an appropriately early stage of the pregnancy, every woman should be able to procure an abortion (subject to proper medical advice) if she wishes to have one. Before enumerating those reasons and discussing some of the pros and cons I must say a little about the basis of the law of abortion.

The basis of that law is “Thou shalt not take any life”, whether the proscription be regarded as a divine command or as an ethical or social rule. If human personality begins at conception, those for whom the proscription is a divine command must, so far as I can see, condemn all abortions as entailing the deliberate destruction of a living human foetus. The extent to which those who hold such opinions are prepared to recognize that politics is the art of
the possible presumably varies considerably. For aught I know, there may be devout Roman Catholics who, though they cannot condone the performance of an abortion by a co-religionist, even on facts such as those of Boume's case, are prepared to acquiesce in an extensive liberalization of the law on the ground that, in the imperfect world in which they find themselves, an absolute prohibition of abortion does more harm than good if only because it encourages resort to the backstreet abortionist.

I am quite incapable of discussing the medical aspects of the statement that human personality begins at conception. No doubt there is a sense in which the statement is true, but the fact that the life (if that is the right word for the foetus) is entirely dependent on the mother may be thought to justify legislation on the lines of the English Abortion Act according to which the mother is entitled to have her pregnancy terminated on what may be broadly described as social grounds; the preservation of the mother's health or that of another child of hers, or the prevention of the birth of a seriously handicapped child are social values in the name of which the life of the embryo may be destroyed. Presumably it is along lines such as these that those who consider that human personality begins at birth, and base the general prohibition of abortions upon a social or ethical rule that innocent life must not be taken, would seek to justify exceptions to the general prohibition. They may also seek to justify the general prohibition on two further grounds, the maintenance of the population and the preservation of the sanctity of life.

So far as the first ground is concerned, I do not propose to discuss the merits of laws designed to combat a declining birth rate. Suffice it to say that the birth rate is not declining now. In any event, it is open to question whether a country whose population is prepared to abort on a gargantuan scale rather than propagate deserves anything other than a decreasing population. It is anybody's guess how great the increase in abortions would be if all prohibitions on properly performed abortions were removed tomorrow. The increase may not be a very vast one; it is reasonable to suppose that most pregnant women want to have their child and of those who do not a fair proportion would not be inclined to resort to abortion. The possible detrimental effect of the legalizing of all properly performed abortions on the notion of the sanctity of life can be considered in conjunction with the first of my reasons for canvassing such a drastic change in the law.

My three reasons are the ineffectiveness of the present law, the prevalence of the backstreet abortionist, and the undesirability of the birth of unwanted children. It must be appreciated that I have the English scene primarily in mind, but I would be surprised if what I have to say has no bearing on the situation in New South Wales.

The Effectiveness of the Law

There is a fantastic variation in the suggested statistics, necessarily based to a large extent on guesswork, relating to the performance of unlawful abortions in England. Sometimes the figure given is 30,000 a year, but 200,000 is also mentioned; yet the English criminal statistics for 1966 give the number of abortions known to the police as 208 and the number cleared up
as 189. In the case of every offence the annual gap between the number actually committed and those known to the police is probably a striking one, but can there be any to equal this? As often as not, the abortionist who is prosecuted is a professional without qualifications or one who has caused one of his or her patients illness. The time has come for us to recognize that such prosecutions are inspired as much by the desire to suppress the unqualified and occasionally incompetent abortionist as by the hope of substantially reducing the number of unlawful abortions. I admit to a belief that the number of abortions would increase if properly performed abortions were legalized but I have already suggested that the increase might not be a great one, and it would be in legal operations performed with that high degree of skill we have all come to expect of the medical profession.

The only argument that I can think of in favour of the continuance of the present ineffective law of abortion is that its repeal so far as abortions properly performed by doctors are concerned would be the thin end of the wedge. If abortions are to be lawful on the mere request of the woman to a doctor, why not legalize the killing of babies soon after birth by their mothers or at their mother's request? To this and all other variants of the wedge argument, I would reply that, from the legal point of view, it is convenient to treat human life as beginning at birth. The reason is that, from that moment, a baby ceases to be necessarily under the control of its mother. It is arguable that there is no moral distinction between a mother who requests a doctor to terminate her pregnancy because he says that the chances are that the child will be born with a serious handicap, and a mother who requests a doctor to kill her baby soon after birth because she is told that the baby will only survive with some serious handicap. The argument would turn on the definition of morality, but even if the answer were that there is no moral distinction it is highly expedient that the law should draw distinction. The wedge argument does have some force once a child has been born. If it is liable to be killed by or at the request of its mother, how long is it to be subject to this liability? This is not the place to discuss the case for euthanasia, either of the very young or the very old; but the case does seem to me to be called upon to face arguments of the "wedge" nature which are not available against the case for the performance of abortions by doctors at the woman's request.

The Backstreet Abortionist

There would be something to be said for putting the encouragement it offers to the backstreet abortionist at the top of the list of objections to the present law. In each year a certain number of women must die quite unnecessarily in consequence of the activities of such abortionists and it is unnecessary to enlarge on the objections to their practices. The backstreet abortionist, an expression which I use to cover any abortionist from a shady doctor to an unclean old woman who does an occasional young girl "a good turn", will certainly continue to exist so long as abortions by doctors are illegal in the case of healthy women who have no family problems and carry healthy children. My reason for putting the objection under consideration second on my list is the existence of some evidence that resort to the backstreet abortionist continues in countries where abortions properly
performed by doctors have been legalized in all cases. The cause may be financial, but there may also be cases in which the shame of going to hospital in order to be aborted accounts for the recourse to an illegal abortion. It is however important to bear in mind that law can have a long term effect on public opinion. If women who have the misfortune to become pregnant against their will and wish to have their pregnancy terminated constantly go to hospital, the occasion may gradually cease to be regarded as shameful, even when the woman is unmarried.

The Unwanted Child

The present general prohibition on properly performed abortions undoubtedly increases the number of unwanted children who are born each year. It is unnecessary to enlarge on this objection to the law. I suspect that I attach less weight to it than do many other people. It seems to me that the remedy may be an alteration in society's attitude towards illegitimacy. In any event adoption is becoming a relatively simple matter.

III. FURTHER QUESTIONS

The suggestion that all abortions properly performed, at the mother's request, by doctors, should be lawful gives rise to further questions. What is likely to be the reaction of the medical profession? Should all abortions be performed in hospitals? Should the prohibition on abortions by persons who are not doctors be absolute? Should the present prohibition on women aborting or attempting to abort themselves be retained?

The Medical Profession

I think that most people would approve of the insertion in any legislation legalizing abortions of a provision on the lines of Section 4 (1) of the English statute, freeing those with conscientious objections from any obligation to perform the operation apart from such obligation as might in exceptional circumstances be imposed by the common law. In a letter to the London Times of 29 April 1968 the Secretary of the British Medical Association criticized the provision of the English Act legalizing abortions if the continuance of the pregnancy would affect the health of another child of the woman. He said, however, that as the provision is now law, the performance of an abortion in accordance with it could not be regarded as an infringement of medical ethics. The performance of an abortion at request is unethical by the standards of the medical profession in England and New South Wales. Would it continue to be unethical if such abortions were legalized? I am not competent to answer this question. I recognize that any general removal of the prohibition on abortions could be wrecked if a sufficient number of doctors refused on conscientious grounds to perform the operation; but it would surely be a very grave step for a professional body to declare that to be contrary to professional ethics which the legislature approves. Doctors are the servants of the community, not its paternalistic guides.
Hospitals

It will have been observed that the English Act contains the general requirement that the operations it permits should take place in hospital. Although I do not pretend to have pronounced views on the subject, I would favour the inclusion of such a provision in legislation legalizing the performance of abortions by doctors on request. I can give three reasons for this view. In the first place, the decision to have an abortion is one which a woman should only make after the most serious consideration and the most thorough medical advice. The fact that the operation had to be performed in a hospital and not at home would emphasize the seriousness of the occasion. Secondly, the fact that the operation could not be performed in a private nursing home would serve to free the practice of abortion from the all too prevalent and, at present, all too justified belief that there is one law of abortion for the rich and one for the poor. Finally, it is important that records of abortions should be kept, and the practice of keeping records is likely to be best maintained if the general rule is that all abortions should take place in hospitals. It must be admitted, however, that teething troubles are being experienced in England in relation to this very question of records.

The Unqualified Abortionist

It is arguable that the performance of an abortion by someone who lacks the requisite medical qualifications is always a negligent act. Accordingly, there may be those who would say that it would be sufficient, in New South Wales, simply to repeal S. 83 of the Crimes Act, leaving the unqualified abortionist to be prosecuted where appropriate under S. 54 for causing grievous bodily harm by a negligent act or omission. It would not be possible to adopt an analogous course in England because we have no such general crime of causing bodily harm by negligence as that created by S. 54 of the Crimes Act. In any event, the seriousness of the occasion seems to warrant a special absolute prohibition on the performance of abortions by unqualified persons. The common law is capable of dealing with the exceptional circumstances of emergency when it becomes necessary for an unqualified person to operate.

The woman who operates on herself

It is so dangerous for a woman to seek to procure her own miscarriage that, in spite of my firm adherence to John Stuart Mill’s general principle that the criminal law should intervene only to prevent harm to others, I am not sure that I would object on principle to the continuance of a provision like S. 82 of the New South Wales Crimes Act which punishes a woman who seeks to procure her own miscarriage. The provision raises very difficult theoretical issues concerning the extent to which the law can be paternalistic. When, if at all, is it right for the law to seek to prevent people from doing harm to themselves? I do not propose to go into those issues now. I am opposed to the continuance of a provision like S. 82 because I believe it to be completely futile. Has any woman ever been prevented from seeking to abort herself by the reflection that the conduct is illegal? The deterrent is the woman’s very natural dislike of producing harmful consequences to herself. Many women may have been driven to self abortion by the fact that it is illegal for a doctor to procure their miscarriages, but that is simply a further argument for the suggestion made in Section 2.
CONCLUSION

It is customary to examine jurisprudential issues raised by proposals to reform the law of abortion in terms of the relationship of law and morals. To what extent should conduct which is normally considered to be sinful or revolting be punished by the law as such? I am the last person to doubt the importance of this question, although I doubt whether it is a particularly realistic question in the case of abortion because I doubt whether most people in England or New South Wales consider the practice to be either sinful or especially revolting. The point I wish to make, however, is that, once the problem is considered in the terms of the efficacy of the law, of the extent to which the law can be expected to influence people’s conduct, the solution is easy. Legally, the prohibition does comparatively little to prevent abortions. In this, more than in other cases, legal prohibition carries many evils in its wake; that is why I would abolish the prohibition.
THE PSYCHIATRIC PROBLEMS OF THE ABORTED WOMAN

Dr R. Vickery*

Since abortion, and especially therapeutic abortion, raises problems which directly involve religious, political, social and philosophical values, it is not surprising that the psychiatric literature and comment about abortion take on the nature of a debate. Whilst this is obviously less so in cultures where abortion reform has been more liberal for some time, as in Russia and to a lesser extent in Japan and the Scandinavian countries, it is in English speaking countries such as the United States, United Kingdom and Australia, where liberalization has been delayed, that psychiatric opinion about abortion and its sequelae is so varied. Glanville Williams in 1958 said that in its treatment of the consenting mother English law on abortion was theoretically the most ferocious in the world. The fact that we have waited so long to consider changing these theoretically ferocious laws suggests certain cultural differences in themselves from countries such as Russia. This means to me that any assessment of other countries' experiences with therapeutic abortion and its sequelae have always to be psychiatrically considered in this context.

Now there are psychiatrists, as there are gynaecologists, who have subjective, personal, usually religious, reasons for believing that abortion can never be therapeutic, and whose bias is obvious in reporting sequelae in therapeutic abortion. There are others just as subjective who claim that psychiatric morbidity after abortion is a myth, and who say that any ill effects of induced abortion are exaggerated, and even see this as a means of reinforcing cultural and sexual taboos. Over all, I feel that from the psychiatric viewpoint it is significant that in the recent United Kingdom abortion reform changes the Royal Medico-psychological Association in its memorandum recommended liberalization of abortion law rather wider than their A. M. A. and obstetric and gynaecological colleagues, and that they felt that consideration should be given to the remote effects of the pregnancy on the entire family unit. Now, there is no indication—as yet in the Australian medical literature of any strong body of psychiatric opinion against the new United Kingdom laws, but I think it is too early to assess this yet.

As a background to later discussions of the psychiatric sequelae of abortion I felt that it was useful to consider first the variables in relation to women themselves who come along to us apparently motivated to seek abortion. I say “motivated” expressly to indicate the need, except perhaps in cases of subnormal mentality, marked psychosis or irresponsibility, that the decision to terminate should come from the mother herself. Obviously the marital status of a woman is all important, for various reasons. Kinsey’s research group, in his third and last book in the United States in the late 1950s, showed that among unmarried women, where taboos against illegitimacy were stronger, there was a much higher rate of illegal abortion. For similar reasons widows, divorcees and women who were separated from their husbands sought abortion much more frequently. Abortion is also the problem of married women who have several children; the more children the

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more likely she is to seek abortion. It has been interesting in the psychiatric literature to see that Scandinavian psychiatrists until recently have puzzled at the lack of reference by English or American colleagues to the so-called "worn-out mother" syndrome. In the United States Kinsey's group studies of women who had sought abortion found that of a random group 94 per cent had sought illegal abortion and only 6 per cent had been therapeutically aborted. They suggested that serious psychiatric sequelae to illegal abortion was rare. My experience with worn-out mothers and unmarried girls, all things being equal, is that they not only tolerate illegal abortions extremely well but are so relieved at times that they refuse to name their backyard abortionist even in dying depositions. By the same token, many of us have had patients, married and unmarried, who claim to have had a staggering number of illegal abortions without any apparent unfavourable psychiatric sequelae. A woman's social and economic status in our culture appears to play some role in her decision to seek abortion. Most studies of unmarried girls suggest that those in the higher socio-economic group sought abortion rather more readily than their lower cultural counterparts, who more often tended towards "shotgun" marriage. The degree of religious devoutness of a woman will both influence her decision to seek abortion and determine an unfavourable reaction to it — especially guilt. For obvious reasons women of staunch Roman Catholic faith, for instance, would feel guilty even in contemplation of abortion and even on medical grounds such as disease or cancer. Now, in these cases we have logically the inconsistency of the same woman urgently demanding an abortion for realistic motives and at the same time rejecting it. Without necessarily considering religious devoutness, it is our feeling that conscientious women, with a strong or punishing conscience, seem more prone to guilt feelings, regret and depression after an abortion. This group of women, particularly if unmarried, are obviously much more shameful of being pregnant in the first instance, and for this reason terrified of exposure. Moreover they are as well much more susceptible to implicit criticism or hostility from either medical or nursing staff during and after termination or as a result of a decision about termination.

An important factor to be considered is an assessment of a woman's motivation to have an abortion, and how much her decision is made or influenced by her husband, her parents or the putative father. There is a well-known Swedish study by Ekblad in 1955 of the effects of therapeutic abortion, which suggested an increased risk of serious self-reproach about the abortion in cases where the woman had been influenced by others to seek submission for termination. By the same token, it has been interesting to me to see at times how doctors, including psychiatrists, have tried to persuade women either to have or not to have an abortion, and usually with quite different motives from those of interested relatives. I personally feel that this could be a factor in increasing the incidence in these women of post abortal guilt.

I feel cultural factors have to be considered in regard to both the motivation to have therapeutic abortion and the production of guilt feelings after it. Ready availability, staff attitudes, keeping of records, public submission to medical, obstetric and psychiatric review, all these are just some of the variables which will inhibit many women from seeking legalized
abortion. In the unmarried group, where secrecy is usually felt to be all important, there would seem to be good reasons for assuming that in our culture there will still be be many girls turning to illegal abortion rather than undergoing the public hospital exposure of a therapeutic abortion.

Finally, it would seem to me that the over-all personality or ego strength of women seeking abortion must remain a major factor in the decision to seek abortion and the response to it afterwards, and those of us who have had the confidence of, for instance, unmarried nurses, university students, trainee teachers, and other girls with good ego resources, are frequently surprised at the strength that these girls show when faced with an unwelcome or unwanted pregnancy, and the number of times in which they will arrange an illegal abortion with virtually no advice or assistance from anyone, although some of this is obviously from their guilt and their need for secrecy.

In turning now to the psychiatric sequelae of abortion, I would prefer to exclude spontaneous abortion, because this must occur in many women motivated to continue the pregnancy, and here regret and even guilt and depression can follow after these spontaneous abortions, particularly when the original feeling about the pregnancy was one of not wanting it. I only mention this group because so many studies of the sequelae of abortion include this group with induced abortion and tend therefore to load the responses suggestive of regret and guilt rather higher than they would otherwise have been.

Much more information is available psychiatrically in regard to therapeutic than illegal abortions, for obvious reasons. Kinsey's research group, which I mentioned before, where they had 94 per cent of women who had been illegally aborted, was a retrospective study. I felt that their findings were significant so far as the United States was concerned, and so far as showing that less than 10 per cent of these women, in retrospect, reported psychological upset over their illegal abortions, and of those who did, it was largely in general emotion terms in much the same way as people describe their response to broken engagements, bereavements, etc. While this was by no means a careful study of psychiatric sequelae to illegal abortion, the study does appear to show reasonable statistical evidence of no subsequent sterility or damage to the woman's capacity for orgasm. In other words, this could be interpreted as significant evidence that there is no major sexual maladjustment as a result of therapeutic, or more particularly, illegal abortion.

In reviewing the literature in regard to therapeutic abortion one is struck by two factors. Firstly, in countries like Russia and Japan where legal abortion is less restricted and where the greatest number of abortions are performed, there is little reported evidence of post abortal psychiatric sequelae, except in cases where a psychiatric illness was present before the abortion; but one is struck in all reports by the lack of information in regard to premorbid personality or previous psychiatric illness in aborted women who did have sequelae, and the failure in many instances by doctors to follow up women for a long enough post-abortal period. Secondly, in countries less permissive (and I include now the Scandinavian and European countries) it did seem that therapeutic abortion in these cases was followed more often by
The Psychiatric Problems of the Aborted Woman

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guilt, regret or remorse over the abortion. Almost all European, and some Japanese, studies indicated immediate post-abortal feelings of mild or serious self reproach in an average of about 25 per cent of cases. Those studies which extended beyond the post-abortal period suggested that the guilt feelings or the regret about the abortion did become much less marked with time. But more information and much larger follow-up studies are needed to confirm this.

