

# **The Making of a Model: A New Kind of Health Facility**

The failure of the New York State Legislature to take any action on the abortion issue in 1969, combined with our growing security in relationship to the legal authorities, led us to look for a new and more dramatic way to challenge the abortion statute. The next logical and meaningful step seemed clear: open an abortion facility in New York City in violation of the law. Our two parallel goals would be to demonstrate the feasibility and safety of performing abortions prior to ten weeks of gestation as an outpatient, ambulatory office procedure; and second, to expose the hypocrisy of a law which allowed "therapeutic" abortions for the rich but denied them to the poor. In order to fulfill these goals, we would follow, and in a very real sense mock, the prohibitively expensive hospital procedures.

The year before we had fantasized about setting up an "abortion ship" just outside the three-mile limit under a foreign (Japanese) flag. We even went so far as to have a friend whose specialty was maritime law investigate the implications of such a project. Concluding that there was some risk involved, he recommended that we attempt to implement the idea. He foresaw only one real danger: the support of the country under whose flag our ship sailed might collapse should the U.S. government bring pressure to bear. We halfheartedly and unsuccessfully tried to raise funds for the ship, all the while envisioning a steady stream of women descending on New York's Hudson River with oars slung over their shoulders, ready to row out to the ship. The philanthropic reaction was negative. Then when our medical advisors raised doubts about safety, the plan was permanently filed away.

With the unanimous consent of members of the New York

CCS, we held exploratory meetings with Aryeh Neier of the N.Y.C.L.U. and our lawyer, Ephraim London. Perhaps because London had always insisted that we act in a circumspect if not cautious manner, we were astonished and totally unprepared for his enthusiastic reaction. London and Neier both believed that while the legal risks of establishing a clinic were greater than those we faced in the early days of the New York CCS, we might, by acting judiciously, "get away with it." Basically, "acting judiciously" meant that no one would profit financially from the clinic, and everything about it would be open and above board.

With the backing of London and Neier, we began seeking friendly gynecologists and psychiatrists who would be willing, perhaps, to risk their careers by joining us in this venture. While several gynecologists responded affirmatively and met with us over a period of months, only one, Dr. Bernard Nathanson, was absolutely committed. Nathanson had helped pioneer a liberal interpretation of the restrictive New York abortion law at St. Luke's Hospital. Through his efforts and with his assistance we had been able to obtain therapeutic abortions for minors, married women, and some poor women, none of whom really qualified under a strict definition of the law. Each legal abortion we helped arrange at St. Luke's and elsewhere—always more complicated because of the psychiatric consent necessary—was an occasion for celebration. It seemed reasonable that the more therapeutic abortions were done, the more commonplace the procedure would become, particularly for the medical personnel. Also attitudes would be changed by firsthand contact with the patients, and in the long run the legislative picture would be affected. While Nathanson was not the only gynecologist to push his hospital to do more, he was one of the few advocates of abortion law reform who was also willing to practice what he preached. To our disappointment we were able to find only one sympathetic psychiatrist, and even he wavered as time passed. This hesitation was perhaps because our plans called for psychiatrists simply to provide "rubber stamp" approval to a woman's request for an abortion, not a terribly attractive role for a professional.

By December, 1969, we had drawn up a confidential prospectus for a Reproduction Crisis Facility under the auspices of the New York Clergy Consultation Service on Abortion. Its stated purposes were:

1. To establish a pilot project which would seek to prove the feasibility and safety of performing abortions prior to ten weeks in an outpatient, ambulatory, office procedure.
2. To assist women with problem pregnancies by providing counseling, examinations, psychiatric consultations, medical assistance, and contraceptive education.
3. To provide women with safe, inexpensive, and humane treatment regardless of ability to pay.

The concerns of London and Neier were clearly incorporated into the prospectus:

It is a significant purpose of the experimental project to establish the feasibility of providing medical services to women with problem pregnancies at a minimum cost without refusing service to anyone because she lacks funds. The facility will be a completely nonprofit operation.

All personnel (except unpaid clergy counselors) would receive salaries commensurate with going rates for professionals in the medical field.

