Emphasis is placed in this paper on the need for hospitals and physicians to alter their attitudes, so as to be able to handle legalized pregnancy termination. The conservatism of institutions and professionals is seen as a barrier to obtaining the full benefits, for women and for society, of the new abortion laws.

ABORTION: PHYSICIAN AND HOSPITAL ATTITUDES

Robert E. Hall, M.D.

THE major effect of abortion liberalization on the medical community has been not to broaden its views but to polarize them. On the obstetrical service of every hospital, no matter how large the staff, there seem to be two or three doctors who do more than half of the abortions. And the rest of the staff regards these doctors with esteem not markedly higher than that previously reserved for the back-street abortionist. In part these castigated few who do most of the abortions may be motivated by greed; more largely, I prefer to believe, they have come to recognize the granting of abortions as a social as well as a medical obligation—an obligation which they accept willingly as part of their response to the demands of today's society. Their colleagues, who do only an occasional abortion on previous patients and the daughters of friends, still cling to the belief, perhaps defensible 50 years ago, that they, not pregnant women, should decide who should have an abortion. Although a U.S. Supreme Court decision is expected, in the foreseeable future, to establish abortion as a constitutional prerogative, a new generation of doctors may well be required to give this decision *de facto* as well as *de jure* status.

The following statement by Dr. George S. Walter supports my view[1]:

". . . One of the largest deterrents to a liberalized abortion policy, in spite of the public clamor, is the health profession itself. Abortion is foreign to the attitudes fostered in physicians during their medical training; the gynecologist, the one to do the abortion, has a basic psychologic conflict. A whole generation of professional health workers refuses to let the myth die out that abortion will irreparably harm a woman and somehow place a stigma upon her. Physicians remain adamant. The male physician won't let the woman decide—reminiscent of the moralistic attitude about pain relief in childbirth before Queen Victoria demanded it for herself. The pregnant woman symbolizes proof of male potency, and if the male loosens his rule over women and grants them the right to dispose of that proof when they want to, the men then feel terribly threatened lest women can, at will, rob them of their potency and masculinity. This flaunting of traditional subservience may be one of the more powerful and less conscious determinants of our irrational opposition to granting women the right to decide matters in this crucial area of their lives. It may also function in the frequent professional insistence upon sterilization as a 'package deal' with abortion. In this way the male physician can maintain control."

In New York State where I practice, the law, as of July 1, 1970, permits abortion through the 24th week of pregnancy if performed by a licensed physician with the woman's consent. This is

not, strictly speaking, "abortion on demand," for it goes without saying that a physician may refuse to do an abortion; but many doctors seem to feel threatened if a woman even asks for an abortion, although they readily acquiesce when a woman asks them to deliver a baby.

The New York law has been supplemented by guidelines issued by the State Department of Health, which recommended that abortions be performed only in hospitals or hospital-affiliated clinics. Only New York City has had the wisdom to incorporate this recommendation into its Health Code, which carries the force of law. Office abortions have thus been outlawed in the city, but does this mean that they will cease? Unfortunately, it does not. The lure of all that tax-free income is just too great.

Office Abortions Unsafe

Yet, in my opinion, office abortions are not safe. There are statistics to prove this. In Hungary, for example, where almost 200,000 abortions are performed per year—all of them in hospitals and all during the first 12 weeks of pregnancy—the early complication rate is 1.8 per cent.[2] In New York State, 200,000 is the minimum estimate of abortions to be performed yearly under the new law. If even half of these abortions are done in doctors' offices, this will mean there will be 1,800 women a year suffering from uterine perforation and hemorrhage in a setting unsuitable for providing remedial care. And actually the complication rate will be much higher in New York because doctors there lack the expertise that their Hungarian colleagues have acquired with 14 years of legalized abortion, and because these complications are much more common with the late abortions which are permitted in New York and not in Hungary.

While most obstetricians remain reluctant to do any abortions, a few do most of the hospital abortions, and an unknown number do abortions in their private offices, a new problem has arisen in connection with the residents in training. Although they generally accept the idea of abortion in principle, they claim that doing several abortions a day for a few months interferes with their over-all training experience. One becomes a little skeptical of this explanation on learning that they would be more willing to do hospital abortions if remunerated for their work, that they are almost universally eager to moonlight in abortion clinics at $12.50 an hour, and that they certainly intend to do abortions in their private practices. But their attitude must be reckoned with, perhaps by adding another man to the house staff or hiring an outsider to do the abortions.

Hospital Restrictions

Another enormous obstacle to the proper implementation of New York's abortion law has been the arbitrary development of inconsistent but largely restrictive hospital policies. Some hospitals insist that abortion applicants live within a certain geographical district, although this is not required of other patients; some ask this of clinic but not private patients. Some hospitals insist on parental consent if the patient is under 21, some under 18, some under 17. Some insist on the husband's consent, some insist that the pregnancy be under 25 weeks, some under 21, some under 13. Some insist that cases after the 12th week be reviewed by a committee, some after the 20th week. Some insist that the patient stay overnight, some that she undergo general anesthesia. Some insist on a complete work-up, including Papanicolaou smear, pregnancy test, serology, and chest x-ray.

In other words, some hospitals make it as difficult as they can for a woman to get an abortion. They make the entire process so expensive that women

cannot afford it, so time-consuming that the pregnancy becomes too far advanced, or so restricted that women cannot qualify at all. And none of these stipulations are in conformity with the spirit or the substance of the law. The healthy young girl who wants an abortion in the first trimester should be interviewed and examined; she should be admitted to the hospital in the morning a few days later, aborted under local anesthesia by suction curettage, sent to the recovery room for a few hours, and discharged home the same day. For private care the hospital bill should not exceed $150 and the doctor's fee $300. For the indigent this entire service should be free.

Hospitals claim that they do not have sufficient beds for abortion cases, but very few beds are required. Twelve hundred abortions a year can be done on a single shift in a four-bed room. Hospitals claim that they do not have sufficient space in their operating rooms, but an operating room is not necessary. An ordinary treatment room can be easily converted for this purpose. They claim that they do not have sufficient paramedical personnel, although one nurse and an aide should suffice. Furthermore, the space and staff for these procedures will soon be freed by the decrease in septic abortions and obstetrical deliveries that will follow the legalization of abortion.

Alternative Solutions

It is small wonder, in view of the intransigent conservatism of so many of our more prestigious hospitals, that abortion centers and clinics are being established throughout the state, soliciting referrals and willing to abort any woman who has the right amount of cash in hand. This sequence of events is tragically similar to that of the birth control movement in the early 1900s. When the hospitals evaded their responsibility for prescribing contraception, outside clinics were set up to provide this service. If a patient wanted birth control advice, she was referred to that clinic down the street. This arrangement worked for contraception because there is no medical risk in fitting a diaphragm. It will not work for abortion. Hospitals should be forced, by law if necessary, to assume full responsibility for the performance of every abortion in this country until simpler, safer methods are available.

Despite testimony to the contrary, there are enough doctors and hospitals to handle legalized abortion on a national scale. There are more than 20,000 qualified obstetricians in this country. If only 10,000 perform an average of two abortions a week, this will amount to one million abortions a year. And if the hospitals cooperate by providing the limited staff and space necessary, these one million cases can easily be handled on a semiambulatory basis. Assuming that abortion will soon be legalized across the country, the job will remain to persuade the hospitals to open their doors and the doctors to open their hearts.

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