Many studies stressed the high incidence of pregnancies following therapeutic abortion, especially in Japanese and European countries, and there was a tendency to equate this high incidence of pregnancies with regret and guilt in the immediate post-abortal period. This must certainly be the case with some women. The more ready availability of contraceptive pills and other contraceptive measures in our culture raises doubts as to how often compulsive pregnancy is important in this case, but no study, I feel, gives sufficient evidence to say that women fall pregnant again after therapeutic abortion purely and simply as a restitution for the abortion itself. I feel that in other instances the pregnancy which occurs after the therapeutic abortion may represent an inner unconscious need to be pregnant. We see this quite frequently in grandmothers in their late 30s and 40s whose children have just produced an infant themselves and who have jealous feelings and a need to identify with their daughters in so many ways. I think sometimes it may be simply a healthy response to changed circumstances when women fall pregnant after a therapeutic abortion, and of course others of us less charitable might say it was pure carelessness. Be that as it may, there is a high incidence of pregnancy following therapeutic abortions, and, for an example, a study in Japan shows 30 per cent of women followed for twelve months post therapeutic abortion regretted the abortion and 50 per cent of them were pregnant within 18 months. Now, we could call this a recidivist group, and this group has prompted psychiatrists and gynaecologists to suggest that legal abortion in this group (which is essentially the married group) should be reserved for those who have sterilization performed at the same time. In other words, we ensure that the woman has no regrets about abortion beforehand. There is a body of psychiatric opinion — including my own — which believes that the psychiatric sequelae and problems of sterilization should be considered separately from abortion, at a later date if possible.

As mentioned before, the greater the premorbid conscientiousness and religious devoutness the more likely is the woman, especially if unmarried, to regret the pregnancy and the abortion. There is a tendency by many authors to equate guilt or regret with psychiatric debility, especially depressive illness. Now certainly psychiatric and serious neurotic depressive illness does follow therapeutic abortion, but the incidence is markedly less than in pregnancy and especially after childbirth in the puerperium. Again quoting Ekblad’s study of 1955, he found that post-abortal (post therapeutic abortion) 14 per cent of women had moderate guilt and 11 per cent serious guilt, but of that number only 1 per cent were sufficiently disabled by guilt or depressive illness as to be unable to carry out their household duties or their work. A very interesting and worthwhile study by Simon and Centuria reviewed five European studies which they felt could be logically compared and showed that the findings ranged from 43 per cent of women with severe guilt post abortion, an additional 12 per cent with psychiatric illness, to 0 per cent in both
categories. Again I would stress the lack of information in so many reports about the premorbid personality of the women who did become disabled post abortion and regarding the effect of the passage of time on the responses of these women.

Some psychiatrists argue that pregnant women never suicide and should never be aborted because of suicidal threats, but this is not true. Others suggest that post abortal suicide does not occur. This is also not true. What does seem to be substantiated is that post abortal suicide and psychotic depression do occur, but less commonly than in the puerperium after natural confinement. What is probably just as significant is that many cases of serious depressive psychotic illness beginning or worsening in pregnancy are not cured by termination alone but, for other dynamic reasons, require added psychiatric therapy as a treatment for the psychosis or depression, including hospitalization, drug treatment, or even shock treatment. It is this group especially which have been aborted therapeutically in this country, and to some extent also in the United States and the United Kingdom. It is interesting that some Scandinavian studies suggest that women refused abortion on psychiatric grounds did rather better afterwards, from the psychiatric viewpoint, than those who were therapeutically aborted; but it is also obvious that those who were aborted were aborted because of serious psychiatric disturbance at the time, or because of their overall psychiatric vulnerability — factors which would definitely increase the risk of after effects of abortion. I think that it is significant, furthermore, that good Swedish studies have shown that not less than 50 per cent of women who became disabled after therapeutic abortion had been under care in a psychiatric institution at some time prior to their abortion. I think that it is significant, too, that we don't know for sure how many women refused abortion in Scandinavian countries resorted to illegal abortion later. This is a field which is very much in need of study, and I am sure that the English psychiatrists will be studying this now, with their new laws.

As a sidelight to this, and perhaps another issue, is the very conclusive (to me) body of Scandinavian evidence in relation to what I would call the unwanted child. Professor Forsman of Sweden in 1960 followed up for 21 years a group of children who were born of mothers whose applications for therapeutic abortion were refused in the years 1939–1940, when abortion was first legalized in Sweden. I think his findings were significant in the sense of showing over 50 per cent of these “unwanted children” to be living in precarious circumstances with a significantly higher incidence of poor education, psychiatric consultations, criminal tendencies and maladjustment.

To get back now to psychiatric sequelae to abortion, there is overall agreement that women with diagnosed psychiatric illness or insufficiency prior to abortion continue to have some difficulty afterwards. These women can become worse or psychotic post abortion, and certainly need careful psychiatric observation and follow up. But the evidence seems that the overall risk of their developing a serious psychiatric illness during the pregnancy, and especially after confinement, if they are allowed to go to term, is very much higher. It would seem to me that the women who were in the past therapeutically aborted for serious psychiatric illness, especially depression, were the ones who were most likely to develop psychiatric illness after
abortion. Despite this, even if the situation could become temporarily worse, most psychiatrists would advise termination therapeutically. They would prefer to support and treat a woman after therapeutic abortion than throughout and after her pregnancy, with a greater risk of serious puerperal complications. This is quite apart from any feelings that they may have about the ill effects that mothers who are not aborted may have on the rest of the family unit, and particularly on the "unwanted child" when it is eventually born.

As a sidelight, it is interesting to see, especially in psychiatrically vulnerable and, quite often, pre-psychotic women the so-called "anniversary reaction" after abortion. This is usually a depressive reaction, and it can appear after either illegal or therapeutic abortion. These women, on either the anniversary of the date of the abortion or the expected date of the birth of the child had the abortion not occurred, developed a significant depressive illness, and quite often this went on to suicidal attempts.

But even when women are considered to be psychiatrically vulnerable, abortions do not always make things worse. In many cases assumed to be extremely vulnerable abortion is, psychiatrically, a most insignificant event. In others it is a stabilizing factor. A large number of women who are seriously disturbed before the operation respond well and improve mentally following it.

In regard to the effect on a woman's attitude to either her husband or her sexual partner, this seems to be enormously variable. Whilst Kinsey's group studies of illegal abortion suggest no serious long term disturbance of sexual or marital relationships, the immediate effects on a woman's attitude of the discovery of an unwanted pregnancy and the subsequent abortion are less clear. Psychiatrists such as Deutsch say that the woman's attitude to the man is often disturbed in a most decisive manner by an unwanted pregnancy. He is sometimes prevented from interfering, with even a tendency to eliminate him entirely in an illegal abortion. Moreover, the immediate effect of an abortion is frequently that, despite the best understanding of the partners before the abortion, a change, even if temporary, takes place in the woman afterwards. It is as if she says, "I am not the same as before". Strangely, the stronger the love relationship that may have existed prior to the abortion, the stronger may be the feeling in the woman of being devalued. Realistically, this attitude does not normally last, and it is obviously so much determined by the premorbid personalities of both the woman and her partner or husband, but it would appear to be more common in unmarried women. These attitudes are much more common in premorbid disturbed women, particularly those with delayed sexual maturation and insecurity in the feminine and maternal roles. It is our impression that a number of women with repressed feelings of inferiority or insecurity in the maternal role, whilst unconsciously wanting abortion, are made to feel devalued and guilty by the thought of abortion.

To conclude, I would indicate that many Australian psychiatrists would appear to support the Royal Medico-psychological Association's memorandum of last year and the recent United Kingdom abortion reform law. To go further and consider the unrestricted right of any woman to decide to have an abortion, as in Russia, is a slightly easier decision for psychiatrists than it is
for gynaecologists. Abortion is a surgical procedure with physical risks, and the gynaecologist is the one who must assume this responsibility. To abrogate this responsibility to the decision of the patient is considered by some doctors to be a violation of the standards of medical practice. They say that in no other medical situation would doctors permit their patients to assume such responsibility. On the other hand, most psychiatrists would want to ensure that unrestricted abortion reform would lead to less post abortion psychiatric sequelae both in the woman and, more particularly, her family. It would seem possible that unrestricted abortion could lead to less guilt and regret afterwards; but remember, most of us feel that this guilt and regret in itself is insignificant and transient. I wonder as well, in our culture, how much the guilt and regret after abortion is almost a normal emotion.

I seriously doubt whether liberalization of the law would reduce the incidence of serious post abortal illness, which, even if uncommon, can be serious and can lead to suicide, as in the puerperium. This I believe to be largely determined by the premorbid personality or psychiatric vulnerability of the woman before abortion. Unless all abortions are screened psychiatrically some vulnerable cases will be missed, and a prophylactic opportunity is lost.

I believe that there are many women who will continue to resort to illegal abortion under a modified legal system as has now become law in the United Kingdom, either because they will be rejected for therapeutic abortion under the law as it apparently stands, or because of their need for secrecy or refusal to have their pregnancy made public. This would be much more of a problem in unmarried women.

In assessing the sequelae of abortion it is important to look at the benefits to the entire family unit, both now and in the foreseeable future. Many psychiatrists believe that environmental factors and family atmosphere are vital to the personality development of every growing child, and this makes one reluctant to encourage the birth of children into what psychiatrists call a pathogenic home environment. Many psychotic and grossly neurotic mothers are pathogenic, we feel, towards their children; and any woman who does not want her baby, even if she changes her mind later, can become a pathogenic mother because of conscious and unconscious mental processes relating to pregnancy. It is interesting to speculate as to how many youngest children in many families would be in this world today if our abortion laws were more liberal, especially the youngest by many years in a family. I say this because some psychiatrists believe that a youngest child in a family, particularly if the youngest by many years, is rather more vulnerable to nervous illness in later life.

Finally, it is salutary to me as a psychiatrist, in seeing and assessing women for therapeutic abortion under our current New South Wales law, to remember the number of them I have seen who, as a result of discussion, mobilizing social resources, and offers of psychiatric assistance, have happily decided to continue in their pregnancy and proceed to term with no subsequent psychiatric sequelae. I like to think all doctors can respect a woman's need to decide finally on abortion herself but be able to advise them objectively on this; but overall I think this is just wishful thinking.
First I must thank the Institute of Criminology for the opportunity to participate in this seminar. I must say that Mr Roulston seems to be a master of the ambiguous phrase, because when writing to me and giving me the topic for this particular presentation, "The Medical Problems of Abortion", he was kind enough to refer to my "wide experience".

The whole problem of abortion is, of course, shot through with ambiguities and inconsistencies and ambivalences, particularly for doctors. Doctors seem just as confused as anyone else about abortion, and the number of letters to the medical press, in the last twelve months particularly, is ample testimony to this.

We have heard from Professor Cross what the law has to say about this, or, particularly in this State, what it does not have to say. But what about the practice? Abortion enters obstetrical and gynaecological practice usually in one of three ways: either the need to consider, and perhaps perform, a therapeutic abortion; or in the form of a patient who is suffering from complications after an illegal abortion; or as a request from a patient who has an unwanted pregnancy that she wishes to be terminated.

I should like to speak first about therapeutic abortions. It is quite clear that there obstetricians really haven't got a leg to stand on. There is, in a word, absolutely no provision in the law in this State for terminating pregnancy. But of course, as we all know, the practice is quite different. The subject of medical ethics and medical jurisprudence was never one that seemed to me to be taken particularly seriously in undergraduate teaching — certainly it was overshadowed by other subjects — but I nevertheless retain an impression of three points.

The first is the one to which Professor Cross has alluded, the Crimes Act of New South Wales, which said quite clearly what was unlawful. But it has always been inferred, or there has been speculation, that because it prescribed clearly what was unlawful, after all, lawful termination might exist.

Then, if I recall, some note was also taken of the Infant Life Preservation Act of 1929 in Great Britain. This Act recognizes the right of a child to independent existence, but it does permit the interruption of pregnancy if it is done in good faith for the purpose only of preserving the life of the mother.

And then again great store was placed on a third point, and this was Mr Justice MacNaughten's summing up in the case of R. v. Bourne. This immeasurably broadened the field for therapeutic abortion, at least in Great Britain. It at one step allowed psychiatric indications as being valid for the termination of pregnancy.

Influenced by all these, there has grown up in this State a practice which has gone on for long enough to be called traditional. It has never been challenged nor, I imagine, is it ever likely to be challenged, and in practice the obstetrician feels reasonably free to act in what he considers to be the best interest of the patient. If he feels that the continuation of her pregnancy is detrimental to her physical or mental welfare, and if he has his opinion confirmed by a colleague of what is technically termed "standing", he would then induce an abortion. Very rarely is he confronted with a situation where the patient's life hinges on his decision. Mostly, cases are "borderline and involve specialist consultation, perhaps admission to hospital and careful laboratory assessment of the particular problem that may perhaps be held to indicate a therapeutic abortion.

I should like to illustrate the practice in this State, that we have already heard a little about from our Chairman, by showing you some figures from one of the large obstetrical hospitals in Sydney, which I don't think supplied figures to Mr Roulston. This hospital is certainly not in the van, but neither is it to be numbered amongst the least.

The first slide shows the number of therapeutic abortions performed year by year in the period 1962 to 1967. These are contrasted with the total number of confinements. You will see that the number of confinements has remained relatively static (approximately 4,500) and so, too, really, has the number of therapeutic abortions. In 1962 there were rather more than in most of the other years. These, as I will show you later, were disproportionately due to psychiatric indications, but this was entirely by chance, these figures have no statistical significance. The vintage year of 1962 happened to coincide with a rubella epidemic, and this is why the figures are inflated over and above the others. But by and large you can see that they have remained remarkably constant.

The indications for these (and the total number was 62) are broadly divided up into medical, surgical, psychiatric, foetal indications, social, and eugenic. These categories are by no means mutually exclusive.

The medical indications were, as you see, for heart disease, renal disease, tuberculosis, diabetes, and what might be called medical malignancy, that is to say, where there was no question of surgery being involved.

The surgical indications were a crippling bilateral arthritis which prevented the patient from walking and had grossly deformed her pelvis, and a surgical malignancy — it was a cancer of the cervix where pregnancy coexisted.

The 16 psychiatric indications (reactive depression and schizophrenia) were in these instances primary, but there were certain psychiatric overtones to some in other groups.

The foetal indications were almost exclusively those of rubella. Only 2 of these 20 were performed for Rh incompatibility. Rhesus incompatibility is one complication of obstetrics which is rapidly disappearing because of the ability now to prevent sensitization occurring. It is likely that this will soon
disappear entirely from what have been held to be valid indications for therapeutic abortion.

Rubella is worth saying a word about. This is something of a paradox. Rubella in the first three months has constituted one of the commonest indications for therapeutic abortion, and the prospect that a child may be mentally or physically abnormal can certainly be a valid indication for termination if fear of this happening has an adverse psychological effect on the mother. Of course, in theory, consultation should always be held with a psychiatrist to assess this adequately, but in practice this seems not by any means always to be done. If the rubella is properly documented, and if the mother expresses some concern, an obstetrician will usually only have his opinion endorsed by another obstetrician.

The social indications were only quasi-social. This is one case where psychiatric factors played a very important role as well.

The eugenic indications were, as you might expect, serious deformities likely in the children of the particular mother, or where there was serious incidence of hereditary disease.

The techniques used in performing these therapeutic abortions are of interest too. Most of them were by dilation and curettage of the uterus, and this reflects the fact that terminations are usually done quite early in pregnancy. The operation of hysterotomy is one where the abdomen is opened and the uterus is incised and its contents evacuated through an abdominal incision. This is done where the pregnancy has progressed beyond (on the average) 12 to 14 weeks, and where an attempt to empty the uterus by curettage would be extremely hazardous. Total hysterectomy, which seems a rather radical way of terminating a pregnancy, was done in 2 of these 62 cases because there was coincident uterine pathology that demanded treatment in its own right although it wasn’t primarily a factor in deciding for the therapeutic abortion. In 22 of the 62 cases sterilization was performed at the same time.

These techniques are not, of course, the only ways of performing abortions. In Scandinavian countries in particular, abortifacient pastes are used. When introduced through the neck of the womb into the lower part of the womb, these have an irritating effect and induce the uterus to contract and expel its contents. But these were not used in this series and they are very little used in the United Kingdom or in British Commonwealth countries generally.

One technique which has not yet made its appearance in Australia, but which certainly will make a medical impact, is a form of suction apparatus combined with an electro-mechanical vibrator. There have been glowing (if that is the right word) reports in the Eastern European literature about the ease and facility of this technique, so much so that it is being done (if one can believe this) on an outpatient basis attended by only minimal pain, indeed, only discomfort, and minimal blood loss. This is certainly something that needs to be taken note of. The apparatus, this electro-mechanical vibrator, apparently speedily dilates the cervix and allows the sucking apparatus to be introduced through the cervix and the whole contents of the uterus to be sucked out through the tube in vacuum cleaner style. One Russian refinement also incorporates a rotating screw that manages to, as it were, mince the material that is removed.
The last slide that I want to show you has, again, no statistical significance. It is just to show you that no notable religious group was exempt in this 1962 group of patients on whom therapeutic abortion was performed.

Mr Roulston has already indicated the wide differences in the application and interpretation of this practice of therapeutic abortion. This is perhaps even more strongly highlighted by a letter which appeared in the British Medical Journal about three weeks ago written by Dr MacLaren from Birmingham. He was writing about something quite different, but in the course of his letter he referred to the difference between two Scottish cities, Aberdeen and Glasgow, both of which undoubtedly offer a very high standard of ethics and obstetrical care. In Aberdeen, where there is a School very conscious of socio-economic factors, it seems that 1 in 50 pregnancies end in therapeutic abortions, whereas in Glasgow 1 in 3,750 do. He makes the comment that without doubt (I wouldn’t know if this is true or not, but I give it to you for what it is worth) social and economic pressures in the slum areas of Glasgow overshadow those of Aberdeen.

But even here the same sort of variation is certainly seen. The Abortion Act of the United Kingdom is making a considerable impact in this country. I think that this seminar tonight is evidence of that, and it is going to stimulate increasing interest about our position here. I think, therefore, that it is worthwhile commenting, from the doctor’s point of view, on some of the provisions which have concerned the doctors in the United Kingdom and which may come to concern us here.

We have already mentioned the egregious omission of rape, and I would certainly endorse that from the personal point of view. I feel that this most certainly should have been included.

The second point which has concerned doctors in England has been the interpretation of what is called the “conscience clause” — the ability for a doctor to object on conscientious grounds. Some consultants, it seems, have imagined themselves involved in a court action because they have refused to terminate a pregnancy in a patient who has been sent to them by another practitioner. It would seem that this is probably a groundless fear. The Medical Defence Union of Great Britain, who have had this question referred to them for an authoritative answer, although it has not yet been tested in law, feel that quite apart from the doctor’s rights under the conscience clause the gynaecologist is under no obligation to terminate a pregnancy if in his considered clinical opinion the operation is not necessary.