A C.P.A. would be hired to handle all bookkeeping and checkwriting work. The accountant would make quarterly reports which could be (if necessary) open to the public at any time.

The New York State law in 1969 required that a woman obtain letters from two psychiatrists attesting that her life would be in jeopardy if the pregnancy were carried to term. These letters were then presented to the Committee on Therapeutic Abortions of her gynecologist's hospital. If the committee approved, the abortion could be performed. If it disapproved, she was denied the abortion no matter how compelling her reasons might be. Since most hospitals had fixed quotas for therapeutic abortions (none wanted to become known as abortion mills), applying for one often resembled Russian Roulette.

In the facility we planned, a woman would also require two psychiatric recommendations. We intended, however, to locate psychiatrists who believed that *any* woman contemplating an *illegal* abortion was a threat to her own life and thus eligible for a therapeutic abortion. Our Committee on Therapeutic Abortions would be composed of prominent medical and lay professionals who would, without question, accept the psychiatrists' recommendations. Consequently no woman medically eligible for a first trimester ambulatory abortion would be refused service at our clinic.

The real difference between our administrative procedures and those of New York hospitals would be the elimination of red

tape and substantial reduction in the expense. Since the New York law did not specifically require that abortions be performed in hospitals (that practice was dictated by medical tradition), the authorities would be hard pressed for legal grounds upon which to deny us the right to exist.

After some months of holding small, private meetings at Judson Church, the participants decided to bring together several key people in the abortion movement for the purpose of informing them and eliciting their support for our project. Included in that larger group were luminaries like Dr. Alan Guttmacher, Dr. Robert Hall, and Harriet Pilpel, Esq. After a few gatherings it became clear that support from them would be delayed. As one participant wrote, "I do not think we are ready to act upon it." Several proposed that discussions continue for an indefinite period until there was unanimous agreement upon every point.

Foolish though it may have seemed, our nucleus group decided to go ahead without the support of the more cautious. They could continue to meet and discuss, but the women who needed abortions might not be able to wait until a "perfect" plan was developed. Following the experience of the New York CCS, we were prepared to strike out with an imperfect effort that would in time be modified and/or improved. At the very least, women would be receiving abortion services which were superior in every way to those offered by "illegal" abortionists.

As we began to develop plans for the project, we determined that 2,300 square feet would be needed. Everyone agreed that the clinic should be located close to Judson Church since it would be operating under the auspices of the New York CCS, and Arthur Levin, a friend of Judson, began scouting the area. Nathanson began preparing a list of equipment needed to outfit the clinic, some of which would be purchased outright and some of which would be rented. Faced with the prospect of being closed down by the authorities, we did not want to invest too much money in medical equipment.

Our first obstacle centered around the rental of office space. Signing a lease for one or two years would legally commit us to paying rent whether or not we were forcibly constrained from operating, and it was a foregone conclusion that structural changes would need to be made in any rented space, an expensive necessity that could conceivably be wasted. In the absence of legal

guarantees that we would not be challenged by the authorities, we had no choice but to proceed on the assumption that our clinic would indeed be shut down. Such a presupposition forced us to avoid any long-term lease arrangements or investments in structural changes for a facility we might use only briefly.

The initial money required to get the clinic going was estimated at \$40,000. While a foundation grant was hoped for, a loan was a more realistic possibility. The commitment to repay either a foundation or a bank discouraged us from any long-term rental. In our preliminary budget we had estimated income at roughly \$5,000 per week and expenses at about \$3,000 per week. On that basis if all went well and we were permitted to remain open for five months, the \$40,000 could be repaid. If we continued beyond five months, our estimated surplus would be over \$60,000 in the first year. This surplus was to be plowed back into improved and expanded patient services, lowered fees, and, if necessary, charitable contributions, so that at the end of a year an official audit would show no profit whatsoever. This was consistent with our own philosophy as well as our lawyers' recommendations.

