

## **When the Changes Come: Implementing the Law**

What proved to be a far-reaching initial decision, after the legislature acted, was that on July 1, 1970, when the new law went into effect, the Clergy Consultation Service in New York would dissolve. This decision, which later was to prove perhaps premature, was based on the premise that the decision about abortion really should be left between a woman and her doctor and that no person, either psychiatrist or clergy, should be involuntarily placed between a woman and her physician. There was a lot of talk in Albany that an amendment might be added to the law which would make it mandatory for a woman to see a social worker or professional of some kind before she could attain an abortion. We could see the possibility of clergy taking the place of psychiatrists as patsys for the Ob/Gyn profession again removing from the doctor responsibility for granting a woman, barring medical contraindication, this elective procedure. The proposed amendment never developed, but the possibility helped us decide to go out of business the day the law changed. For three years the clergy had been spending large amounts of their pastoral time counseling women; and they were tired, deserved to rest, and wanted to go back to other causes and responsibilities which they had neglected. All of us were ready to counsel any woman who wanted help in making her decision, and all the clergy agreed to stand ready for that possible need. But the ensuing months proved that most women do not require counseling once the stigma of involvement in an "illicit" act is removed and safe procedures are provided in hospitals and clinics. Of course women continue to worry or agonize over the decision, but in most cases they do not require the services of a professional when abortion has become a simple elective medical procedure.

The next important decision we made after disbanding the clergy

as counselors was to reconstitute them as advocates of women seeking abortions in light of the guidelines of the Health Department and the conservative medical profession's insistence that abortions must be performed in hospitals. We felt that the hospital system in New York City, with a built-in prejudice against this new procedure and already overtaxed and understaffed, would create chaos in a new medical delivery system. We decided, therefore, that the clergy could become "watchdogs" of hospital abortions and advocates of women hassled and harassed by an unsympathetic hospital bureaucracy. We created for the purpose of accomplishing this task an organization called Clergy and Lay Advocates for Hospital Abortion Performance. It had a phone and a coordinator, Ms. Barbara Krassner, a member of Judson Church and a fervent women's rights' advocate. Any woman who had trouble getting an abortion in a New York City hospital could call the number and receive assistance for getting her abortion at the earliest date. When necessary we would intercede for her.

The reason for our work was not only to facilitate the woman's abortion but also to amass evidence of the inadequacy of the hospital system to absorb both first and second trimester abortions, as well as the economic infeasibility of such a system. On July 1, the day the law went into effect, all the bureaucrats of the medical establishment and the Health and Hospitals Corporation were assuring everyone that there was no need to talk about setting up freestanding clinics, that the hospitals of the city could easily do all the abortions required, and besides clinics were not all that safe. On that date the backlog of women already registered at hospitals and waiting for abortions was 717. On August 12, the backlog was 1380 women. On September 17, it was reported that the number of women waiting was 2500. At the rate of 100 abortions a day being performed in New York hospitals, that was a three-week waiting list. By September 18 when the Health and Hospitals Corporation claimed that the abortion program in city hospitals was a "success," the waiting period for women seeking merely to be examined averaged from three to four weeks in length. Women in the early stages of pregnancy began to be shuffled from one hospital to another, and cash in advance was being demanded of even the poor, despite the public posture of the Corporation that no resident of New York City would be denied a hospital abortion whether she could pay for it or not.

From July 1 to October 1 we gathered documentation on the whole hospital system and its failure to provide an efficient, safe, low-cost abortion for women requiring that service. We were able to substantiate our charge that only the law had changed. Most of the bad characteristics of the "illegal" days—the victimization, the cruelty to women—were still with us; only the characters of the problem had changed. Under the Health and Hospitals Corporation's implementation of the law, a woman could spend days and weeks being shoved from one hospital to the next before she found someone willing and able to help her. Often this meant that she was delayed from an early, safe, ambulatory abortion (performed until twelve weeks) to a difficult and sometimes traumatic saline abortion (performed after the sixteenth week of pregnancy), unnecessarily endangering her health. There was no referral system worthy of the name for pregnant women. Under the law, doctors (now called not "abortionists" but "Ob/Gyns") were charging the same prices as the old illegal abortionists. The poor and the young who had suffered the most when abortions were illegal were still having the hardest time.

The Health and Hospitals Corporation pretended that the system was performing beautifully and encouraged the Board of Health to pass stringent guidelines for freestanding clinics that made them mini-hospitals. The Board of Health's inclusion of these regulations in the Health Code was an ill-founded and precipitous decision, based on no pragmatic experience and made without proper evaluation of the hospital system's handling of the abortion demand in the city. The medical establishment failed to mobilize public and voluntary hospitals to provide sufficient abortion services, to establish any adequate city-wide referral system, or to investigate means of terminating early pregnancies in alternative medical facilities. This failure added up to a nonfulfillment of their promise to provide the women of New York City with early, safe, and inexpensive abortions.