Another point is the impression that termination may be permitted on social grounds alone, thus opening the floodgates virtually for abortion on demand. In this context I think that it is well worth noting that social factors, even in the situation of the practice here in New South Wales, have always been taken into account, and rightly so, when assessing the impact of pregnancy on the health of the mother. One obvious and telling example of this is heart disease in the mother. It is important to consider her housing, her age, the size of her family, what domestic help she has. All these things bear on the prognosis of her heart disease and therefore will have some bearing on the functional capacity of her heart. Returning to the impression
that some people have of termination on social grounds alone, this misgiving seems to have arisen from the provision that permits the practitioner to take account of the woman’s actual or foreseeable environment. In theory this has been answered by pointing out that the test is whether there is risk to the health, be it physical or mental, of the woman herself or of any existing child in her family. The test applied is the risk to health, but yet in practice there may be some reason to feel concern about this clause.

Again, Dr MacLaren mentions in his letter of three weeks ago, and I quote him, “Already, and remember the Abortion Act became law on April 27th in the Midlands, hospital and private abortion practice are in competition. A telephone number is freely available in Birmingham to a so-called social worker, who in turn will pass on the name and address of a ‘sympathetic’ doctor. This private group, headed by the local group of the Abortion Law Reform Association, also plans a private ‘abortorium’ with surgical staff imported from another city on a fee for service basis”. It remains to be seen whether a writ will be issued against Dr MacLaren by the Chairman of the Abortion Law Reform Association.

The last point that is concerning doctors, and one of the most important ones perhaps, is the question of increased demand. This is very real, and already it is happening, as again letters testify. It seems that up to three times the number of requests for terminations are already being made in hospital outpatient departments, and this certainly may well lead to difficulties in priorities and could very easily prove an embarrassment to hospital resources that are already strained. There may be very real difficulty in deciding who should have the priority — the patient for an abortion (who of course should be aborted as early as possible after the decision is taken, because it becomes increasingly complex and hazardous the longer the pregnancy goes on), or the patient for investigation for some obscure, and perhaps quite important, gynaecological condition, or the patient who is simply waiting for non-urgent elective surgery which may well make a contribution to her well-being.

I would like to turn now to a consideration of the complications of the technique itself. I am sure that no one has a livelier awareness of the depredations of the back-street abortionist that the obstetrician, because he has to deal with the results, both immediate and remote. There is reason to believe that in Sydney at least back-street abortionists are becoming fewer and fewer. It would seem that illegal abortion in Sydney has been put on a very highly sophisticated basis. There seems to be sound pre-operative assessment to determine what can be done safely. There seem to exist facilities which differ, reputedly, very little from hospital operating theatres, general anaesthesia is very commonly provided, there is operative expertise, and there is a post-operative follow-up of sorts. This probably leads to a low complication rate. But complications nevertheless do occur. The reason that I want particularly to stress complications is that there is unfortunately a tendency to regard induction of abortion as a trivial operation free from risk. Those without specialist knowledge (and this certainly does include some members of the medical profession) are influenced in adopting what they choose to regard as a humanitarian attitude to abortion by a failure to appreciate just what is involved.
I don’t want to weary you with a lot of statistics about the incidence of complications. In any case, many of them are suspect, as has already been indicated. A not unreasonable starting point might be to quote some of the Scandinavian figures, since there has been something approaching legalized abortion there and relatively freely available abortion exists. The operative mortality initially varied from 0.9 to 3.5 per 1,000 cases. More recent figures from Denmark are lower, about 0.7 per 1,000. But this nevertheless is about three times as high as the present maternal mortality rate in England and Wales. This maternal mortality rate includes septic abortions as well as those complications of later pregnancy. In more recent Danish figures, a non-fatal serious complication rate of not less than 3 per cent seems to exist with legalized abortion, and abortions there, remember, are done under optimal conditions by people presumably skilled. One certainly would need to dissect these on the basis of techniques, but I think there is some validity in the figures nevertheless. Morbidity rates of up to 15 per cent are also reported. I haven’t seen any really convincing incidence figures about long term sequelae. These are certainly real, but one can only guess at them.

I think to meaningfully discuss complications — and again at the risk of repetition I would stress that in any consideration of abortion one can’t feel that one is discussing it fairly and completely unless one has some understanding of the techniques — I would like to mention a few points in operative techniques which do have a bearing on it.

I would like to show you first the surgical anatomy of the uterus. What we are looking at in the first diagram is a section of the abdominal cavity and pelvis taken directly through the midline. Here, right in the centre of the field, is the uterus. You will notice that it lies immediately behind and above the bladder, and immediately behind the uterus is the rectum. What is not shown in this figure are multiple loops of small and large bowel that are in relation to the uterus lying above, beside and in front of it. The figure below is a section taken a little to one side of the midline so that the midline organs of bladder and uterus are not cut in half so to speak. The relations here are no less important. Running down beside the uterus in the two layers of peritoneum are very substantial bloodvessels. This uterus is not, of course, pregnant, but during pregnancy, with the enlargement of the uterus, there is tremendous hypertrophy of these bloodvessels. They become very substantial indeed. And this view, cut off here for convenience, is the ureter. This conveys urine from the kidney down to the bladder. The ureter lies in close relation to the side of the neck of the womb.

The standard technique of termination is by curettage, and this is done usually within 6 to 8 weeks of gestation. Up to 10 weeks it is relatively safe, 12 weeks becoming a bit hazardous (even experts in this technique would feel a certain reticence in doing it at 12 weeks) and it would rarely be able to be safely attempted above that period of gestation. I am not suggesting that obstetricians and gynaecologists approach this operation in fear, trembling and great trepidation, but at least they approach it with a very lively appreciation of what may go wrong.
Here we are looking at the section of the pelvis with a pregnant uterus. Now, the first point is, of course, that the patient must be carefully examined to determine the position of the uterus and its size, and it is important, too, that the bladder be empty. If this is not empty it not only hampers a proper assessment but it also makes it more liable to damage. The dilation you see is going on here; there is an instrument gripping the anterior lip of the neck of the uterus and a dilatator is being introduced. Dilatators have to be introduced very carefully. If they are not, and they are introduced too forcefully, perforation may occur. Not only may perforation of the uterus occur, but a ring of muscles that lie at the junction of the neck of the uterus and the body of the uterus, and on which the integrity of pregnancy largely depends, may be ruptured. This produces no ill effects at the time, but it predisposes to a characteristic type of spontaneous abortion which occurs in the middle three months, and later, when the patient may be having a wanted pregnancy, then she may, without warning, abort, and consistently abort at about that time because of trauma sustained long before.

The next step after dilatation is to loosen and remove, by means of a curette, the contents of the cavity of the uterus. This has to be done with extreme delicacy of touch, because it is an operation which is largely done blindly and with tactile sense. It also has to be done with controlled speed, because there is inevitably a certain amount of bleeding, and sometimes, if the pregnancy is advanced to 12 weeks or so, considerable bleeding. It is not by any means difficult for the curette to perforate a uterus. Now, remember the relations of the uterus: a curette may perforate the uterus and may involve the big bloodvessels lying along the uterus itself, and this can produce torrential haemorrhage that may even require hysterectomy for its proper treatment. The bowel itself may be perforated, and this will of course result not only in damage to the bowel but in the dissemination of highly infective contents into the peritoneal cavity, a faecal peritonitis, and quite possibly death. The bladder may be perforated, and this will result, until it is surgically closed, in a permanent passage, the bladder never filling up, and the constant drainage of urine through this hole made into the bladder.

It is not impossible for the whole of the lining tissue of the uterus to be removed, not merely the pregnancy itself, so that the patient may never again have another period. — Nothing is left but the muscular wall and a thin layer of fibrous tissue covering it. It is by no means uncommon for adhesions to develop in the cavity of the uterus, and these cause the walls to adhere. Depending on the extent to which this happens, the patient may have scanty periods and not be able to conceive, or no periods at all, because the whole cavity is obliterated by adhesions.

The next step involves using a pair of forceps to grasp some of the fragments of tissue and remove them, fragments that have not been entirely removed by the curette. This may also, if a perforation occurs, result in a loop of bowel being drawn down. You probably all remember a case not so very long ago from Newcastle where a considerable amount of bowel was withdrawn and the doctor dealt with the situation by cutting it off. Even if there is no perforation, it is by no means impossible for a portion of the wall of the uterus to be removed by the forceps, leaving a permanent deficiency, a weak spot. There are no consequences at the time perhaps, but in a
subsequent wanted pregnancy this will be an area of weakness which may rupture during the course of the pregnancy or is particularly likely to rupture, with disastrous consequences during labour itself. All the fragments of the conceptus have to be removed, because the fragments that remain not only can be a cause of further persistent bleeding, but since they are dead tissue they will form a perfect nidus for bacterial infection.

Perhaps the most serious complications of all are the infective ones. Infection can result not only from fragments remaining and becoming infected, but also from infection being introduced at the time. Infection of the lining of the uterus, spreading through the wall may involve the peritoneal surface immediately adjacent, with the result that an abscess may form. The tube, of course, may become infected and as a result permanently blocked, with inescapable sterility to the patient. Pus dripping out of the tube may form an abscess in the pelvis which will require surgical intervention and may result in the formation of quite serious adhesions in the pelvic cavity. There may be inflammation in the veins, as you see illustrated on the far side of the diagram, inflammation that will spread to involve larger and more serious veins and result in quite serious and permanent incapacity.

The last picture is just one briefly to show you what is involved in an abdominal hysterectomy. On the left hand side we can recognize that there has been an incision made in the abdomen, and you are looking at the uterus lying underneath the abdominal wall which has been opened and the foetus removed with the cord still intact and the placenta and membranes still intact. Paradoxically, this operation is not attended by quite as many complications, but this operation nevertheless leaves a scar in the uterus, a potential weak spot, which in a subsequent wanted pregnancy may be liable to rupture. I know it is very easy to overstress the complications, but until we get more precise evidence of their exact incidence I do feel that this is something which has always to be taken into account in any thinking or discussion about the subject.

I said at the outset that doctors seem as uncertain as anyone else about abortion. As far as I am aware, there has been absolutely no sampling of medical opinion yet in this country and, as Dr Vickery pointed out, there has been no professional association that has yet seen fit to make any definitive statement about it. Now, Professor Cross in his paper did ask a very pertinent question, and one which Dr Vickery also touched on. Professor Cross wondered whether it would continue to be medically unethical to perform abortions at the request of the patient if such abortion on request were legalized. I would like to finish by giving you what I think ought to be the reply. I feel that it would still have to be regarded as unethical. The doctor's prime responsibility is always to his individual patient. The doctor must be regarded as the best judge of treatment which would be in the interest of the patient's mental and physical health. The patient herself is in no position at all to assess the dangers and the results of any operative procedure, including termination of pregnancy. I agree with Dr Vickery that it would be entirely contrary to all accepted surgical practice for a patient to decide when an operation should be necessary.
PROPHECY

Australian abortion laws will change radically and become much more permissive within the next few years. Narrow definitions of "health", mental or physical, will be followed by broader ones and socio-medical indications. As the line between the "medical" and the "social" will continue to be further blurred, it will no longer matter much whether indications for a legal abortion are socio-medical or plainly social. The laws are unlikely to sanction elective abortion but in fact we shall be moving towards this as a de facto policy.

Maybe around the late seventies, governments all over the world will begin to intervene, indirectly by various disincentives, directly by law if need be, as to the number of children a couple can have. There will be an uproar about compulsion in which J. S. Mill, Hart, and the Griswold case will be cited. Learned books and articles will defend "the right to reproduce" — from the first moment of marriage. The slogan now used to advocate elective abortion — "a woman's body is her own" — will be used to defend elective childbirth. Developed countries will actively promote and endorse the very latest in contraceptives, a large number of underdeveloped ones — including those still nominally Catholic — will endorse and promote abortion.

A LOST BATTLE

Those who want abortion law reform in this country have already won, without anything in the nature of a major local battle. They still feel beleagured, but they are mistaken. The forces opposed to change, which seemed so powerful and well-entrenched only yesterday and which are still seen as such by most people, are in fact very weak. They will fight rear-guard actions, but they will lose. They will lose without knowing what hit them.

As a political force in fields which are widely perceived as "moral", the Churches are no longer to be taken seriously. They are unable to function as effective interest groups or to deliver the votes when it comes to the crunch. This was shown over the uniform divorce legislation and, more recently, at the state level in Victoria and South Australia over gambling and drinking issues. The advice of the Churches is being increasingly ignored over contraception, and it will be ignored over abortion.

Don't let's be fooled by gazing with fascination — of horror or of joy — at what a single police inspector can do and is doing in Melbourne. Consider, rather, these points:

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1. Abortions cannot be stopped. It is possible to control how abortions will be performed and it is possible, in principle, to stop professional abortionists. No modern society in fact is willing to invest the resources necessary for the latter objective. The de facto consequences of abortion laws are that they shift the method of abortion — from the official to the illegal, and, at times from the illegal termination induced by a doctor to one induced by a quack. They are powerless to do anything to deter self-abortions. They are powerless because in order to make even an attempt to do so seriously the government would have to set up a huge apparatus of control, maximize the number of informers, break down all notions of privacy and impose the most severe punishments on women.

In most countries there is not even an attempt to prosecute the woman, or where there is one from time to time — as in France — the woman is let off with a suspended sentence. Self-induced abortions, whatever the formal legal position, are hardly ever treated as criminal or illegal activities.

2. Those who stand for the status quo are on the defensive. The mass media, especially television, are increasingly in sympathy with reform arguments and attitudes. No major or even minor interest group these days advocates that laws against abortion should be strengthened. The polls and surveys do not usually ask questions about tougher law enforcement let alone about tougher laws. These have been excluded by tacit consensus as serious alternatives from the spectrum of possible public policies.

3. The gentlemen's agreement between the police and those abortionists who are registered medical practitioners of course breaks down from time to time — when there is a death, or when someone decides on a blitz. But it is the norm and of very long standing. It cannot be entirely explained in terms of corruption. In part, it means that under-staffed police forces put the "suppression of abortion" very low in their order of priorities, if it figures there at all.

4. The most recent battle over reform was in England. The specifically Catholic bodies were unable, and some of them were unwilling, to mobilize much support. At a late stage a counter-organization to combat the activities of ALRA — the Abortion Law Reform Association — was set up. It was SPUC — the Society for the Protection of the Unborn Child, christened the Society for the Propagation of the Unwanted Child by its critics. It was able to attract a few MP's and a handful of prominent gynaecology and obstetrics professors. There are three relevant points about SPUC: (a) From the start it excluded Catholics from its Executive, i.e. the moral theological arguments were seen as a political handicap. (b) It went for a Royal Commission, but it did not oppose Steel's bill completely, nor was it opposed to all abortion. (c) It had the support of the (London) Daily Telegraph and partial support from The Times, but no other papers.
One may argue about the language which Cardinal Heenan used to describe the facts, but not about the empirical content of what he said:

“There has been a tremendous decline in the acceptance of the moral law. Who would have believed it possible even 10 years ago that in England an abortion bill will go through almost unchallenged? How strange if only Catholics were to stand up for the sanctity of life in the womb — as if being against abortion is, like fish on Fridays, something odd the Catholics go in for.”¹

5. Those who, like catholics, are opposed to all direct abortion, have lost out long ago. In most countries abortions to save the life of the mother can be performed. Yet, not so long ago this and the alleged mother vs. child dilemma were the centre of the debate. Then there began a shift towards discussion of indications for abortion in terms of “mental and physical health”. From the 60’s onwards — Thalidomide, Finkbine case — the “deformed fetus” and “rape” began to be discussed more frequently. The narrowly medical indications began to decline. Catholics who had always maintained that many of these operations were not necessary on purely medical grounds had a very hollow victory — for the psychiatric indications began to be fashionable.

6. However, the most important behavioural indicator towards attitudes to abortion can be inferred from what has not happened about IUDs — the Intra-Uterine Contraceptive device, which comes in the shape of quite pretty loops, bows and rings. Since 1966 IUDs have begun to be used with some frequency especially in underdeveloped areas. By 1967 there were 3 million insertions in Asia, 100,000 in the Middle East, 150,000 in Latin America. The percentage of married women, aged 20—44, with IUD inserts was: South Korea 17%, Taiwan 13% and Pakistan 3%. (IUDs are less safe than the pill, with about 2—3% of pregnancies within one year; retention rates after two years varied widely — from 43—65%).²

By 1968, two million insertions had been made in India, and the most authoritative estimate of global insertions was “probably between 6,000,000 and 8,000,000 [women], or nearly one half the number of women currently using oral contraceptives”.³ So far most of the research on the method of action of IUDs has been on animals. At present it is stated to be “unlikely that one mode of action or one particular effect will be found common to all.”⁴

1. Catholic Weekly, 23.6.1966. I have not seen any detailed summary of the struggle around the English bill, but the earlier stages are well covered (in terms of pressure group analysis) in John Barr. “The Abortion Battle”, New Society, 232, 9 March 1967, pp. 342—46. Perhaps the best indication of the weakness of the opposition can be gained from the fact that its leader, Norman St John-Stevas did not even try opposition in principle. He wrote that opponents of the bill “have made it clear that they would welcome a moderate, well drafted reforming statute, based on full knowledge of the facts.” Letter in Times 11.7.1967.


4. Ibid.
There is no agreement on how the IUDs work, and that depending on highly technical disputes as to technical—not popular—definitions of “conception” and its relationship to nidation, it is possible to argue that IUDs should be classed as abortifacients rather than as contraceptives. It is also possible to argue that whether the conceptus is destroyed before or after nidation is morally irrelevant and that if IUDs cannot be classified as abortifacients then they should be seen as “devices destructive of the conceptus and thus involving the moral malice of abortifacients.”

However, the Catholic Church to my knowledge has not made an official statement on the point and there has been no major organized campaign by Catholics against IUDs as (being equivalent to) abortifacients. Such a campaign presumably would have to centre around the notion that in addition to the 25 million or so global abortions per year, which are seen as feticides, there now exist some 6 million women who go in for feticide every time they have intercourse, during which they would otherwise conceive.

The absence of a major campaign in the popular Catholic press seems to me highly significant. It foreshadows what will happen if and when the (infamous) post-coital pill becomes available. In other words, moral positions are rapidly being undermined—so far as their impact on behaviour is concerned, at the very least—by technical developments.

All this means that the opposition to abortion is being constantly weakened.

RATIONALITY

The history of abortion, of comparative legal and religious attitudes toward it, and of the abortion-law reformers remains to be written. To be of real value, it would have to be considered in connection with the history of infanticide. Leaving aside here the question of moral distinctions between the two, if any, the point is that at least in some societies it might be profitable to extend the “backstop” analysis to infanticide: abortion can be viewed as a “backstop” when contraception does not take place or fails; infanticide might be worth analyzing both as an alternative to abortion and as a “backstop” when abortion is not available or when it fails. Thus in some countries for some periods an analysis in terms of substitutions might be profitable. Two of these might be Japan and Australia: in Japan at least part of the recent story is one of legalized abortion being forced on the government and part of the explanation of its widespread acceptance would possibly lie in its replacing infanticide which historically was widespread. (To a much more limited extent this may also apply to Poland.) In Australia, there are gruesome stories of infanticide and of baby-farming, especially towards the turn of the century. As far as I can see at the moment from about the 1880’s onwards illegal abortions were in fact partly substitutes for infanticide.