Sometime in January or February of 1970, it appeared certain that physical space for the clinic could not be obtained unless we were willing to sign a one-year lease. Coincidentally, a brownstone owned by and located behind Judson Church, which for two years had housed a residence for runaway youth, was vacated as that experimental program ended. Through the years the brownstone, a three-story structure, had housed the Judson Health Center and had been a residence for artists and writers in training, as well as the residence of the associate minister and church custodian. In the absence of church plans for other programs to occupy that space, it was inevitable that the question of its availability for the abortion clinic would arise. Faced with no other alternative and determined to carry through with this extended testing of the New York law, we eventually asked Judson to house the abortion facility.

The Judson Church Board Minutes of March 24, 1970, read as follows:

The Board considered a proposal from Howard Moody that the second floor of (Judson) House be renovated for use as an "abortorium." Howard

explained that whether or not the abortion repeal bill is passed, a model will be needed to show women, doctors and hospitals that abortions can be safely performed under office conditions. Setting up such a program would probably cost about \$40,000, and there should be little difficulty about raising this. The volume (of patients) would start at about 35 per week and would hopefully increase with the recruiting of additional doctors. Cost of the operation should average about \$75 with patients paying according to their resources. Ron Bailey reported that the (Judson) House Committee had approved the proposal. . . . The Board voted to accept the recommendation of the (Judson) House Committee giving authority to the staff to move ahead. . . .

In the three years that Judson had housed and given staff to the New York CCS, the church's own commitment to the needs and rights of women had been strengthened. Like the clergy counselors it was willing to risk testing the law on new and potentially more dangerous ground.

Early in April, 1970, the New York State Legislature unexpectedly, by a margin of one vote, passed the Cooke/Leichter Abortion Reform bill. Within days we received a call from Dr. Hale Harvey in another state, asking if we would like him to come to New York and set up a clinic which would be ready to open on July 1, the day New York's abortion law would go into effect. Our answer was an enthusiastic yes. Harvey's offer to come to New York made it unnecessary for the CCS to establish a model abortion facility; we were confident that Dr. Harvey would do it instead.

To explain this decision to let Dr. Harvey establish the clinic rather than ourselves, it is necessary to backtrack just a bit. Early in 1969 we had been visited by a young woman just returned from a year in London where she had done research on sex education and abortion referral groups. She thought that we would be interested in learning more about the English situation. Born in Oklahoma, schooled in New Orleans, she planned to enter the graduate program in philosophy at New York University. At this initial meeting with Barbara Pyle, then twenty-two years old, we heard for the first time about her friend Hale Harvey III. Dr. Harvey had practiced medicine in the South, and taught philosophy and ethics in a university, and in 1969 was devoting his energies to epidemiological research in medicine and public health. His area of interest and the subject of his doctoral thesis was "An Epidemiological Approach Toward Mak-

ing Good Decisions About Ethical Problems in Medicine and Public Health," with special emphasis on sexuality. Deeming abortion an epidemic, Harvey had set his own ethical path: He would perform abortions despite the illegality of the procedure in his state. Our interest was more than mildly aroused by this meeting, and Barbara Pyle left with a promise to invite Dr. Harvey to visit with us to discuss his future plans and explore possible areas of cooperation.

The meeting with Dr. Harvey took place some weeks later, and it was the only time we ever invited an abortionist to meet with us at Judson. Harvey turned out to be a curiously impersonal but totally dedicated man. After explaining his theory of abortion as an epidemic (we already knew that he was absolutely correct about this) and describing the process which had led him to decide to perform abortions, Harvey concluded by offering his services to us. Impressed by his sincerity, we forced ourselves to beware that beneath a surface of concern and conviction, hidden from view, must lie some form of self-interest. But during the year that we referred patients to him, we never detected any secret motive, only genuine compassion and concern for the welfare of women.

With our expression of interest at that time, Harvey returned home and opened a suite of offices in a downtown hotel. Referral arrangements were worked out; and at Harvey's insistence the fee which patients paid was to be determined by the clergy counselor at \$100, \$200, or \$300. At no time during the year which followed did Harvey ever complain or indicate that we were setting fees too low.