5. As the F.D.A. report puts it coyly: “Adequate data is still unavailable to answer several basic scientific and clinical questions related to the intra-uterine devices. Research support should be provided as follows: 1) to elucidate the mechanism of action of the intrauterine devices...” Ibid., p.15.

These are admittedly very speculative remarks. To return to my theme: I would like to suggest that, if we are willing to assume that the acceptance of moral codes is shaped in major ways by social development, we can begin to understand why the traditional Catholic code has been unable to fix actual behaviour, why its acceptance has declined. I am speaking here only of a very small part of the globe, i.e. developed societies. I do not know enough of the history of the others to say anything useful about them on this point.

My hunch is that we might look for a major part of the explanation — there won't be such a thing as "the explanation in terms of a single factor — to Max Weber's concept of rationality as a major distinguishing characteristic of "modern" society. Weber’s notion of rationality is very complex. For our purposes we need a rough-and-ready concept of heuristic value. We can, being quite loose and being deliberately so, here think of rationality as any calculating approach, concerned with costs vs. benefits, and hostile to the unplanned, the arbitrary and the unpredictable.

The ideology of the birth control movement as it emerged from the 1880’s onwards fits well enough into a rationality map. It spread from the middle and upper middle to the working class. It was closely tied to the notion of controlling one's (family) environment. Its characteristic emphasis was control of the consequences of reproductive behaviour by mechanical means. These means were assessed by such criteria as efficiency, cost, failure rates per woman-hour, investment of motivation which was required, etc. Given ambitions about raising living standards, no amount of hostility by the medical profession and of horror stories about the disastrous medical effects of birth control spread by doctors7, nor of opposition by Church and State8 seem to have been able to affect the direction of the general trend — which does not mean that they had no effects on its speed or its mode of manifesting itself in behaviour.


8. In very different vein: John T. Noonan, Jr., Contraception: A history of its treatment by the Catholic theologians and canonists, Cambridge, Mass. 1965: Peter Fryer, The Birth Controllers, London 1965. Noonan's book is a superb piece of work and a model of historical writing, its treatment consistently includes social data and it is much more exciting and of much greater general interest than its subtitle would suggest. If I had to name one work which shows how the history of such a topic should be written, it is Noonan. Fryer is a well documented good journalist's job, and full of curious. I do not know of any work on the history of the positive law which is comparative. For England, see Bernard M. Dickens, Abortion and the Law, London 1966; for a symposium on current legal and medical and theological views, see David T. Smith ed. Abortion and the Law. Cleveland 1967; for a Catholic view which includes extracts from early legal codes — rather selective and with superficial comment, but handy — and an excellent 80 page appendix (in part II.) of 'Statutory materials on abortion — the United States and its territories'. see Eugene Quay, "Justifiable Abortion — Medical and Legal foundations", The Georgetown Law Journal, 49 (2), Winter 1960, pp. 173–256 and 49 (3), Spring 1961, pp. 395–538, published in book form by the N.C.W.C. Washington. The single most convenient summary (in German) of the formal legal position on abortion in Europe, with major extracts from the relevant laws, is: Herbert Heiss, Die Abortsituation in Europa und in aussereuropaischen Landern. Stuttgart, 1967 which also summarizes the data re numbers, morality, morbidity etc.

For anthropological data showing the almost universal prevalence of abortion, consult: George Devereux, A Study of abortion in primitive societies, New York, 1955; George Murdock, Social Structure, New York, 1949; Clellan S. Ford and Frank A. Beach, Patterns of Sexual Behaviour, New York 1951.

There is then a basic clash between a moral code such as the Catholic one which proceeds from the assumption of fixed moral natures, i.e. acts which are, by their very nature and without reference to their consequences good or evil in themselves and a society in which a calculus of consequences is a major strand.

Once individuals go in en masse for a calculus which ends with the conclusion that under some circumstances abortion is "the lesser evil" then, empirically, if you wish to minimize abortions you must discover the factors which determine their calculus, or if you like their preference curves. Now whatever those opposed to changes in abortion laws and interested in the primacy of the moral point of view, as they see it, have done this is one thing they never have done. The various proposals for "doing away with the conditions which lead to abortion—seeking" — ranging from tougher laws to increased family allowances — have not been based on any serious research as to the determinants of sexual behaviour. By and large there has been exhortation on the one hand and a priori assumptions as to disincentives and deterrents on the other. I am, of course, not suggesting that this field is the only one in which this has happened. (cf. the changing evaluation of imprisonment.)

It is not always unfair to cite "extremist" statements for at times they bring out the character of a doctrine much more clearly than more moderate or less crudely phrased ones. My present central point — that the total prohibition of direct abortion does not leave room for a calculus of any kind, or, perhaps put better, does not allow for the concept of "cost" at all — can be illustrated by Catholic statements of this kind:

"An innocent fetus an hour old may not be directly killed to save the lives of all the mothers in the world." 9

Or: "It is preferable by far that a million mothers and fetuses perish than that a physician stain his soul with murder." 10

I do not wish to assert, a priori, that the approach to abortion in terms of its being an inherently evil act can have no impact on behaviour. But it would be extraordinary, granted my assumption that what types of morality people accept must be explained in terms of social and cultural factors in their environment, if such a possible impact were widespread in developed societies. Industrialization — Marx made this point long ago, but thought it was uniquely tied to "capitalism", which it is not — tends to dissolve fixed and static relationships and concepts. As an influence on behaviour, theories based on moral natures of acts per se might be relevant in other kinds of societies. Thus I am told that Ireland is fairly free from abortion. If that is so one should investigate the facts to see what the special conditions under which Catholic moral theology is empirically relevant as to abortion-behaviour might be, and to see whether the Irish case is in fact an example of such possible relevance.


From the angle of a social scientist, then, the key question is not so much whether it is philosophically possible to divide acts into acts, consequences and circumstances 11 nor to propound a philosophical critique of the more subtle aspects of catholic position. Its complexities — the distinction between direct vs. indirect abortion, the relevance, if any, to the abortion issue of theories of mediate vs. immediate animation, the issue of ectopic pregnancies, or the status of terata (monsters) 12— need not concern us here at length.

Only two comments about them: First, I cannot recall any specific discussion of self-induced abortion which is of course one of the most frequent methods, especially among the poor, in the works I have read which are largely those intended for priests or Catholic doctors. This is one indication of the gap between mass behaviour and the way trained men


12. For a useful summary of the most frequently cited statements by the Sacred Penitentiary and the Holy Office, the Encyclical of Pius XI and the two allocations of Pius XII, see T. Lincoln Boucaren ed. The Canon Law Digest, vol. 3, Milwaukee 1953, pp. 669—70. The brevity of the early statements, between 28 November 1872 and 5 March 1902 is striking, as is the gap between 1902 and the Encyclical of 1930. Vatican II refers to matter only in passing: “...From the moment of its conception life must be guarded with the greatest care, while abortion and infanticide are unspeakable crimes.” Walter M. Abbott, S. J. ed., The Documents of Vatican II, London 1967, P. 256.

For texts on medical ethics, see e. g. McFadden, op. cit.; Edwin F. Healey, Medical Ethics, Chicago 1956; Austin O'Malley, The Ethics of Medical Homicide and Mutilation, New York 1919, esp. chs. 3, 5; and G. Kelly, Medico-Moral Problems, St Louis.


I am indebted to Fr. Paul Duffy, S. J. for references and for giving me access to the library of Canisius College.
visualize it which is so very typical of professionals, whether Catholic or atheist. Second, if the Catholic Church should ever want to move away from its complete moral prohibition of all direct abortion — I am not suggesting that it will do so, nor even that it should do so — it would not be hard to make the necessary distinctions. They could then rest, perhaps, on the distinction between mediate and immediate animation. Very crudely and inaccurately: the Church has always been against all abortion, but it used to make a distinction between stages of the development of the fetus which in turn was tied to theories about the precise moment of animation. The non-animated (unformed) fetus was distinguished from the animated (formed) fetus for most of the history of the matter so far as the gravity of the offence and the penalties, censures, and irregularities incurred were concerned. (This was not the case between 1588—1591.) The relevance of the distinction began to disappear after 1869 and it is now considered irrelevant by nearly all theologians so far as its possible effect on the (il)licitness of abortion are concerned. But Fr. Donceel claims that a "slowly growing minority" rejects the standard view. It would be possible to move towards a different and more permissive attitude towards abortion, but, if tradition is to be invoked, only in the first six weeks. If this ever happened — it would bring the Catholic position somewhat closer to that of Islam. For Islam, contraception has always been licit, and the vast majority of its theologians and canon lawyers take the position that abortion up to the fourth month is also licit.

Whatever future developments, it is safe to predict that the idea that the application of the "natural law" is simple will decline. There are already straws in the wind that this is so.

It is also possible that the whole way we look at this issue will be radically changed if a cheap and safe "abortion pill" becomes available. This would (a) considerably reduce the role of doctors and (b) make it impossible to assert any kind of legal control which was effective. It would of course be possible to legislate against such pills, but given that they are safe and cheap, and that not all countries would do so, this would merely mean the creation of smuggling and a black market.

13. Donceel (see note 12) at p. 167.
14. Olivia Schieffelin (ed. and comp.), Muslim Attitudes towards Family Planning, New York 1967, pp. 4, 6, 8, 12, 43, 50, 77, 103, 132, 133. But Al-Ghazzali, considered by some Islam's greatest theologian, seems to have condemned it from the moment of conception while yet also distinguishing between "grades of existence" of the fetus which he correlates, in four stages, with increased degrees of iniquity involved in abortion. ibid., p. 58.
15. "In the light of the moral law, the simplicity of the matter [direct abortion] leaves little more to be said." Charles McFadden, Medical Ethics, 5th ed., Philadelphia 1961, p. 135.
There is the whole area of the distinction between legality and morality. I must resist any temptation to traverse this here. It is sufficient to point out that in this field Catholics have much more room for immediate flexibility. As far as I am aware there are a number of statements by people in authority as to what the attitudes of Catholics and the Catholic Church towards legislation of this kind should be in a pluralist society. But there is nothing, to my knowledge, which could be called an “official” position. If correctly reported in the press, the position of the Rev. Robert F. Drinnan (a Jesuit priest who is dean of the Boston College Law School) during an international conference on abortion in 1967 may become more representative than it would seem now. Father Drinnan “suggested that a better solution might be to repeal all laws prohibiting abortion in the first 26 (sic) weeks of pregnancy. After that period of gestation, he said, the law should consider a fetus viable and interference with it homicide. This would avoid giving the state the power to permit selective destruction of life, which he said has been done for the first time in Anglo-American law by states that have adopted the model penal law code of the American-American Law Institute.”

Status of the Fetus

I have said nothing so far as to whether the fetus is or is not a human being from the moment of conception. Although Catholics attach central importance to this point I do not think one can say much about it. It seems to me a conceptual issue and anyone even vaguely familiar with the long and unsettled dispute in philosophy over the status of “being”, “individuals”, “persons” and so on will know that there is no chance at all of this issue being “settled”. To settle it one would first have to agree as to which type of philosophy is to be “decisive” and such a notion seems to me plainly absurd.

We can use a number of definitions, and I will cite later the two surveys I know of which show how some people answer this kind of question and make it clear that there is no agreement. We can and do use different criteria. It seems self-evident to me that if you are opposed to abortion law reform and believe the status of the fetus from the moment of conception is an important or even crucial part of your argument, you will choose appropriate criteria which make the fetus, by stipulative definition, human from the moment of conception. The same will happen for other positions – you will pick other criteria. So the rabbits are put into the hat first and then pulled out and this seems to me the case for any of the widely different possible definitions.

17. New York Times 8.9.1967. cf. “The only alternative for those who desire to change America’s present abortion laws is to have existing abortion laws repealed”, he [Drinnan] said, adding that “such a repeal would not mean that the state approves of abortion but only that it declines to regulate it.” But he suggested that legal protection viable fetal life could be asserted after the pregnancy passes the first 26 weeks. Removal of the question of abortion from the law, he argues, “neither concedes nor denies to individuals the right to abort their unborn children. It leaves the area unregulated in the same way that the law abstains from regulating many areas of conduct where moral issues are involved.” Detroit Free Press 8.9.1967, cf. Newsweek 18.9.1967, p.69.
It is sufficient to point out that if we consider the fetus as human from the moment of conception, very little is in fact resolved. It certainly in no way follows that if we kill it, as we do in abortion, we therefore "murder" it. "Murder" is a moral or a legal or a moral and legal term and there is nothing whatsoever from stopping us from making the standard discriminations between murder, manslaughter, justifiable homicide etc.

Moreover, there are all kinds of other decisions we must make about whether a fetus is capable of having legal rights, and if so, which; about whether it is capable of having moral rights, and if so, which; about how we can resolve the clash between its rights and other rights we might care to specify, and how to decide how wide the range of holders of these other rights should be.

One can empirically determine by survey, how the term fetus is used and what given groups assert as to when its life as a human being starts. No representative study on this exists, but there is an exploratory one. Seventy-six graduate students in public health, from 7 special public health fields, were surveyed. Fifty-six were Americans, 35 were men and 41 women. Open questions and probing were used, answers were coded independently by two researchers. Significantly, one response, that of a Buddhist, proved uncodable – he saw life as a continuity, with no "beginning". The sample was about evenly split between those who thought a human life begins before and those who thought it begins after birth. Just above 1/3 thought it began at conception.

<table>
<thead>
<tr>
<th>&quot;When does a human life begin?&quot;</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Before conception</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>At conception</td>
<td>27</td>
<td>35</td>
</tr>
<tr>
<td>During the 1st trimester</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>During the 2nd–3rd trimester</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>Before birth —50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>At birth</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>At viable birth</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>Sometime after birth</td>
<td>13</td>
<td>17</td>
</tr>
<tr>
<td>N. A., uncodable</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>76</td>
<td>100</td>
</tr>
</tbody>
</table>

The respondents were asked to give their reasons for holding these beliefs. These were much of the same kind as I have found by informally asking this same question around Sydney. I reproduce only the most extreme position at the upper end of the scale, for this a human life begins sometime after birth. "1. When it starts to recognize and respond to environment. 2. When it takes on recognition, relates self to environment. 3. When it starts to develop personality, becomes socialized. 4. The soul enters the body sometime after birth, and it becomes human. 5. Within the first 24–72 hours after birth; when it can live independently of mother and of artificial supports."
Two-thirds were very or fairly confident of their position, 1/3 showed considerable uncertainty. There was discussion of the characteristics which subjects considered most significant in defining the growing new life as a human life. Foci of primary and secondary definitions were extracted, and abridged, they are: 1. Spiritual or religious. 2. Biological growth process. 3. Identified by others. 4. Psychological growth process. 5. Independent existence. 6. Interaction with others. 7. Personal and social characteristics. These foci were then related to the beliefs re the beginnings of life. As expected, those who used spiritual or religious definitions (a minority) tended to place the beginning of life earlier than those who employed psychological, sociological, or cultural definitions. Biological definitions were spread, with some stress on the early point of the scale.

Religion was closely correlated with definition — the major splits being as follows: When the data were simplified between human life begins “sometime prior” vs. “at or after” birth there was a fairly clear gap between Catholics, Fundamentalists, and Moderates on the one hand versus Liberals, Secularists and Jews on the other. However, if one looks at the list of all six alternatives within the scale this gap, though it still exists, becomes much less and disagreement within a given religion increases sharply.

Women tended to believe that a human life begins at an earlier point than men, and focus more on biological growth. Only men picked independence from the mother, personality, or sociocultural definitions.18

If we had comparative national surveys of this kind combined with intensive studies at the micro level we might be able to make some progress on the empirical issue: What, as a matter of fact, is the relevance of holding given beliefs about (the beginning of) human life to (a) abortion behaviour and (b) social behaviour?

We have no data on this at all. If we hold other factors constant would we find that women who believe that human life begins with conception have fewer abortions than those who do not? No one has any idea. It is of course, since this debate is strongly ideological, possible to find data or alleged data that Catholics have pro rata higher abortion rates than non-Catholics. I do not produce them here since they are based on very peculiar or no sampling, and, more important even, none of them has tried to hold all other factors apart from Catholicism constant i.e., if they’re worth anything, which I doubt, they might merely be disguised data as to social class or disguised rural-urban differentials.

The sanctity of life

This argument can, like any other, be put in a stupid form so that a single abortion somehow triggers off a radical fall in all-round respect for life. But it need not be put this way. We can cast it in the form of a probability statement: An official sanctioning of abortion — and I would accept on this subject the hidden premise that if governments permit abortion many people will conclude that they are not immoral — would increase the probability that moral inhibitions against the destruction of other forms of life for reasons of convenience would decline and would, in the long run, decrease the legal protection afforded to such forms.

If this were the case would it be a strong argument against more permissive abortion laws? This would depend on what kinds of moral prohibitions were in fact undermined, if any. If it were true that a given legalization of abortion made legalization of euthanasia much more likely this would not count as a good strong argument with many. (An unknown proportion of those who favour one also favour the other.) But say it could be shown that respect for all forms of human life were strongly affected or that there is a reasonable probability that it is likely to be. Say we concluded that infanticide of healthy children would increase or was pretty likely to do so, or more generally, that the murder rate of adults would go up this, surely, would be a very strong argument against liberalizing abortion laws.

I have never seen any evidence that this would happen or is likely to do so. Most of the time, what is said simply assumes the issue in question has been settled; it assumes not only that various kinds of what is called "murder" are morally equivalent but also that they will be perceived as such, and that people will act on this perception.

At the crude debating-point level simplistic assertions can easily be met with equally simplistic replies. There is no obvious correlation between indices so that a "soft" abortion policy entails or is empirically highly correlated with less respect for life, while the opposite holds for a tough one. Stalin's reversal of the permissive abortion policy of 1920 came at the time of the great purges, in 1936, and the 1955 reversal to great liberalization came at a time when there was more "respect for life". Abortion was made a capital offence in Nazi Germany in 1943 and in Vichy France — a woman was hanged for it in 1943.

At a more respectable intellectual level, take the most striking example of how complex real life is and how the dogmas of religion and of standard progressivism fail to note this. Read, re-read and ponder this extract from page 9 of the official Yugoslav Health Workers' Code of 1964:

"A health worker should regard abortion as biologically, medically, psychologically and sociologically harmful. Corresponding to the principle of socialist humanism and medical knowledge, human life must be respected from its beginning. Therefore the health worker should consciously endeavour to see that the true humanistic privilege of maternity be valued above the privilege of abortion. His profession of health worker obliges him to seek in every individual case the type of professional aid which will best help the situation of the wife and the family. At the same time his profession charges him to strive for such conditions in society that abortion, because of planned parenthood, becomes unnecessary." 19

It is thus quite possible to (a) consider abortion harmful in all its aspects, (b) maintain that "human life must be respected from its beginning" and yet (c) accept what is considered as a transitional abortion policy as the lesser evil.