Through that experience we learned what a difference it made to patients when they felt the doctor had a genuine interest in their well-being. Harvey had a unique style and used his imagination to provide extras that no other "illegal" abortionist would have even considered. For example, he put colorful potholders on the stirrups of the operating table for both the comfort and pleasure of patients; he told patients calling for appointments to bring along their knitting or magazines or something else to occupy them while waiting; he had cokes and cookies available post-operatively for patients who had not eaten for twelve hours; and he mimeographed a sheet of things to do for patients with free time before catching their return flight. This combination of extras,

plus excellent medical skill, made women feel good about the doctor, themselves, and the experience. Patients back from their appointments repeatedly told us that they had been "treated like an individual," and we understood how important that was. With the passage of time the consistently good reports brought back by women we had referred persuaded us that Dr. Harvey was basically sincere.

With this experience behind us it seemed too good to be true when Hale Harvey telephoned in April, 1970, to discuss his plans for establishing a clinic in New York City. We believed that any facility which he designed would include in its structure the concerns we shared in common: low cost, quality care, humane treatment, and a willingness to serve the poor. On that score we were not disappointed. The nonprofit facility that Harvey founded, the Center for Reproductive and Sexual Health, is a tribute to his deep concern for the abortion problem and its humane treatment.

Dr. Harvey had established the clinic which we expected would be the model clinic that we believed was needed. But there were still many problems to come. It is doubtful that there had ever been in the annals of social change and legal reform such a dramatic victory as we experienced in New York State with the repeal of the eighty-three-year-old abortion law. A testimony to that fact is how ill-prepared all concerned were for the problems which were to come. Perhaps the Clergy Consultation Service was better prepared than most groups and institutions simply because the firsthand experience both with referral and medical practices including the medical economics of abortion forearmed us for the ensuing contests.

Our task until this point had been primarily pastoral, using our offices as concerned professionals in counseling women and acting as enablers in discovering and maintaining safe, efficient medical sources for procurement of an abortion. With the changing of the law so that abortion up to the twenty-fourth week was permissible, the task of the clergy shifted from the pastoral to the prophetic. Now anyone who knows anything about the history of church/world relations knows that pastors are indulged but prophets are stoned. In our new role the CCS in New York had to insure on behalf of the rest of the country the kind of medical delivery system that would afford lowest-cost, quality abortions for the thousands of women who would begin seeking care in a

place where the procedure was now legal. The challenge before us was fairly clear. How could we utilize and capitalize upon the vast experience we had garnered in the three years of "illegal" counseling and referral of women and the identification of competent medical resources? We had developed over the years several firm convictions about the innovations that would be necessary to provide safe, low-cost, and humane abortions in the city when the law changed.

The first and most significant conviction we held, one which went against all medical opinion with the exception of that of a few doctors who had experience with outpatient abortions, was that first trimester abortions (first twelve weeks) need not medically, and for economy should not, be performed in regular hospital settings, but rather they should be performed in ambulatory, outpatient facilities (known in the trade as "free-standing clinics"). Our adversaries were the Department of Health, Health and Hospitals Corporation, and most of the medical profession, including ardent abortion law reformers like Dr. Robert Hall. As far as those people were concerned, the CCS was a group of non-professional, inexperienced laymen. After all, what did a group of clergy know about medical matters? This prejudice on the part of the physicians was understandable, but it overlooked our heavy experience which had taught us a great deal about abortion practices and techniques. In three years CCS nationally had referred perhaps 100,000 women for office abortions without a single fatality.

In the four months between passage of the 1970 New York Abortion Law and July 1, its effective date, Hale Harvey and Barbara Pyle created the first freestanding abortion facility in the United States. The Center for Reproductive and Sexual Health (or "Women's Services," as the clinic came to be called), opened its doors on July 1 in a professional medical building on East 73rd Street in Manhattan, innovating procedures that would later be duplicated elsewhere in New York as well as in other states.

Harvey relied heavily on his earlier experience. Unconsciously following Frank Lloyd Wright's architectural principle that "form follows function," he rejected the mythology of the traditional medical establishment, which would have dictated an impersonal and inhumane hospital atmosphere. He trusted instead in his own knowledge of what was desirable and necessary to insure patient

safety; he built into that facility a component of compassion that was by itself revolutionary in the history of health care in this country.