19. M. Hren, J. Herak-Szabo and A. Mojic, "Abortion in Yugoslavia within the Framework of the Themes of the Conference", in: Sex and Human Relations, Proceedings, Fourth Conference of the Region for Europe, Near East and Africa of the IPPF. International Congress Series No. 102. Amsterdam 1965, pp. 89—92, at p. 91. Emphasis supplied. In Yugoslavia punishments for women who had abortions were repealed in 1951, and the law was liberalized, to a limited extent, in 1962 and to elective abortion in 1960 — a commission calls attention to contraception. In 1964 there were 37 legal abortions per 100 live births (150,000 abortions) and another 50,000 hospital abortions.
The question Catholic moral theologians and others have asked seems to me most important, and it can be asked in such a way that no assumptions which are specific to a given creed are smuggled in from the start: What, as a matter of fact, can we ascertain about the causal effects of illegal as compared with legal abortion on those forms of "human life" about which we can reach agreement that they are to count as forms of human life? Such would be my preliminary formulation.

On this point, the standard progressives are much more to blame than are the Catholics or others who prefer to think in mainly moral terms. True, Catholics have not done their homework — they have not formulated their objections clearly, nor have they stated what they would accept as evidence which they would accept as refuting them. But in their defence it could be said that if the issue is to be cast in empirical terms it falls outside the province of moral theologians — though not of sociologists who happen to be interested in moral issues, whether they are Catholics or not. However, it is the standard progressives who here have fallen flat on their face. For the Catholic point can, quite clearly, be rephrased in such a way that anyone who works in terms of costs vs. benefits would have to take it seriously into account. It seems to me quite obscurantist on the part of people claiming to be empirically minded that they should casually dismiss this issue. It is a point which might very well lead to a major entry on the "cost" side of the balance sheet. Take the nearest analogy — divorce. It's of course true that divorce has not "destroyed" marriage as a social institution but would anyone seriously claim it has had no major and discernible effect on various aspects of marriage? So, I would think, with abortion: I find it very hard to take the scare debating points seriously — but then many a post Vatican II Catholic would not, either: "The emotional argument that abortion will necessarily lead to mercy-killing, or euthanasia, is faulty". 20

But I find it just as hard to believe that legalizing abortion would have only effects I'd approve of or would have no major social effects at all.

Dangers

An argument which is pretty frequent and which, though in no way specifically Catholic, is at times used by some Catholics is the point that reformers have allegedly vastly exaggerated the danger of illegal abortions, and, that if this is so, it weakens the case for legalization. It is of course true that in such an emotional debate "horror" stories a-plenty are part of the currency. I for one cannot assert that one side is much better than the other. As to the problem as such: not all reformers rest their case on the danger point; it need not be a part of their argument, though it often is. On the

20. "Thinking of Abortion?" Reign of the Sacred Heart 32 (12), December 1966, pp. 20—21. In spite of its brevity this is a very suggestive and worthwhile piece — it seeks some clues to the question raised by the Rossi study why most Americans including most Catholics, favour some form of legalized abortion. It wonders why the American bishops have not made "a relevant statement — which would go beyond" the customary 'thou shalt not' by proposing a rational frame, in contemporary language, within which the moral issue could be discussed and understood. But on second thoughts we are unwilling to blame the bishops for any current lack of guidance. Moral theology has not done the homework which must precede any worthwhile statement". (p.21) It then drops the standard term of "murder" in talking about abortion and makes some tantalizingly brief suggestions as to why this "killing process" is "made acceptable" for many people. This type of enquiry, which does not beg the question from the start needs encouraging. So does discussion of Catholic views on the legality of abortion. See Michael Deakin "Catholics, Abortion, and Pluralism", Catholic Worker, 386, June 1968, pp. 9—11.
factual issue, there are clearly huge differences between countries — what is true for Chile (five times higher chance of dying from an illegal abortion than a normal childbirth) or for Turkey (where 10,000 mothers die every year through illegal village abortions and the maternal mortality rate through abortion in Ankara is 5.7%, with 27% of those aborted becoming sterile) need not be true of Australia. For N.S.W. (1964), when criminal abortions accounted for 5 of the 28 maternal deaths, it has been estimated that the death rate from criminal abortion is about 0.3 per 1,000 abortions, “compared with a rate of 0.28 per thousand deliveries excluding criminal abortions.” If so then “in this state criminal abortion is not a lot more dangerous than allowing pregnancy to terminate naturally.”

I cannot accept the “danger” argument as a worthwhile one either for or against legalization, unless it be made part of a general proposition and comparative data on other operations are given. If this is done, and the general principle of the role of the state in relation to medical dangers is stated clearly, one might consider it a relevant argument.

**Promiscuity**

The argument that legalized abortion would “encourage” promiscuity seems emotionally effective while being utterly worthless.

As a moral argument it is immoral and despicable since it appeals to nothing but fear. Unless it is meant to assert that legalized abortion would encourage both pre- and extra-marital intercourse, it is irrelevant for married women who of course — at least in developed countries — form the vast majority of those seeking and having abortions. If taken seriously, it would be a much stronger argument against permitting contraceptives even for the married lest they “encourage” promiscuity. Moreover, the argument assumes that no moral distinctions can be made between types of pre-marital and extra-marital intercourse, a position on which there is much less consensus than there used to be.

The argument is a very bad one, which might account for its frequency and its powerful appeal.

**The Doctors**

My hunches about doctors are extremely speculative and are based on what seems to be common to them as a group regardless of whether abortion is legalized as in Eastern Europe and the USSR, or partly permitted, with crucial bureaucratic restrictions, as in Scandinavia, or largely illegal, as in Australia. (I have not been able to get anything on Japanese doctors so far.)


It may be useful to recall the global position in the early and mid 60's. The figures are, of course, guesswork but generally accepted.

**Global abortion position – 1960’s 23**

<table>
<thead>
<tr>
<th>A. Total abortions p.a.</th>
<th>approx. 25 million of which</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Illegal abortions</td>
<td>approx. 17,428,000</td>
</tr>
<tr>
<td>C. Legal abortions</td>
<td></td>
</tr>
<tr>
<td>(a) Eastern Europe, Scandinavia and Japan</td>
<td>approx. 1,753,000</td>
</tr>
<tr>
<td>(b) U. S. S. R. (1958–59)</td>
<td>approx. 5,829,000</td>
</tr>
</tbody>
</table>

In undeveloped countries, especially Latin America, the ravages are incredible. The best studies exist for Chile – though even there only based on those who come to the attention of hospitals, maybe 40% of all abortions: 50% of women surveyed had had abortion; of these 75% had had three or more, with the highest incidence amongst the poor marrieds aged 25–29 with 3–4 living children. Abortions done by midwives (about 46%) had a 46% complication rate, self-induced ones (about 25%) one of 66%. Death from an illegal abortion was four or five times more likely than that in childbirth. Material mortality due to abortion accounted for 40% of all material deaths – it was 111 per 100,000 (vs. 0 – 3.4 per 100,000 legal abortions in Hungary, Czechoslovakia and Bulgaria, 1959–1964). 24

It is not possible to argue that medical warnings have no effect since there is no control group of warned vs. unwarned. However, it is hard to see them as a serious deterrent – women persist in having abortions and in self-induced ones with gruesome instruments even where mortality is very high.

In part, sections of the medical profession and the public health people have simply overplayed their hand, especially in countries where de facto dangers are much less. By giving the impression that illegal abortions must be death dealing they have opened the door to the argument from personal acquaintance based on a single case: "She seems all right, so why shouldn’t I be.” In part they have not done much to popularize concepts such as morbidity, nor have they managed to reach consensus on relative dangers. There is no agreement in the literature on how, in a given country, legal or illegal abortions compare in terms of various dangers with other operations or with childbirth.

Moreover, what is perceived as a relevant risk depends of course on what you’re aiming at and the medical costs of abortion must seem quite different to a determined and desperate woman than they would be to a male doctor.


2. There has been much too much concentration on the exceptional cases — rape, incest, a possibly deformed fetus, danger to life. By now four American states — Colorado, North Carolina, Maryland and California — have passed more permissive laws on abortion, all based on grave impairment of physical or mental health of the mother, substantial risk of grave physical or mental defect in the child, or pregnancy resulting from rape or incest. These are based on the 1962 model code of the American Law Institute. But it has been estimated that if similar laws were passed in all American states — 25 were considering reform in April 1968 — only 15% of those abortions now performed illegally could then be performed legally. Besides, a legal abortion costs round $US300.

BIRTH CONTROL

Nor does the spread of contraception offer, as many birth-controllers used to hope, an immediate “solution” to the abortion problem. There is increasing agreement that the earlier ideas of how contraception would spread and how successful it would be are simplistic — they tended to neglect issues of motivation. Work by Lee Rainwater and Stycos or Kingsley Davis has shown that cultural factors are of great importance. There may or may not be a “culture of poverty” but there is a “culture of contraception” — a point made many years ago by the French Catholic, Fr. Lestapis. (He derived its structure from a priori views and got it nearly 100% wrong but still ought to get credit for the idea.) Generally speaking the point I made earlier in this paper about rationality seems to be correlated with social class. The poor, those in rural areas, and those discriminated against on grounds of colour are less likely to behave in a rational manner — in the sense I’ve used the term — than the relatively well off. This is a function of their environment, one in which they are, and feel themselves to be, the playthings of fate and in which they have, and feel they have, very little control over what happens to them. I would like to suggest that, just as in the field of political science, we have found a close relationship between political apathy and feelings of powerlessness so a similar relation exists in the field of the control of the consequences of reproductive behaviour.

How far away we are from eliminating all “accidents” and making, as the cliche goes, “every child a wanted child” can be gauged from a report of the latest survey by two leading US specialists, Professors Norman Ryder and Charles Westoff. It shows that “of all the American couples who intend to have no more children only 21% can be said to have enjoyed complete success in controlling fertility”.

A Protective Screen

It would be foolish to blame doctors for concentrating, in so far as they are interested in the abortion issue at all, on the exceptional cases. The same point can be made about social workers who love the marginal “interesting” case but are reluctant to say or do much about those who are just plainly poor, or about academics who are willing to spend a good deal of time with students “in trouble” but not do very much with the general run-of-the-mill student. We are all in the same boat here: the concentration on the exceptional, dramatic and “hard” case acts of course as a protective screen. Through selective perception we screen out the impact of the general mess and keep our peace of mind or, if you prefer, cognitive balance.

Elective Abortion?

So it is hypocritical and smug to point the finger at doctors and ask them to “face the real issue” — the plain fact that the huge majority of women who want an abortion, 85% if the US guess can be generalized, have none of the standard “indications” but simply do not want the child. This became clear to me after reading my first few dozens of books and papers in this field — just how many rapes leading to pregnancy were there — the chance of a single act ending in pregnancy being between 1:25 and 1:50 according to Tietze. How frequent was incestuous intercourse leading to pregnancy, and so on?

To face the fact that this is the key issue about abortion is extremely uncomfortable to say the least, and it is only in the last two or three years that this point has started cropping up in the literature of the “respectable” reformers. Till then it was very much a point made by people dismissed as outside the pale. However, I am pretty sure that this point — the “right to have an abortion”, the agitation for the abolition of all laws prohibiting abortions — can no longer be treated as marginal. At the September 1967 three-day international conference on abortion, which had all the “right” status symbols — jointly sponsored by the Joseph P. Kennedy Jr. Foundation and the Harvard Divinity School and held at the Washington Hilton Hotel — Professor Louis B. Schwartz of the University of Pennsylvania Law School, who helped to draft the A.L.I.’s model penal code put this rather coyly when he said that adoption of the code “will not solve all the problems. Most abortions are sought by married women who may have a number of children and want no more, or by unmarried women over the ‘age of consent’, or by married women who find themselves pregnant after the husband has deserted them or been killed, where the prospective mother faces the prospect of raising a fatherless child while working for a living.”28 Professor Schwartz, it will be noted, starts with the main group but immediately proceeds to “hard cases” to minimize the shock. Dr Christopher Tietze, of the Population Council, who is generally considered as the top Western expert in this field — Professor K. H. Mehlam being the “Eastern” one — was more direct when he said that “the vast majority of illegal abortions performed in the United States involve a healthy woman wishing simply to head off an undesired pregnancy.”29

29. Ibid.
There are very few things about abortion I feel can be stated with a great degree of certainty, and simply — this statement is one of the few and I am quite sure that it applies to this country. We do *everything* to hide this by thinking and writing in terms of all possible "indications" for abortion, from rape to socio-economic indications, all indications *except* that of: "I do not want to bear this child". The reason is of course that, especially since most of debate is conducted by males, we feel that there must be some complex "justification" for such a desire, that the preference as such is not sufficient.

Yet the whole issue of elective abortion will come to the fore. Earlier this year the American Civil Liberties Union adopted elective abortion — usually known as "abortion on demand" — as its policy and listed five civil liberties which, it believed, all abortion laws violated. Since this statement, though brief, is the best summary of this kind of approach and since the magazine which reprinted it 30 is not widely known in Australia, I reproduce it as an appendix to this paper.

Doctors have a fairly easy way of screening out the issue of "social abortion", let alone of elective abortion: they can adopt a narrow definition of "health" e.g. the Oxford Concise one of "soundness of body" rather than go for the broad W. H. O. view of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". The narrower one's concept of health and of medicine, the easier it becomes to see demands for social and elective abortion as an *intrusion* on one's proper field of work.

30. *Current*, May 1968, pp. 26—28. In the same issue (pp. 28—31) an article by Dr Alan F. Guttmacher, president of Planned Parenthood — World Population and Visiting Professor of Obstetrics and Gynecology at the Albert Einstein School of Medicine is extracted (from his "When Pregnancy Means Heartbreak", McCall's, April 1968). His essential points are: 1. Abortion on demand would "vastly reduce the army of neglected and rejected children", cut by half the 300,000 illegitimate children born in US each year. It would cut shotgun marriages which contribute heavily to the high divorce rate among teenage brides. 2. It would almost eliminate illegal abortion "and thereby in large part get rid of one of the many flagrant practices that foment disrespect for law. It would also reduce social, economic, and ethnic discrimination in an important segment of medical care and protect the life and health of hundreds of thousands of women each year." In Hungary and Czechoslovakia "legal abortion imposes one-twentieth of the maternal hazard of childbirth. Deaths from illegal abortion have declined over 80 per cent in Hungary since the institution of abortion on demand . . . ." 3. It would cut the US birth rate (18 per 1,000; population growth down from 1.7% in 1957 to 1%) and in terms of "air pollution, water contamination, urban congestion, increasing unemployment" this is still too rapid.

Guttmacher then deals with the arguments that abortion is murder; that it will change basic human values; or that it has frequent undesirable psychic and physical reactions — three points he considers unsound. But he opposes elective abortion "at least now for the United States . . . ." His reasons:

1. At present polls show the public does not want it. But by 1975 state laws may be liberalized, and then it is "likely" that "a safe, effective pill is discovered that any woman can take on the 25th day of a menstrual cycle, whether or not she is pregnant, [so that] the matter of repealing abortion laws becomes strictly an academic matter." 2. Elective abortion "reduces the necessity to use effective contraception, and as a physician I feel it is better physically and psychologically to prevent pregnancy than to terminate it through abortion." 3. Elective abortion "relieves the male of all responsibility in the sphere of pregnancy control."

He believes the A. L. I. code is too restrictive and favours adding a number of social indications.
3. There is also the aesthetic aspect: abortions are of course always a lesser evil, no one advocates them per se. They are an admission that birth control has failed. They are crude, and normally do not require much skill. They are monotonous operations. It is hard to see a specialist or any other medico acquiring status through being a superb abortionist. (Compare abortions and heart transplants.) Hence there is a fear by many doctors that if they “give in” they will be swamped by requests, and that even though elective or social abortion does not mean one has “a right” enforceable against a particular doctor to have one’s pregnancy terminated it might in the long run mean this. These fears are hard to assess, they are certainly not plainly silly. It is all very well for outsiders to talk airily about liberalizing the law or the rights of the woman — most of those who do so will never have to do an abortion.31

Moreover, abortion on demand is highly likely to lead to an undermining of specific medical counter-indications, precisely because it will raise the issue of what are “medical” counter-indications and who finally decides this. True, in all Eastern European states which have elective abortion there are medical counter-indications and also limits as to how late the pregnancy may be terminated — usually it must be within 12 weeks — and how soon you can have a legal abortion after the last one. But there is also a complex appeal procedure in some of these countries against the judgment of a given doctor.

31 Commenting on an abstract of a paper by H. Melvin Radman and William Korman (Obstetrics & Gynecology 21, February 1963, pp. 210—225) dealing with perforations (in hospitals) during D. & C. the editor of the yearbook comments: “Despite the fact that d. and c. is considered a ‘minor’ operation and turned over to young assistants, harm can result from it.” Comment by editor in P. J. Greenhill ed. Yearbook of Obstetrics and Gynecology, 1963—64, Chicago 1964, p. 392. See the discussions in 1937, 1960, and 1961 whether it was advisable to do D. & C’s in one’s private office — the main reason why this was thought inadvisable was not medical but fear of being accused of doing abortions. Yearbook ed. Greenhill, 1957—58, p. 358; 1960, p. 368; 1961—62 pp. 384—5 (on procedure for office curettage). Cf. the comments by a Swedish doctor, Dr Sjovall that if abortion were on demand then since there exists “extreme reluctance” of gynaecologists to do them “we would have to force a lot of Gynaecologists to perform the operations against their will, . . .”; and the comment on this point by Dr K. Miltenyi (Hungary) that it was not a personal issue — there are rules in every state which do not depend on personal opinion, e.g. compulsory schooling. “Discussion”, in Sex and Human Relations. Amsterdam 1965, pp. 103, 104. A popular but worthwhile book which deals with abortion in Britain and puts great stress on the role of the doctors in carrying them out is Paul Ferris, The Nameless just re-published as a Penguin.

The general point is that as long as there is any legal control (and there is some even in countries with elective abortion policies), doctors have a de facto quasi-judicial or quasi-administrative-tribunal function on this issue.
4. I say nothing about the influence of medical ethics. The Hippocratic Oath, two World Medical Association codes, and sometimes the UN "Declaration of the Rights of the Child" of November 1959 are often cited. I do not know what influence, if any, medical ethics has, what the ethical views of doctors in fact are, and how they feel about the standard moral arguments about abortion. (Their views as to legal indications for abortion are available, and presented in Part B.) Presumably Japanese doctors feel differently from Australian ones, but I have no material which enables me to go beyond the standard platitude that "cultural factors are bound to be important."