A suite of perhaps a dozen doctors' offices was rented, each with a tiny private waiting room. The offices, commonly referred to as procedure rooms, contained only an operating table, a vacuum aspirator, and small sterilizer—all designed to be nonthreatening to the patient, who in such a space could observe effortlessly everything that was happening.

The outer waiting rooms were converted into counseling offices where young women, many of whom had undergone abortions in Harvey's original office, would explain in detail, using a pelvic model for illustration, precisely what would occur when the patient entered the procedure room. The nurse/counselors had been hired for the facility on the basis of their empathy and sensitivity toward patients, a quality which Harvey considered to be more important than education and experience. The role of the nurse/counselor was to alleviate any fears and anxieties that the patient had about abortion while at the same time preparing her both psychologically and intellectually for the procedure.

To the early horror of the New York medical community, counselors, not all of whom were R.N.'s, assisted the doctor during the abortion. This practice enabled them to provide continuous reassurance and comfort to the patient, explaining each step along the way just before it happened and eliminating the patient's fear of the unexpected.

The facility was decorated in bright, cheerful colors in order to create a warm, intimate, and friendly atmosphere. Harvey's conviction was that even a healthy patient would feel sick, in the face of a cold, sterile hospital environment; since abortion was not a sickness, the atmosphere associated with hospitals needed to be avoided.

In its first month, some seven hundred women, all referred by Clergy Services in surrounding states, had abortions at Women's Services. Glowing reports began flowing in from patients who had returned home ecstatic about the humane and compassionate care they had received. It was immediately clear that Harvey and Pyle had created the ideal setting for the delivery of a new kind of health care, a fact which was not lost on the entrepreneurs, businessmen, and doctors who in the following months opened

dozens of similar facilities around the city. Women's Services was the model they had to duplicate in order to arouse the interest of other referral groups. Copy and compete they did, even on fees, not voluntarily but only because the existence of Women's Services allowed them no choice.

The day before Women's Services opened, we went to see it for the first time with Harvey and Pyle. On the drive uptown, Harvey turned to us and asked how much patients should be charged for the procedure. Since the lowest cost for an abortion up to that time had been \$300, we said, "Let's try \$200." Without a moment's hesitation he said, "Fine, we'll start with that." He also suggested that Clergy Service counselors should, at their own discretion, be able to reduce the fee to \$100 or even to nothing. In the belief that no woman should receive a free abortion, that both her dignity and self-respect would be damaged by such charity, we persuaded a very reluctant Harvey to agree that poor women would have to pay a token fee of \$25. It seems incredible in retrospect that we (the clergy) had to *force* Harvey to agree to such an arrangement, but he had brought to New York the same air of innocence and compassion which had characterized his practice earlier.

The task of the National Clergy Service, upon seeing the kind of facility that was developed in those early months, was to keep that clinic alive, with statistics showing its relatively low complication rate and with consistently favorable feedback from patients who were referred by Clergy Consultation Services. In order to achieve this goal, we did two things. The first was to undertake a continuous monitoring of all its services to patients, passing along to the staff the benefit of our endless feedback. Two complaint forms were developed at the beginning. One was for clergy counselors to use in reporting any major or minor problem which they or their counselees had encountered at Women's Services. The other complaint form was used by nurse/counselors at Women's Services to provide clergy with reports of any striking weaknesses or omissions in their counseling. This two-way reporting system, profitable to both Women's Services and the CCS, was most beneficial to the patient herself. We also did all we could to encourage licensing of the clinic, defending it before health and hospital officials, all of whom were suspicious of this fledgling upstart of a facility that within six months was doing as

many first trimester abortions as all the municipal hospitals in New York City combined.

Our desire to develop a model health facility which would demonstrate that first trimester abortions could be done safely out of the hospital in an ambulatory, outpatient medical clinic with humane care at a low cost would have been a fantasy had we not possessed a national referral network. This network proved to be a resource much more important than money. For some three years the network had been consistently concerned about supplying safe and, wherever possible, low-cost abortions to women in a high-demand/low-supply black market situation.

The existence of this network composed of clergy and lay people across the country who cared and were committed to working together in the creation of a highly professional, effective, voluntary referral service was what made possible the origin and development of Women's Services. It was literally the clinic the clergy built, not without the medical creativity and administrative know-how of its founders Harvey and Pyle, but certainly the clergy were the decisive factor in its evolution. The volume of women coming from Clergy Services, the strong sense of patient advocacy, the follow-up and feedback of the clergy—all enabled us to exert significant formative influence on Women's Services.

Let's look at the record of what the cooperative action of the Clergy Services accomplished in the area of price control during the first two years of that facility. CCS had long experience with the problem of price while dealing with "illegal" abortionists in the days before liberalized laws. CCS had set the price at the opening of Women's Services in July, 1970, at \$200 (that was the lowest going rate that we knew). With the help of a large, steady volume of patients, that price was pushed down to \$125 within one year. Let it be understood that in New York City during the same period, an abortion in a doctor's office (first trimester) was, and still is, \$300, and hospital abortions ranged from \$300 to \$500. Since WS was one of the first clinics to be licensed by the N.Y. State Department of Health and approved by the N.Y.C. Health Department, it was natural that most abortion clinics would look at this facility and imitate its best features. Some of the commercial clinics voluntarily did so, but others only involuntarily lowered their prices in order to compete with WS.

The establishment of a reasonable fee for first trimester abortions in New York City was singularly due to the cooperative venture of CCS and WS.

Further, the CCS effected through the creation of WS not only the lowest priced abortion in the whole country (California was still locked into the hospital system), but it also helped to build into the facility's structure consistent, concrete financial aid to the poor and the young who could not afford the full fee. Women's Services and its Board of Trustees accepted a formula to be applied nationally with Clergy Services and later with other groups that wanted to refer patients: one out of every four patients referred could pay only the token fee of \$25. The national formula was very important because women in surrounding states closest to New York City, even though they were poor, could be referred in larger numbers so long as the national percentage of patients paying \$25 did not exceed 25 percent of the total patient load. For example, at times New Jersey CCS would refer two out of every four women at the token fee, but the Iowa CCS would refer only one out of seven women at the rate of \$25, thus providing the economic balance needed to meet the formula. It was amazing that this could be done by a clinic with the lowest top fee in New York.

However, this generosity on the part of WS initiated at the insistence of National CCS was later to prove the source of the clinic's most serious problems. When abortion procedures began being performed in large numbers by many doctors in many different facilities, referral groups sprang up all over the country. Some of these were commercial and others were nonprofit, including groups such as Planned Parenthood, Women's Liberation, and college counseling services. These groups developed their own relationships among the competing clinics in New York City with one omission: a hard-nosed deal that would include a formula for assisting the poor. Consequently, women who could pay were referred to one or another commercial clinic, and the poor were referred to the Clergy Services whose medical facility in New York took all the poor, as they had from the beginning. No group "dumped the poor" on WS with malice aforethought. They just did not understand the long-range implications of their actions, namely, that they would eventually scuttle the facility whose increasing ratio of service to the poor might unbalance

its nonprofit economy. These referral groups suffered from a normal provincialism and failed to recognize that abortion is a national problem. Clergy Services understood that better and encouraged the national office to negotiate in their name because of the power of corporate action. This Nader-like principle is the secret at the heart of consumer advocacy. If a person only cares that *one* woman with a financial problem gets helped and has no perspective on *all* the women in the other parts of the country who have the same problem, what is forfeited is the united action that could make available a lot more help for many more women. If the white middle-class clergy or lay counselor in Kansas doesn't care whether the poor of Connecticut get abortions, then that counselor doesn't understand the difference it makes in regard to what clinic or under what terms referrals are made.