Part B

THE STRUCTURE OF PUBLIC OPINION

What are the views of the public and of special groups on the legalization of abortion? Since there are only two Australian surveys, I will review other data I have. What is their relevance?

a. They have no determining force as influencing what I think I ought to believe – I cannot speak for anyone else on this point.

b. They have no force in determining what Catholics should believe, their Church not (yet) being run on Gallup Poll lines. They do, however, show whether claims by church leaders or the church press as to de facto Catholic beliefs are true or false. With all the limitations of polling these views are certainly more representative of Catholics as citizens than those which others claim they have on a purely a priori basis. Hence figures of this kind may contribute something to help Catholics themselves decide what their position on abortion laws (as distinct from the morality of abortion) should be. It is clear that many well informed Catholics who are anxious for "dialogue" simply do not know to what extent the official Catholic position has become unrepresentative of the actual beliefs of Catholics. Thus, a well meaning Melbourne academic starts his article as follows: "Official Catholic spokesmen, and without doubt a large majority of those for whom they speak, adopt a hard line on abortion: abortion is no different in kind from murder, as the foetus is, at all stages of its development, completely human."

I am sure that the writer is sincere in his beliefs about that "large majority" – but they happen to be false, as the evidence from surveys even with all the qualifications made about it, clearly shows.

c. They have great force for the purposes of the criminal law if, but only if, one broadly subscribes to the sort of view which differentiates between morality and the law on the one hand, and, on the other agrees that there should be no criminal punishment except for "behaviour that falls below standards generally agreed to by substantially the whole community" with of course plenty of area for dispute as to what "substantially" means in terms of survey percentage. I take it that no one would claim that it could mean less than 51%, but as to how much more it should mean, there would be the usual debate.

This point of view has been put nicely and briefly by the American Law Institute. Referring specifically to abortion it commented:

"The criminal law in this area cannot undertake nor pretend to draw the line where religion or morals would draw it. Moral demands on human behaviour can be higher than those of the criminal law precisely because violations of those higher standards do not carry the grave consequences of penal offences. Moreover, moral standards in this area are in a state of flux, with wide disagreement among honest and responsible people. The range of opinion among reasonable men runs from deep religious conviction that any destruction of incipient human life, even to save the life of the mother, is murder, to the equally fervent belief that the failure to limit procreation is itself unconscionable and immoral if offspring are destined to be idiots, or bastards, or undernourished, maleeducated rebels against society."

After discussing the relation between intercourse and procreation, and the population issue the comment continues:

"To use the criminal law against a substantial body of decent opinion, even if it be minority opinion, is contrary to our basic traditions. Accordingly, here as elsewhere, criminal punishment must be reserved for behaviour that falls below standards generally agreed to by substantially the whole community".

They show, in a rough manner, existing gaps between law and opinion. Nothing follows from this in itself unless we subscribe to the view expressed in the quotation just given. If we do not, we can of course draw precisely the opposite policy conclusion: Don’t adjust law to opinion, adjust opinion to law.

e. They are one of the very few areas in which we have some consensus on what the facts are, or were at the time the surveys were taken. This exists in so few areas surrounding the debate on abortion, that a few relatively hard data should be welcome.

A. Doctor’s views


202 or nearly 50% “Yes”. Sample has 7% RCs. No further details available.


Comment: Not sufficient detail available, but in any case neither a random nor a quota sample, but a self-selected one through response rate. No importance on its own.

2. **New York — Obstetricians and Gynecologists, 1965—January 1965**, questionnaire survey of 2,285 (all) obstetricians and/or gynecologists in N.Y. — 62% response rate. 85.3% of respondents — constituting 50.4% of all obstetricians — gynecologists in N.Y. state favor liberalization of abortion law on the lines of A. L. I. model penal code. (Main indications "a substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother, or that the child would "be born with grave physical or mental defect, or the pregnancy resulted from rape...or from incest.")


**Comment**: All right, subject to standard limitations of questionnaire method.

3. **New York State Hospital Doctors, 1966—Summer 1966** survey by subcommittee of the N. Y. County Medical Society of all 394 state hospitals. Response rate: 69% of 274 hospitals. Of these 79 had no obstetrical service and 35 were Catholic, leaving 160 hospitals as a basis. Of these 139 had performed therapeutic abortions in the last 5 years. Should therapeutic abortion boards be required and if so by whom? 44% — yes, by medical profession; 39% — leave to discretion of hospital; 15% of respondents (21 doctors of whom 14 were Catholics) — yes, required by law.

As asked their views on existing N.Y. laws: (n — 136 doctors) 75% liberalize + 9% abolish i.e. 84% feel too restrictive; 9% unchanged, 7% enforce more rigidly — this means 21 doctors of which 14 were Catholics.


**Comment**: as (2) but distribution of religion should have been given. One of the very few polls which asks the question about more rigid enforcement of existing laws which should always be asked.

4. **U. S., Canadian and overseas Psychiatrists, 1965—December 1965** questionnaire survey of all members of the American Psychiatric Association: 12,974 abroad with 40.6% (5,289) response rate; 794 abroad with 33.1% (263) response rate. "Yes" replies only

U. S. A. = U. S. A.  C = Canada  O = all other

Do you believe a pregnancy should be interrupted . . . .

a. When the life of the mother is endangered?

U. S. A.: 97.1%  C: 94.5%  O: 93.9%
b. When the physical health of the mother might be impaired?
U. S. A: 86.5% C: 81.2% O: 74.5%

c. When there is a significant risk that the mental or emotional health of the mother might be jeopardized?
U. S. A: 88.8% C: 86.1% O: 77.6%

d. When there is a significant risk that the child would be born mentally or physically defective?
U. S. A: 90.2% C: 78.8% O: 79.6%

e. When the pregnancy resulted from rape or incest of a girl under 16?
U. S. A: 91.7% C: 86.7% O: 78.6%

f. When the pregnancy resulted from rape or incest of a girl over 16?
U. S. A: 86.3% C: 77.6% O: 69.4%

g. Whenever the woman requests it?
U. S. A: 23.5% (many with qualifications)
C: 14.5% O: 13.3%


Comment: Note the U. S.—Canadian differentials on eugenics, rape and incest. A good survey, subject to limitations of the technique. Overseas figures inspire less confidence but are “pulled back” by relatively small gaps between them and U. S.—Canadian pattern. No questions on socio-economic reasons.


“Are you in favour of liberalizing the existing laws on therapeutic abortion?”

All replies: Yes: U.S. 86.9% Canada 84.9%
No: U.S. 13.1% Canada 12.3% 2.7% qualified

By type of doctor

<table>
<thead>
<tr>
<th>All psychiatrists</th>
<th>U. S. A. in favour</th>
<th>Canada in favour</th>
<th>against qualif.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All psychiatrists</td>
<td>94.6%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non R. C. only</td>
<td>93.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Interns</td>
<td>87.8%</td>
<td>9.9%</td>
<td>2.3%</td>
</tr>
<tr>
<td>Specialists (obs. gyn.)</td>
<td>83.7%</td>
<td>86.0%</td>
<td>11.9%</td>
</tr>
<tr>
<td>G.Ps</td>
<td>82.3%</td>
<td>82.3%</td>
<td>14.3%</td>
</tr>
<tr>
<td>R. C. doctors</td>
<td>49.1%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
The table below gives the specific conditions and the percentage of physicians who thought these should be indications for a legal abortion. 2.3% in U.S. and 6.4% in Canada gave no legal indications when asked about specific conditions.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Canada</th>
<th>U.S.A.</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Substantial risk of maternal death</td>
<td>77.7%</td>
<td>76.5%</td>
</tr>
<tr>
<td>b. Pregnancy after rape or incest</td>
<td>70.2%</td>
<td>75.1%</td>
</tr>
<tr>
<td>c. Direct, positive evidence of fetal abnormality</td>
<td>72.1%</td>
<td>71.7%</td>
</tr>
<tr>
<td>d. Substantial risk to maternal physical health</td>
<td>68.2%</td>
<td>69.7%</td>
</tr>
<tr>
<td>e. Possibility of fetal abnormality</td>
<td>51.3%</td>
<td>62.7%</td>
</tr>
<tr>
<td>f. Substantial risk to maternal mental health</td>
<td>61.3%</td>
<td>60.6%</td>
</tr>
<tr>
<td>g. Substantial risk of mat. suicide</td>
<td>59.2%</td>
<td>58.6%</td>
</tr>
<tr>
<td>h. Substantial risk to mat. emotional health</td>
<td>39.2%</td>
<td>44.5%</td>
</tr>
<tr>
<td>i. Illegitimacy</td>
<td>20.7%</td>
<td>29.1%</td>
</tr>
<tr>
<td>j. Socioeconomic reasons</td>
<td>24.5%</td>
<td>26.6%</td>
</tr>
<tr>
<td>k. At request of pregnant woman for any reason</td>
<td>9.4%</td>
<td>14.3%</td>
</tr>
</tbody>
</table>


Comment: Compare with (4) and again note difference re eugenic reasons. Presentation of U.S. data not as full as those of Canadian. U.S. response rate not given but apparently somewhat lower than Canadian one. Usual qualifications re self-selected questionnaire method.


a. 69.5% approve of ALRA aims; 8% approve with minor reservations; 8% approve some grounds; 10% disapprove; 4% unclear or N.A.

b. "Do you consider that an abortion in hospital conditions in the first 12 weeks of pregnancy is a safe operation for a woman in good health?"

Yes – 84% Fairly safe – 5% Yes, in first 10 weeks–5% Various reservations–2% No–4% N.A. and D.K–4.5%

c. "In your experience which causes more psychological trouble (a) having a hospital abortion (b) having a child against one's will?"

(a) 10% (b) 57% Doubtful 14% D.K. 11% N.A. 8%

Comment: Comparison with May 1967 poll (7, below) shows pro-ALRA self-selection or suggests this, but less than one might think. Treat this with some caution. Note that on the comparative and much more "social" question hesitation goes up to round 1/3. Note striking consensus on safety of abortions, given conditions stated.

7. U.K. Doctors, 1967. — May 1957, National Opinion Polls survey, random sample of G.P.'s on their attitude to the medical termination of Pregnancy Bill:

<table>
<thead>
<tr>
<th>Opinion</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generally satisfactory</td>
<td>59%</td>
</tr>
<tr>
<td>Unsatis. — too restricted</td>
<td>6% i.e. 65% for liberalization</td>
</tr>
<tr>
<td>Unsatis. — should be more restricted</td>
<td>21%</td>
</tr>
<tr>
<td>Unsatis. — disapprove all grounds</td>
<td>10%</td>
</tr>
<tr>
<td>Undecided</td>
<td>4%</td>
</tr>
</tbody>
</table>

Comment: Satisfactory sampling — random survey. Striking in showing small minority opposed to all change. A chance was missed to correlate opinion with religion — a great pity. Of Britain's 22,000 doctors nearly 5,000 are Catholics (Madeleine Simms, letter in Observer 11.6.67) so if they had been solidly against all grounds the figure for this would have been above 10%. Some must have voted for "more restrictions" and otherwise — but we do not know the distribution.

B. Clergy


a. "Has the foetus the same rights as an adult human being from the moment of fertilization of the ovum?"

Catholics: Yes — 80%
Protestants — nearly all ‘No’

Has same rights:

<table>
<thead>
<tr>
<th>Time</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>at birth</td>
<td>31%</td>
</tr>
<tr>
<td>at viability (28 weeks)</td>
<td>45%</td>
</tr>
<tr>
<td>at quickening (16 weeks)</td>
<td>16%</td>
</tr>
<tr>
<td>no data</td>
<td>8%</td>
</tr>
</tbody>
</table>

Methodists, Congregationalists and Quakers most liberal.

b. Should an abortion be legal for (Protestants: Yes)

i. preserving physical health | 84%
ii. preserving mental health | 83%
iii. serious risk of defective child | 68%
iv. rape | 84%
v. incest | 76%
vi. if pregnant girl under 16 | 49%
vii. taking social grounds “into account” | 57%
Catholics: 5% for rape — nothing else.
89% of Protestants thought the existing law was unsatisfactory.


_Comment_: The question on the rights of the fetus is very badly phrased — “adult” should not have been used. No sample or percentage for London clergy is given, nor figures for sub-samples. Very poor, of exploratory value only.

9. C. Police — 1963

"Only 24 per cent of the policemen who were questioned in 1963 said they thought abortion should be a criminal offence."


_Comment_: No details of sample, exploratory only.

D. Catholics — special groups


<table>
<thead>
<tr>
<th>Approval of legal abortion</th>
<th>Approve</th>
<th>Disapprove</th>
<th>DK</th>
</tr>
</thead>
<tbody>
<tr>
<td>Where mother’s health is in danger</td>
<td>64%</td>
<td>23%</td>
<td>13%</td>
</tr>
<tr>
<td>Where a child may be born deformed</td>
<td>39%</td>
<td>43%</td>
<td>18%</td>
</tr>
<tr>
<td>Where mother wants it</td>
<td>6%</td>
<td>78%</td>
<td>16%</td>
</tr>
</tbody>
</table>

_source_: Sun-Herald 2 April 1967, pp. 45, 93 at p. 45

_Comment_: Not stated whether random or quota sampling but U.K. Gallup has good reputation. Seems all right.

"Support the church" on abortion position 58%
"Oppose the church's stand" 28%
Not sure 14%
Would favour abortion for unwed girl who became pregnant while visiting near an Army Camp 10%
Favour abortion for rape 46%
Favour abortion for mother of young children whose life endangered by the pregnancy 58%
and “more than 2/3 of those under 35”

Under 35: Support Church 58% vs. 30%
College graduates: Support it 58% to 32%

*Source: Newsweek, March 20, 1967, pp. 38–44 at pp. 42–3*

*Comment:* Sample all right, wording of questions not given and details a little vague, but broadly all right.

12. **California Catholics, 1966**—Quota sample, California Poll, adults only.

Given brief (and accurate) description of California law, then asked whether in favour “of very restricted abortion laws, of liberalizing abortion laws somewhat [physical or mental health of mother; deformity of baby] or allowing unrestricted legal abortion?”

<table>
<thead>
<tr>
<th></th>
<th>Restrict</th>
<th>Liberalize</th>
<th>Unrestricted</th>
<th>No. op.</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>25%</td>
<td>56%</td>
<td>9%</td>
<td>10%</td>
</tr>
<tr>
<td>Protestants</td>
<td>24%</td>
<td>58%</td>
<td>9%</td>
<td>9%</td>
</tr>
<tr>
<td>Roman Catholics</td>
<td>36%</td>
<td>46%</td>
<td>5%</td>
<td>13%</td>
</tr>
</tbody>
</table>

*Comment:* All right.

13. **Male N. Y. students.**—Survey by Fr. Bruce M. Ritter, of all-male Catholic Manhattan College questionnaire re, 83% return only 26% “oppose abortion”.

*Source: Time 5.5.67 and Sun–Herald 3.3.68*

*Comment:* One college, no further details. Exploratory.


"Do you agree with abortion under any circumstances?"
Yes – 40% No – 59% DK – 1%

*Source: Catholic Weekly 8.2.68*

*Comment:* Of slight exploratory value only
E. Catholic – National Surveys

15. Germany, 1967 – National survey by Emnid Institute, quota sample. Approving of legal abortion after rape:

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
</tr>
</thead>
<tbody>
<tr>
<td>All</td>
<td>80%</td>
<td>18%</td>
<td>2%</td>
</tr>
<tr>
<td>Men</td>
<td>81%</td>
<td>17%</td>
<td>2%</td>
</tr>
<tr>
<td>Women</td>
<td>79%</td>
<td>20%</td>
<td>1%</td>
</tr>
<tr>
<td>Protestant churchgoers</td>
<td>79%</td>
<td>19%</td>
<td>2%</td>
</tr>
<tr>
<td>Catholic churchgoers</td>
<td>60%</td>
<td>38%</td>
<td>2%</td>
</tr>
</tbody>
</table>


16. U.S.A. – 1962–Gallup poll on Finkbine thalidomide case: “Do you think this woman did the right thing or the wrong thing, in having this abortion operation”?

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>Catholics</th>
<th>Protestants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right thing</td>
<td>52%</td>
<td>33%</td>
<td>56%</td>
</tr>
<tr>
<td>Wrong thing</td>
<td>32%</td>
<td>49%</td>
<td>27%</td>
</tr>
<tr>
<td>No opinion</td>
<td>16%</td>
<td>18%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Source: Sun 25.9.1962


Abortion should be legal for the following indications: (Yes replies only)

<table>
<thead>
<tr>
<th></th>
<th>U.S.A</th>
<th>U.K.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health of Mother</td>
<td>71%</td>
<td>85%</td>
</tr>
<tr>
<td>Defect in fetus</td>
<td>55%</td>
<td>91%</td>
</tr>
<tr>
<td>Rape</td>
<td>56%</td>
<td>82%</td>
</tr>
</tbody>
</table>

Women only – compared by religion:

<table>
<thead>
<tr>
<th></th>
<th>U.S. Prot.</th>
<th>U.K. C. of E.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>72%</td>
<td>89%</td>
</tr>
<tr>
<td>Defect in fetus</td>
<td>55%</td>
<td>94%</td>
</tr>
<tr>
<td>Rape</td>
<td>56%</td>
<td>84%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>U.S. R.Cs</th>
<th>U.K. R.Cs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>58%</td>
<td>61%</td>
</tr>
<tr>
<td>Defect in fetus</td>
<td>43%</td>
<td>71%</td>
</tr>
<tr>
<td>Rape</td>
<td>47%</td>
<td>67%</td>
</tr>
</tbody>
</table>

Source: U.S.A.: Alice S. Rossi, “Public Views on Abortion”, reporting on and discussing the results of a survey conducted (quota sampling, adults) by the National Opinion Research Center in December 1965. Committee on Human Development, University of Chicago, 1966. MS.

U.K., National Opinion Polls, “Survey on Abortion” July 1966. Random sample as part of four of their normal surveys, during which all women interviewed received a questionnaire in a sealed envelope. 3,500 women received these and 2,132 returned them – a response rate of 60.9%.

In spite of the different sample design — the U.K. study refers to women only — rough comparisons are possible since a March 1965 NOP study in England, “Abortion Law”, showed that there were no significant differences on the broad issues between men and women. However, given also different formulation of the questions, the comparisons must be very rough and should only be used with this limitation in mind.

I have compared the following:

Health: U.S.: “If the woman’s own health is seriously endangered by the pregnancy” with U.K.: “If her health would suffer by having a child”. Eugenic: U.S. “If there is a strong chance of a serious defect in the baby.”

U.K. “If the baby was likely to be born seriously deformed”. Rape: U.S. “If she became pregnant as a result of rape”. U.K.: “If she has been raped.”

Clearly, only the ‘rape’ question is strictly equivalent.

18. U.K. 1965 — National Opinion Polls, in March 1965, carried out a very careful and detailed survey, based on a systematic probability sample of electors, on abortion law. This included 5 questions with 13 subcategories, on what the present law on abortion was, what it should be, under what circumstances abortions should be legal, the role of the woman and the doctor and of panels, and suggested punishments for doctors acting illegally and for unqualified abortionists. Replies are cross-classified by class, age, knowledge of the law, region, marital status and religion. Only a few highlights can be given here.