When the commercial clinics put their traveling sales or public relations people on the road to drum up business for their enterprises, they counted on the well-worn practice of divide and conquer as far as Clergy Services were concerned. They counted on gullibility and ignorance of the national picture on the part of new referral groups, or perhaps they counted on blowing a few egos with a lot of personal attention, phone calls, paid trips to New York, and the promise of taking care of your "poor people." This technique was especially effective west of Ohio, and it was particularly interesting that the soliciting agents of commercial clinics never tried to persuade Pennsylvania or New Jersey Clergy Services to refer their clients, including their "poor." Had they done so, they would have been forced to live up to their promises. The poor of Nebraska or Michigan can rarely raise the transportation money needed to get them to New York, a fact which the commercial clinics banked on.

Should Women's Services go under because it tries to serve the poor in large volume while referral and counseling groups, for various reasons, make individual arrangements with commercial clinics in New York, we will have lost a very important tool in implementing the repeal law so that abortions are made available to *all* women regardless of their ability to pay.

The fact that Women's Services is a nonprofit facility, whose application for tax-exemption is pending, distinguishes it from many clinics in New York to which women are being referred. The significance of this fact is clear: individual persons are not

making huge profits from the clinic. Women's Services and the two Planned Parenthood clinics in New York City are the only nonprofit outpatient facilities serving the poor in any kind of volume. Of course this factor is no guarantee in and of itself that these institutions will have superior services; but it does mean that because no profits have to be made, no shortcuts have to be taken in medical care, no trimming of personnel to cut payroll, no shortchanging of service in behalf of "economy" to maintain profits. Whatever money Women's Services makes (after its \$250,000 debt is paid) will be plowed back into patient care and structural improvements, as well as the further lowering of the \$125 fee and the assisting of more poor. That distinction is the fundamental case to be made for the nonprofit facility as long as its services and care are of a high quality. After its tax-exemption is received, this clinic will eventually be able to apply for tax-deductible monies now available to private, voluntary hospitals that serve a community. We know of many community hospitals with great endowments and foundation help which have not served the indigent with anything like the faithfulness of Women's Services. Since July, 1970, Women's Services has performed medical procedures for over six thousand women at \$25 or less. What other commercial clinic which boasts its humanitarian nature and willingness to accept patients at reduced fees can match that record?

Another innovation in health care which was built into the structure and functioning of Women's Services by the CCS is the role of "patient advocacy." During the first year after abortion became legal in New York, National CCS played that part in behalf of the Clergy Services. As we saw the growing need to have someone at the clinic whose primary task was the patient's care and liaison with the counselors who referred her, we prevailed upon the Board of Trustees of Women's Services to create such a position. Seeing the value of the proposal, the Board complied and Marchieta Ceppos was then employed by and is answerable only to the Board. Her major function is the care of the patient, not how much money the clinic can save, not the labor problems of workers in the clinic, not even the protection of medical and administrative personnel who goof off; her job is to see that the patient consistently gets what she paid for in both medical services and human warmth and concern. The welfare and financial stability of the clinic is secondary to the patient's needs. It would not be an over-

statement to say that if there were such an ombudsman in every hospital and health facility in New York a revolution in health care might be possible. We know of no commercial abortion clinic which has or would institute that kind of self-critical watchdog of medical standards and patient care.

Finally, to insure the kind of high quality facility incorporating the concerns the Clergy Services have for patients they refer, Women's Services set up in its charter a Board of Trustees made up of unpaid, nonstaff, public spirited citizens whose only stake in that clinic is to ensure that it functions financially and medically so that it may continue to furnish low-cost, quality-care medical assistance to women in need of abortions.

Women's Services is the clinic that Clergy Services made happen, and without it abortion facilities in New York would be very different. The purpose and strategy that went into the creation of Women's Services with its unique structure is what sets it apart from and makes it different from any commercial clinic. If the advocacy of Clergy Services is to have any permanent meaning, it must be translated into support of a model that we hope will be duplicated in every state and region when the changes in the law occur. But Clergy Services across the country will not need any other first trimester facility as a standard for competitive pricing as long as patients are being referred to New York City. Were the Clergy Services to forsake this medical facility (with its capacity to treat one thousand patients each week) for matters of personal whim, or some small "convenience" or gimmick offered by its competitors, it would demonstrate its failure to grasp the long-range goal of real consumer advocacy in this new medical delivery system.