Knowledge of the law—Those who think abortion is now (March 1965)

<table>
<thead>
<tr>
<th>Category</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Always legal</td>
<td>1%</td>
</tr>
<tr>
<td>Legal in some cases</td>
<td>49.3%</td>
</tr>
<tr>
<td>Always illegal</td>
<td>42.1%</td>
</tr>
<tr>
<td>DK</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

Catholics tended to believe slightly more frequently—about a 5% difference – than C. of E. that abortion was always illegal.
This poll is one of the few which asked about getting "tougher" i.e. it asked whether abortion should be legal in all cases, some cases, or illegal in all cases. However 24.1% thought it should be illegal in all cases, but if this is cross-classified with knowledge of the law it is clear that the answer was usually merely an endorsement of an imagined status quo: 6.1% of those who knew the law (legal in some cases) wanted all abortions made illegal vs. 41.6% of those who did not know it.

**Indications:** 12 questions as to possible indications for legal abortions were asked from all but those who thought all abortions should be legal (6.4%) or illegal (24.1%). "Yes" i.e. "should be permitted" percentages only are given here.

| Indication                                      | All     | C. of E. | R.C. 
|------------------------------------------------|---------|----------|------
| Physical health                                 | 63.9%   | 68%      | 48%  
| Mental health                                   | 62.8%   | 67%      | 46%  
| Deformed child                                  | 51.8%   | 58%      | 33%  
| Large family so that another child "would cause financial hardship and worry" | 30.0%   | 35%      | 16%  
| Illegitimate child                               | 9.9%    | 11%      | 7%   
| Unmarried woman under 16                        | 22.7%   | 25%      | 14%  
| Rape                                            | 55.1%   | 59%      | 37%  
| Incest                                          | 49.0%   | 53%      | 29%  

**Moral beliefs and legal punishment**—This NOP poll, which is methodologically by luck, exceptionally good is the only one I have seen which throws light on what people think should happen to doctors and others who break abortion laws.

It shows beyond reasonable doubt that a clear majority want a doctor who performs abortions on demand punished, though even here only 9.6% wanted to give him a prison sentence. But a huge majority wanted no punishment for a doctor who carried out illegal abortions he thought morally justified. This was endorsed by all classes, regions, religions, and all types of marital status. 63% of Catholics wanted no punishment for such a doctor. (Of course the figures exclude those who think abortions should always be legal (6.4%) or always illegal (24.1%) and only refer to those (66.1%) who thought they should be legal in some cases). Again a huge majority of nearly 79% wanted to send an unqualified abortionist to prison.

All except those who thought abortion should always be legal or illegal were asked:

"In the following cases, which of these should happen to a person who performs abortions which are illegal under the present law.

a. A doctor who carries out abortions for any woman who asks him.

b. A doctor who only carries out abortions which he thinks are morally justified.

c. An unqualified abortionist who carries out abortions for any woman who asks."
Case (a) Doctor — on demand

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>C. of E.</th>
<th>R.C.</th>
</tr>
</thead>
<tbody>
<tr>
<td>A prison sentence</td>
<td>9.6%</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Forbidden to continue as a</td>
<td>33.5</td>
<td>33</td>
<td>36</td>
</tr>
<tr>
<td>practitioner</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heavy fine — £500 or more</td>
<td>29.4</td>
<td>29</td>
<td>22</td>
</tr>
<tr>
<td>Smaller fine — less than £500</td>
<td>14.9</td>
<td>16</td>
<td>14</td>
</tr>
<tr>
<td>No punishment</td>
<td>9.2</td>
<td>8</td>
<td>11</td>
</tr>
<tr>
<td>DK</td>
<td>3.3</td>
<td>3</td>
<td>3</td>
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</tbody>
</table>

Case (b) Doctor — moral self-justification

<p>| | | | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td>Prison</td>
<td>0.9%</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Sordid practising</td>
<td>3.7</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Heavy fine</td>
<td>6.4</td>
<td>6</td>
<td>10</td>
</tr>
<tr>
<td>Smaller fine</td>
<td>14.8</td>
<td>15</td>
<td>17</td>
</tr>
<tr>
<td>No punishment</td>
<td>70.1</td>
<td>70</td>
<td>63</td>
</tr>
<tr>
<td>DK</td>
<td>4.1</td>
<td>4</td>
<td>4</td>
</tr>
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</table>

Case (c) Unqualified — on demand

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<tbody>
<tr>
<td>Prison</td>
<td>78.8%</td>
<td>78</td>
<td>81</td>
</tr>
<tr>
<td>Heavy fine</td>
<td>13.2</td>
<td>14</td>
<td>10</td>
</tr>
<tr>
<td>Smaller fine</td>
<td>3.6</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>No punishment</td>
<td>1.1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>DK</td>
<td>3.3</td>
<td>3</td>
<td>4</td>
</tr>
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19. U.K. — 1966 — National Opinion Polls, July 1966, random sample and then questionnaire to women only in sealed envelope — 60.9% response rate.

"Do you think it should be made easier to obtain a legal abortion?"

<p>| | | | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td>All</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>75%</td>
<td>77</td>
<td>57</td>
</tr>
<tr>
<td>No</td>
<td>20</td>
<td>18</td>
<td>37</td>
</tr>
<tr>
<td>DK</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>NA</td>
<td>2</td>
<td>2</td>
<td>1</td>
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</table>
Indications for legal abortions:

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>C. of E.</th>
<th>RC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health</td>
<td>85%</td>
<td>89</td>
<td>61</td>
</tr>
<tr>
<td>Deformity</td>
<td>91</td>
<td>94</td>
<td>71</td>
</tr>
<tr>
<td>Rape</td>
<td>82</td>
<td>84</td>
<td>67</td>
</tr>
<tr>
<td>Incest</td>
<td>65</td>
<td>68</td>
<td>51</td>
</tr>
<tr>
<td>Under 16</td>
<td>50</td>
<td>51</td>
<td>43</td>
</tr>
<tr>
<td>“Her living condition made it undesirable to have a child”</td>
<td>36</td>
<td>37</td>
<td>30</td>
</tr>
</tbody>
</table>

Respondents were also given an open-ended choice i.e. to write in any other reasons. 86% had no other reasons. 2%: parents of low mentality; 3% parents have their planned number of children and cannot cope with more; 6% if pregnancy “unwanted for any reason whatsoever”; 1% financial position made it undesirable; 3% heredity disease, VD, family history of mental deficiency.

These can be roughly recombined as —

a. Elective or nearly so — 10%

b. Eugenic — 5%

There was a question “Do you think the pregnant woman alone should be able to decide whether or not she has an abortion” for which the “Yes” replies roughly are the same as legal socio-economic indications. (30% vs. 36%) 69% thought she should be able to decide this by herself, there being no significant difference by religion.

Asked to write in “Who else should be consulted?” 48% were not able to name anyone. Of those who did name someone: 37% her doctor; 36% her doctor and another doctor; 20% a special abortion committee; only 13% “Husband, father of the child”; 2% parents, family, close relations; 1% Psychiatrist.

No significant difference by religion.

This question is ambiguously phrased — “able to decide” and “consult” are open to a number of interpretations. When asked: “Should the father of the child have the right to prevent a woman having an abortion?” the father’s role came out more strongly, but still only as a minority view.

<table>
<thead>
<tr>
<th></th>
<th>All</th>
<th>C. of E.</th>
<th>RC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>31%</td>
<td>32</td>
<td>41</td>
</tr>
<tr>
<td>No</td>
<td>56</td>
<td>56</td>
<td>45</td>
</tr>
<tr>
<td>DK</td>
<td>9</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>NA</td>
<td>4</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
**Abortion Experience** – The survey shows that, with a sealed questionnaire, women will reply to questions on whether they have had abortions.

The results, summarized, were: 1946–65: average of 40,000 abortions p.a. of which 31,000 illegal. (Current guesses were between 10 – 100,000). In these 20 years 600,000 women had had abortions, of which 125,000 had had more than one. In addition there were 85,000 attempted abortions p.a..

How performed (illegal ones): Almost 60% self-induced; 21% performed by someone who was not a doctor, and 23% performed by a doctor illegally.

On whom performed: 65% on married women; 28% on single, 56% on women aged 20–30. 58% had children at the time, 45% have had children since.

Cost: The great majority of illegal abortions cost very little – 50% cost less than £1 and 30% between £1 – 50.

Working class women were more likely to have had an abortion than middle class ones; Roman Catholic women were no less likely to have had an abortion than women of other religious convictions.

**Comment:** In my view the subsamples, e.g. by class or religion, are too small to permit statistically significant conclusions. There are figures on Catholics and abortions for e.g. Chile, France, and Italy but all these refer to guesses about illegal abortions and do not permit comparisons between or within religions. It would, however, be fair to say that some countries which have predominantly Roman Catholic populations also have high abortion rates, especially in Latin America. We just do not know whether in such countries being a Catholic does or does not make a difference, if we hold all other factors constant. Any “facts” on this point should be looked at most carefully for their alleged empirical status.

Note that most people in England, while favouring easier abortion laws in 1965–66 also thought that it was a Christian country. Asked, in mid 1965 by a NOP poll: “By and large, do you think of Britain as a Christian country or not?” 79.7% replied “Christian” (C. of E. 85%, RCs 78%), 19% “not Christian” (C. of E. 15%. RCs 21%) and 1.3% were DK/NA.


While the “Yes” replies increased with age, even in the 21–24 year old group 72% thought that Britain was by and large a Christian country.

**USA – 1965** – The late 1965 NORC poll analysed by Dr Rossi (see 17) is one of the most careful. Her major relevant finding as to the percentage approving legal abortion under specified conditions was:
Dr Rossi is able to show that the slight differences mask an important differential effect of education – which has a liberalizing effect on Protestants but none on Catholics. So there are large religious differences among the better educated, low ones among those low in educational attainment. The reason, she suggests, is the effect of parochial schools on Catholics, the longer they stay in them the more likely, in this field, are they to accept the Church’s views. (cf. the work of Dr Hans Mol of the A.N.U.)

But both educational attainment and religious affiliation are, in the US, related to Church attendance, better educated people are more likely to go to church, and Catholics at every educational level are more likely to do so. Church attendance and educational attainment contribute about equally to views on abortion.

So: the least liberal views are held by high church-attending and low-educated; the most liberal views by low church attenders who are highly educated. However, even the least permissive group of high church attenders who have low education approves (with 59%) of abortion for reasons of maternal health. The most permissive group – high education, low church attendance – has the biggest minority (36%) favouring abortion as a method of birth control for the married.

Moreover, the differences which appear in the extract reproduced here as between men and women are insignificant once church attendance (much more frequent with women) is taken into account.

21. Australia 1967 – Here there are only two surveys. Dr D. Chappell and Mr P. R. Wilson conducted one through Roy Morgan’s interviewers in November 1967 and I am most obliged to Dr Chappell for making the results – embodied in a paper to appear in the Australian Law Journal – available to me.

64% disagree with the view that “Abortions should not be legal or allowed under any circumstances” with 27% agreeing, 7% unsure and 2% not answering. Of the 64% who do not object to all abortion 92% would allow it for danger to the mother’s life, 85% for rape, 75% for danger of mental or physical deformity for the child, and only 27% where for economic reasons the mother would be unable to support the
Social Attitudes to and Moral Implications of Abortion

child. 40% of Roman Catholics vs. 69% of Anglicans favour abortion in certain circumstances. Amongst Catholics opposition to all legal abortion correlates with churchgoing — from a third of strong Catholic churchgoers willing to have some legal abortions to 50% of those who are moderate churchgoers and 79% of those who do not go at all. I do not know the relationship between this and educational background.

Sex differentials are given — among the younger the women are more permissive than the men, among the older vice versa — but this may be a disguised effect of frequency of church-attendance. (cf. Rossi)

Dr. Chappell infers that a limited amount of reform is politically possible — he clearly believes it to be desirable. For him the key fact is the 64% who are not opposed to all reform, plus, presumably the fact that he can now point to those 49% of Catholics who do not oppose all reform. The D. L. P. sees it differently. In an article on "The Political Significance of Abortion", in its Victorian monthly (The Democrat 7(2), June 1968, p. 7) it has this sub-heading:

"73% against it"

Gallup polls show that the majority of Australians perceive and reject the evil of abortion for economic reasons (73 per cent, Herald, March 5, 1968). To have it accepted, the malicious intent of abortion must be disguised by spurious claims of care for the mother's physical and mental health".

22. Sydney—Melbourne, 1968 — In early 1968, a Sydney Marketing Research firm, M. F. I. Surveys, appended a question on abortion law reform to one of its regular surveys. A representative sample of homes in two capital cities was used, and the respondents are married women only. I am indebted to the Managing Director of M. F. I. Surveys, Mr Ronald Vickers, for making detailed results available to me. If it were possible to extract data from the Chappell—Wilson survey for married women only, the two surveys might be compared. The main point is that M. F. I. used a rough intensity of attitude measure.

"Should abortion be made legal if carried out by a properly qualified medical practitioner?"

<table>
<thead>
<tr>
<th></th>
<th>Sydney</th>
<th>Melbourne</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, definitely</td>
<td>44%</td>
<td>36</td>
</tr>
<tr>
<td>Yes, most probably</td>
<td>20</td>
<td>26</td>
</tr>
<tr>
<td>Undecided</td>
<td>10</td>
<td>13</td>
</tr>
<tr>
<td>Probably not</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Definitely not</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

26% 25%
The wording of the questions and the sampling base of the two surveys differ— all the same one may point to an emerging picture:

**Antis:** These are made up of a hard core of 21% plus a slightly softer cortex of round 4 – 6%

**Pros:** Here once more the two surveys agree broadly— this group is round 62-66% with 64% as the national average— but the M. F. I. research means that a much higher proportion of the “pros” are “soft” pros than is the case for the “soft” antis.

One can then speculate—and this comes out in the Chappell—Wilson survey when it gets down to particular indicators for legal abortion—that a lot will depend on how the legislation is framed when it comes. But I stress again that the soft cortex of the “pros” is of considerable importance.

Now that the Victorian Liberal State Executive has endorsed a policy of reform which would codify practices which existed till recently amongst reputable doctors in Melbourne, the ALP has followed with a much bolder policy. On the recommendation of its Executive its Victorian State conference endorsed a policy which would make it lawful for a registered medical practitioner to terminate a pregnancy.

1. “To save the mother’s life
2. To avoid injury to her physical or mental health taking account of her “actual or foreseeable” environment.
3. If there is a risk of the child being born with physical or mental abnormality.
4. If the mother is a victim of rape or is of unsound mind.”

(For full text of Conference decisions, see FACT, February, 13, 1970, p. 6.)

**CONCLUSION.**

For good or for evil, the long silence on abortion in Australia has at last been broken. The first pro-reform propaganda pamphlet, by Mr John Bennett has just appeared in Melbourne under the title Abortion Law Reform? Not surprisingly, he used the Chappell—Wilson as well as the M. F. I. survey to back up his case.

The overseas surveys, in their general impact, are clear enough: there is a clear and substantial majority for “moderate” reform. Catholics are deeply divided, with nowhere any indication that a majority of them support the position of their Church to the full. (Gallup Polls have just started in Ireland— will they take a survey?) Doctors overseas are much more inclined to be permissive than one generally assumes Australian doctors to be. Even though we have only two exploratory small studies, it seems that there might be a sizable proportion of people who believe that human life starts only at birth.
But, at the same time, there is not yet much support for the position of the American Civil Liberties Union i.e. that of elective abortion. Even amongst non-church-going highly educated people only a minority favours it. Perhaps this can be explained in terms of punitive attitudes towards “free sex” and fear what a further decline in sanctions might not do. By and large, it is not apparently the case that women as a group differ much from men in attitudes once we take into account church-going and education. Thus there may not be very much to the standard feminist point that it should all be left to the women — that a discussion of abortion by men is like one by dogs about cats.

Reform will come in a manner and style which characterizes most of the debate: it will be dishonest, the arguments for and against it will avoid the key issue of elective abortion, it will be furtive, it will be emotional.

It will also to a considerable extent be irrelevant to what women do and how many abortions they get — but not to the conditions under which they get them.

Personally, if I held the standard “pro-reform” position — which I do not — I would put all my money on that famous “abortion pill” which could be taken regularly so that no women need know whether in fact she was or was not ever pregnant.

If I held that standard “anti-reform” position — which I do not — I would put all my money on encouraging research which would make the woman’s body translucent and the fetus visible.

As it is, I don’t put my money on anyone or anything and must leave you where I am: in doubt.

POSTSCRIPT

To list, let alone analyse, the flood of material on abortion since 1968 would require a new and long paper.

I will offer brief comments on some important new trends.

Changing focus of debate

The key issues in the abortion discussion are shifting — first, there is much more concentration now on elective abortion, second, there is an increasingly close link with ecology.

While there are still many papers written in terms of some kind of cost/benefit approach, the abstract question of the right of the state to enforce “compulsory pregnancy” is now to the fore. Increasingly, the whole burden of the debate is shifting from a concentration on what might justify a demand for abortion to what might justify the government in putting any legal obstacles in the way of such a demand.
The cry for the abolition of all anti-abortion laws was considered “extreme” only a few years ago, by now an increasing number of respectable organizations have embraced it. Partial reforms, such as the A.L.I. code, seem increasingly less attractive. The demand for elective abortion is coming to a head in the United States, where challenges to the constitutionality of abortion laws are on the increase. A number of lower courts have already considered the issue, and it seems that the Supreme Court will have a case before it before long. One cannot guess whether it will decide on the issue of principle or try and postpone such a decision by confining itself to more technical matters.

However, on the whole the trends have been going strongly in support of much more permissive legislation, and indeed in the direction of elective abortion. By now fourteen States have relatively liberal abortion laws. Significantly, some of them, even after a very short experience, are considering further liberalization. Hawaii and New York now have elective abortion, and this is bound to have its impact on other States. Lower court decisions, so far, have gladdened the hearts of the reformers. All recent opinion surveys show a rapidly increasing support for abortion on socio-economic grounds or simply on demand. How much difference, in practice, there is between these two positions depends only in small part on the law: once socio-economic reasons are introduced openly, by their very nature they are bound to be even vaguer than medical, psychiatric or eugenic reasons. Their interpretation must, in practice, lie in the hands of doctors. If we assume that doctors have shifted towards a more permissive attitude and will continue to do so, which seems a realistic assumption, the gap between the consequences of legalizing socio-economic reasons for abortion and abortion on demand will continue to decrease.

Given the recent trends in Western societies towards “de-authorization” it seems reasonable to predict that even if particular legal decisions for a time should attempt to stem the tide, the right of the state to make any laws in this field will come under increasing challenge.

The rise of the Woman’s Liberation Movement will further strengthen this tendency. One of the most fascinating — the fascinating may be that of horror or of admiration or a mixture of both — social processes of the last few years has been the very rapid adaption by the “establishment” of positions held, shortly before, by “extremists” and “outsiders”. *Adaption* seems the right word — it is a separate question how far these positions are then watered down. Is such a policy to be seen as a victory for the rebels and for counter-culture or rather to be taken as a sign of the tremendous strength of the status quo?

However that may be, the key point made by the Woman’s Liberation Movement — that women’s roles are not directly and functionally derived from permanent biological imperatives, that anatomy is not destiny, but rather can be explained as based on sociological factors which are subject to change — will, even though with some watering down, become very widespread in the near future.
This, in turn, will lead to a much more questioning attitude to the whole concept of motherhood. Together with the increasing separation of sex and reproduction it is bound to lead to an ever stronger demand for elective abortion. Thus the process of rationalization, which is sketched in my paper, will continue.

It is highly significant that those who wish to oppose, or at least slow down, abortion on demand have to give ground year by year, at least in industrialized societies. In order to fight the more extreme position they have had to say less and less about their basic opposition to all direct abortion, let alone about "the evils" of contraception.

The link between the abortion issue and population policy is, by 1970, much more complex than it seemed only two years ago.

For most non-experts, the population problem was mainly conceptualized in terms of a crude image of pressure of numbers on food resources. Ecology is a fad at the moment, and like other fads may end in general boredom. But the endless books and newspaper articles will at least leave behind them some general notion that the life-carrying capacity of this globe is threatened not only by the burgeoning of population, but also by the cumulative effect of existing technology and the special environment-destroying potential of newly developed technology. It seems rather likely that, however, the matter is put, some kind of "people = pollution" equation will become increasingly popular and politically relevant.

It may start, as it has in Australia, by a questioning of immigration policy, and especially on its impact on urban resources and the urban environment. But however it starts, it is unlikely that it will be able to avoid the issue of cutting-down numbers. Elective abortion is a very crude, but possibly in some cultures very rapid, way of doing this. If (see below) abortion can be rationalized further so that the operation requires fewer resource-inputs, it seems likely that it may, increasingly, become part and parcel of a deliberate population policy — as it has in Japan.

It will be hard to work out distinctions between abortion policies motivated by some conception of fetal or mother's rights and those which are in fact population control measures. I for one would expect that in many countries the latter might be rationalized in terms of the former — with the supreme irony if we should get compulsory abortions (for population-ecological reasons) imposed in the name of women's rights.

Changing techniques

Since we now have elective abortion in New York and Hawaii, there will be much greater pressure than before for research on more rapid and less time - and resource-consuming methods of performing the operation. In the paper, I mention the implications of some kind of post-coital "pill". More immediately there might be increased use of the suction method and pressure for performing the operation on an outpatient basis.

It is not necessary to guess details — the main point is clear enough: given the British and more recent United States laws and, to a lesser extent, our own in South Australia, research on further rationalizing abortion
methods is bound to increase. After all, one of the main reasons why there was relatively little of it was that abortion was illegal, considered immoral, or both. As these considerations weaken, so research will become an increasingly "normal" thing. Moreover, as the paper makes clear, few doctors like doing abortions, hence now that more and more are under pressure to perform legal ones one may assume that research designed to minimize the number of actual operations will also increase.

Catholic reactions

Catholics protest that the opposition to abortion law reform is not purely "Catholic". This, of course, is true — but it is also true that Catholics are bound to provide the main force for organized opposition. Their present tactics are, increasingly, to call for more factual studies and Commissions — a highly intelligent tactic, since "the facts" are very hard to get, but essentially one which can only be a delaying move.

It is likely that Catholic theologians will in the near future have to find ways by which to save face, for the trends (if my analysis is even roughly right) are heavily against them. They may do this by new stress on the distinction between morality and law or by partial absorption, under a different name, of "situation ethics", or by following Joseph Donceel on the animation—hominization distinction, or by a combination of such moves. It is hard to see a long continuing battle here, for the Catholic Church has no longer the power to enforce its moral standards, and the whole birth control — abortion issue is becoming increasingly dangerous for it in regions such as Latin America.

Australia

On the surface there have been some "dramatic" developments since 1968. Dr Bertram Wainer brought the whole issue to the surface, even forming a party around it, and his allegations against Melbourne police led to an extensive official enquiry. That some police are involved with some abortionists can only have been news to the innocent. So far Wainer's efforts have simply led to police raids in Melbourne and Sydney and a break-down in tacit understandings between some police and some doctors.

South Australia has legalized abortion, following the British Act fairly closely. The Act came into force on January 8, 1970, and it is much to early to judge its results. In a 1969 Victorian case R. v. Davidson Menhennitt J. directed the jury that for a therapeutic abortion to be lawful the accused must have honestly believed on reasonable grounds that the act was necessary to preserve the woman from some serious danger, including danger to physical or mental health, and that the measures taken to procure the abortion were not out of proportion to the danger to be averted. Again, just what difference this will make to the practice of doctors in Melbourne is not known.

In late July 1970 Dr A. I. Adams and Mr W. Sussman published the first decent survey of the attitudes of G.Ps in New South Wales. 76% favoured the reform of abortion laws in New South Wales and 28% favoured elective abortion. The survey was based on a random sample of 92 Sydney G. Ps.
Abortion law reform — roughly on the lines of the South Australian Act — is now official policy of the Labour opposition in Western Australia and Victoria.

In general, while there are now a number of Abortion Law Reform Associations in most States, and while, more recently, there have been some minor demonstrations in favour of repeal of all laws, the position in Australia has not changed as much as it has in U.S.A. Both sides have of course cited those aspects of the British experience which suited them, and, no doubt, will do the same with rival interpretations of the South Australian Act.

Opinion is changing fairly slowly here, though the different wording of various polls makes comparison over time very difficult. A clear majority are still against abortion on socio-economic grounds and against abortion on demand. But the long range forces give little comfort to those who oppose reform.

The general level of debate has not, in Australia, improved a great deal since 1968. The original roneoed version of this paper was quoted in a distorted and selective way by both sides during the agitation in South Australia. It is pretty likely that a similar fate will overtake this version.
Appendix A

The following article, "Protecting Civil Liberties: The Right to Have an Abortion" is reprinted from CURRENT May 1968, pp. 26–28. The article, as excerpted by CURRENT, is published by permission of the New York Civil Liberties Union. This extract illustrates, in non-technical language, some of the major arguments which have since then been put, in legal language, before the U.S. courts.

PROTECTING CIVIL LIBERTIES
THE RIGHT TO HAVE AN ABORTION

Excerpts from a recent policy statement by the American Civil Liberties Union calling for the abolition of all laws prohibiting abortion:

"In the last few years legislatures all over the country have taken note of one of the most persistent but emotionally charged issues of our time, that of the reform of laws forbidding abortion . . . . The American Civil Liberties Union has watched these developments with keen interest. We have studied and debated the issue intensively for more than a year. Our discussion has touched on all aspects of the subject, including the various social, medical, moral and theological approaches, but our final conclusions rest solely on our desire to protect and advance civil liberties — in particular, the rights of privacy and equality and the freedom of each individual [woman] to decide for what purposes her body should be used . . .

"The American Civil Liberties Union asserts that a woman has a right to have an abortion — that is, a termination of pregnancy prior to the viability of the fetus — and that a licensed physician has a right to perform an abortion, without the threat of criminal sanctions. In pursuit of this right the Union asks that state legislatures abolish all laws imposing criminal penalties for abortions performed, for whatever reason, by a licensed physician. The effect of this step would be that any woman could ask a doctor to terminate a pregnancy up to the time that the fetus becomes viable. (The exact moment at which this happens is not known, but the medical profession does agree that a fetus could not possibly live apart from the mother until sometime after the 20th week, and as a practical matter, even with the best medical care now available, not until several weeks later.) In this term, a doctor could accede to the woman's request in accordance with his professional judgment without fear of criminal prosecution. Thus, the decision whether or not to continue a pregnancy would become one of the woman's personal discretion and the doctor's medical opinion. Both would be free to follow their private consciences in determining whether their religious or moral standards were being violated. No fear of criminal punishment would enter into the decision.

"The A.C.L.U. holds that every woman, as a matter of her right to the enjoyment of life, liberty and privacy, should be free to determine whether and when to bear children. It is not a matter for the state to control. As long as criminal sanctions are attached to the performance of abortions, however, this freedom will not be realized. Even the recognition of special 'hardship cases' — danger to the life and mental or physical health of the mother, probable fetal deformity, pregnancy resulting from rape or incest — falls short of satisfying the rights of life, liberty and privacy. Although it is true that a number of well-established religious and moral doctrines forbid abortion, we do not believe that the state has the power to force these particular religious and moral standards upon the entire community. The Union itself offers no comment of the wisdom or the moral implications of abortion, believing that such judgments belong solely in the province of individual conscience and religion. We maintain that the penal sanctions of the state have no proper application to such matters.
UNEQUAL SANCTIONS FOR RICH AND POOR

"The discriminatory effect of the prohibition of abortion involves another area of civil liberties interest, that of equality. At a time when our nation is even more deeply intent upon narrowing the gap between rich and poor and removing the obstacles which prevent the poor from exercising their fundamental rights as citizens, we should not perpetuate the kind of inequality that the abortion laws have produced. The rich can violate the law with impunity, but the poor are at the law's mercy. Any sanction which operates in this manner is not acceptable under civil liberties standards of equal protection of the laws. Moreover, the very fact that the law is so arbitrarily applied and enforced and so universally ignored itself weakens the principle of the rule of law which is the backbone of civil liberties.

"The violations of civil liberties inherent in the present abortion laws are sharply accentuated by the immense medical and social problems to which these laws have given rise. It is no secret that innumerable women secure abortions every year despite the prohibitions of the law. These women must either find doctors who are willing to stretch the technicalities of the law, or resort to frankly criminal abortions, most often at the hands of untrained incompetents. The physical, psychological and social costs of backstreet abortions are too well known to require enumeration. No less tragic are the consequences to the woman who does not have the price of a quasi-legal or illegal abortion, to the unwanted child she later brings into the world, and to the rest of her family.

"The current debate over abortion law reform has revived the oft-heard contention that removal of criminal sanctions on abortion will undermine the morality of our youth and open the door to promiscuity. This is an understandable concern, but the experience of several European countries which have freely available or easily available abortion has not borne out this fear. Moreover, the statistics of abortion now performed show that the great majority of both legal and illegal abortions in this country are now sought by and performed upon married women who already have several children and are pregnant by their own husbands. The primary impact of the laws would seem to fall not on the unmarried and potentially promiscuous teenager but on the married woman with an established family.

"Although the social and medical problems created by prohibition of abortion are without doubt extremely serious, in pressing for legislative abolition of the abortion laws the Union bases its arguments solely on its desire to protect and promote the civil liberties of all citizens. We believe that the abortion laws violate civil liberties in the following specific ways: (1) They deprive women of the liberty to decide whether and when their bodies are to be used for procreation, without due process of law. (2) They are unconstitutionally vague. (3) They deny to women in the lower economic groups the equal protection of the laws guaranteed by the 14th Amendment, since abortions are now freely available to the rich but unobtainable by the poor. (4) They infringe upon the right to decide whether and when to have a child, as well as the marital right of privacy. (5) They impair the right of physicians to practice in accordance with their professional obligations in that they require doctors not to perform a necessary medical procedure. In many cases their failure to perform this medical procedure because of the statutory prohibitions on abortion, would amount to malpractice."

(Policy Statement on State Laws Prohibiting Abortion, American Civil Liberties Union, New York, N.Y., Mar. 25, 1968.)
Appendix B

Reprinted from ATLAS Magazine, August 1966. Translated from NEPSZABADSAG, Budapest. This extract shows some of the uneasiness now existing in some countries with practically elective abortion. It illustrates the interplay of factors relating to “rights” and those relating to “population policy”.

More Babies Wanted
Translated from NEPSZABADSAG, Budapest

Since 1956, Hungary—following the Russian pattern—has permitted abortions in state clinics for women who could give sufficient reason, which in practice meant any woman who wanted one badly enough. Since then the birth rate has dropped sharply. As a result, Hungary is one country that is not concerned with the population explosion but is very much concerned with its depletion. The following partial transcript of a panel discussion of the problem is reprinted from Budapest’s Nepszabadsag (“People’s Freedom”), the country’s leading newspaper and the organ of the Communist Party.

With regard to the birth rate, Hungary takes last place in world statistics: since 1963 the number of births has dropped to an annual 130,000 (thirteen per thousand) and the number of induced abortions has soared to an annual 180,000 (eighteen per thousand). The statistical data give food for thought. It was because of this that our editorial board organized a round-table conference on the problems of family planning and birth control. The participants were Zsuzsa Ortutay, secretary of the National Council of Hungarian Women; gynecologist Dr Zoltan Vadas, department chief in the Ministry of Health; head physician Dr Gabor Doros; pediatrician Dr Laszlo Fulop, head of the abortion committee of District II; writer Gyula Fekete and Laszlo Szabo, staff member of our editorial board.

Laszlo Szabo: There are people who do not see any danger in our statistical data because they consider the present situation transitory. They believe that as the standard of living improves, the matter will solve itself.

Doros: This can be accepted under circumstances while in others it cannot. As far as I know, there are an estimated 30,000 to 40,000 young women who, though they do not have one single child, decide to have an abortion. In my opinion, to give birth to a child and to bring it up is as much the duty of a citizen as—let us say—the defense of the country.
GYULA FEKETE: I approach the problem from another angle. Unless there is some change, the ratio of old people to young will continue to widen in the course of the next few decades. For years, we have only increased our population by the number of people over sixty. The zero-to-six-year-old group faces the prospect of supporting the largest number of old people in the whole world. Have childless parents pondered over this trend and the fact that they will be supported in their pensioned years by the future generation?

There are other ways one can pay one's debt to society. But the most natural way is to have children, and conditions have to be established under which this is encouraged. This means the so-called "dissuading" factors have to be eliminated. Poorly planned housing and distribution of apartments are two such factors. Or the misconception that it is inglorious to be a mother.

Should we interpret your words to mean that a mother must stay at home, and that her only task is to have and raise children? FEKETE: I did not mean that. Women no longer want to be confined within the four walls of their kitchens. They may choose a profession in economic, social or political life. This is one of the greatest achievements of our regime. I know that, in the present times, it would be unrealistic to ask people to have four or five children. But two or three? And anyway: society has the right to count on motherhood . . . On the other hand, this has to be co-ordinated with the fact that the majority of women work and wish to work.

ZSUZSA ORTUTAY: It is an intricate and complex problem. Economic and social changes—industrialization, urbanization, the increase of economic and cultural demands, the restructuration of society—were all factors which had a share in the fact that a great number of young couples no longer want a child. Naturally, these young couples fear that, with the birth of a child, their way of life will change. This is true. On the other hand, only parents know that the joy given by a child cannot be replaced by any comfort. I think it by no means desirable to deny the right of a mother to decide when and how many children she wishes to have. On the other hand, when this law was enforced, we neglected something: it should have been coupled with preliminary education and with the guarantee of available preventive methods. For example, we failed to propagate the use of modern contraceptives. They are not sold in our drugstores. Thus, only abortion remains, which is used by many women, not as a free possibility, but with a libertinism which they abuse. It is not only a matter concerning women, though the right of decision rests with them, for ultimately the family has to decide. Frequently it happens that a husband, who loves his comfort, persuades his wife to interrupt her pregnancy. I think that one of the most important tasks of the council is to reinstate in our society the respect due to motherhood.

Let us hear what the physician has to say who has met many thousands of women while serving on the abortion committee.

DR LASZLO FULOP: The abortion committee has no right, no opportunity to force a woman into continuing her pregnancy. There is a so-called persuasion process, but I cannot cite any example where this was at all successful. Only a few minutes can be devoted to any patient, and we do not have a chance to get acquainted with the circumstances of the applicant. For the time being, the committee is a participant in a superfluous administrative process, and from the point of view of restricting abortion, its work is nil. We also have our "regular customers"—and their number is large—who come to report several times a year. Although we stress the dangers involved and the
tragic conditions they might expect: that they will probably never be able to have children again, they never listen to us. I think that either this system of committees should be ended or it should undergo a basic change.

Is there a connection between sterility and induced abortions?

DR ZOLTAN VADAS: It is difficult to answer this question. One abortion might cause sterility, or produce premature birth at a later date. It also might cause a series of complications, or simply not produce any harmful effects at all. I met a woman who has had twenty induced abortions since she was nineteen. She wanted to have a child when she was thirty-one, after her twentieth operation, but by that time, she was already sterile. It is an unquestionable fact that the abortions are very harmful to the health.

FEKETE: We talk about the equal rights of women, the splendor of motherhood, and yet, in twenty years, we have not managed to achieve a state where family allowances are given to the mother instead of to the husband, who may give it to his wife or not ... I wish to add something to Comrade Vadas' point, and that is that in my opinion around one third of the workers are deeply offended, nervous and angry whenever the problems of the birth rate, family planning and induced abortion are mentioned. The question, however, is one of national interest.

DOROS: I think that it is in the interest of society and even a duty to the country to raise a family. For the time being, it is considered "chic" not to have children, to live childless. The "chic" attitude could be influenced by an adequate taxation of childless parents. Naturally, the money collected in this way should be used exclusively for family welfare. I also think that the maternity leave should be extended, perhaps for one year, and that the working mother should be paid an allowance from this fund until her child is three years old. I would suggest the setting up of a national council for family welfare whose task would be provide modern information and attempt to encourage the raising of families.

What are the ideas of the women's council?

ORTUTAY: We, too, think that the solution to the whole complex of problems should be handed over to some central institution or organization. This institution should do research on the birth rate and families, and at the same time perform extensive enlightening work. An education for family life is a very important task. Doctors, teachers and parents have an important duty to share. They must, however, receive help, for these are matters about which very little is mentioned. The still existing prissiness hinders the acceptance of this topic as natural and mentionable. At present, articles dealing with this subject, vitally important for our society, still arouse a wave of shocked opinions.

FEKETE: May I contribute to the debate. I would make it possible for mothers of small babies to stay at home with an allowance until the child is three years old. I see this sum being covered by the previously mentioned taxation of childless families. For motherhood has not only biological, but also social aspects. Mother love is one of the cornerstones of family life.

VADAS: The present situation of the birth rate gives much work to the Ministry of Health and the health agencies. To solve these problems and the tasks they involve is something with which we have to deal continuously and effectively. May I add that we can attain a healthy birth rate quota and an adequate composition of age groups by an annual "total" of 30,000 extra
births. I am sure that our State will do everything possible for the development of a healthy demographic picture, so that Socialist achievements and ideals may be carried on by a healthy new generation, and not a nation reminiscent of a waning moon. But I think that this is only one side of the question and that society, public opinion and the public attitude also must change. A people building Socialism not only has to plan its economic future, but its demographic development as well.