Our press releases and public condemnation of the city health community began to hurt. We knew they were hurting when in late October pressure was put on Family Planning Information Service, the official referral agency operated by Planned Parenthood, to stop giving our telephone number to women who were having trouble getting hospital abortions. We were very dependent on FPIS for referrals of women having trouble, and the Interagency

Council which represented city health agencies wanted to get advocacy out of the clergy's hands and put it in FPIS where they could control it. Gradually Gordon Chase, Health Services Administrator, began to find out the "truth" about the performance of his hospitals and took steps to rectify that situation. By December, 1970, the situation began to look much better. Clinics began to flourish, and Women's Services, which Dr. Hale Harvey had begun on July 1, proved its capacity to do volume low-cost first trimester abortions in a medically safe setting with counseling and humane treatment. But a year passed before the Health and Hospitals establishment admitted that Clergy and Lay Advocates were right about the impracticality of doing all first trimester abortions at inpatient hospital facilities.

One of the facts that struck us hard in our new role as watchdogs of "hospital abortion performance" was the capacity of structures and bureaucracy to circumvent laws, so that a change in the law which seems like such a significant victory is only meaningful when the new conflicts are identified and resolved. When legal changes come and reform statutes are installed, they are only words in a legislative code and sometimes mean very little. One has only to remember the seeming triumph of the Voting Rights Act of 1964, which was followed by congressional refusal of appropriations to federal officers in southern counties to enforce violations of the people's rights. The new law was an empty victory when it was not accompanied by the creation of new structures that implemented that law in ways which the legislators intended. Being a lobbyist changing and updating laws is relatively easy, but engaging in the reform that makes new laws meaningful is much harder. When the changes do come, one of the surprises in social reform is that some of your "friends" become your "adversaries." For example, many of the people in the health establishment in New York were with us in favoring liberalization of the law, but those same people became our "enemies" as we tried to innovate a new medical delivery system. Those people who saw our activities as a real threat to the status quo had a deep, vested interest in the health and medical profession. They considered our invasion of their field as definitely "meddling." After all, the hospital facility was the standard unit for the practice of medicine, and the suggestion that *hospitals* were not needed for the elective procedure of abortion in the first trimester came as a threat from "outsiders."

This experience was reinforced for us at Judson because we were engaged on a second front in the battle with hospital professionals. In 1968-1969, we helped create and organize for the streets of the East Village a mobile medical unit to service the health needs of young people who were predisposed to stay away from large hospital facilities either for preventive or curative medical service. The large hospital in whose catchment area the mobile unit was located put every obstacle in our path to prevent this experiment from happening. The contention was that only in a "real" hospital with all its resources and backup facilities was it safe to treat diseases and service health needs. We reminded them of the war where frontline medical units worked out of tents in the mud and muck without white walls or uniforms and with a minimum of medical officialism. We opened anyway, and the unit functioned. People who would never darken the doorway of that nearby hospital came with their needs. This experience was another testimony to the powerful, reactionary resistance that people build into organizational status quos. This tendency is the reason that reforms of legal statutes and administrative codes are many times meaningless gestures so that the role of concerned citizen advocacy is an absolute necessity.

As clergy, our involvement with the issue of abortion during a period when no one else was involved, gave us knowledge and credentials in a field which tends to be preempted by professionals, whose prejudices and preferences had never been questioned by nonprofessionals. We knew, for example, that in most hospital units, the Ob/Gyns run the maternity section of the hospital and if abortions were done in ordinary hospitals, not without a certain ambivalence on the part of those making the assignment, the woman who was terminating her pregnancy would be placed in a room with women delivering babies. The psychological trauma resulting from that situation would be cruel treatment for the abortion patient. Our experiences had sensitized us to the woman's fear, anxieties, physical and emotional concerns, and we had no final stake in anything except the woman and her needs. We wanted to make her experience compassionately humane with as little pain and suffering as possible. In the early months after the law was passed, we were outraged when women getting later terminations, up to twenty-two weeks' gestation, were required by the medical authorities in city hospitals to sign a "fetal death

certificate" as the "maternal parent of the deceased." This psychological assault upon women was justified by spokesmen who said the Board of Health must keep statistics. Outrages like this coupled with the judgmental and punitive attitudes among hospital personnel were destructive of whatever dignity and self-assurance women might have had. These factors fortified our continuing insistence that new kinds of medical facilities geared to this particular medical procedure must be created and should be encouraged, not hampered, by health agencies.

Another revelation that came to us when the law changed was the new cast of characters that surfaced to join the number of those providing abortion services. In the "illegal" days when we were fighting for liberalization, our friends were mostly social activists, women's rights' advocates, "single issue" reformers, almost all of them with clear motivations. When the law changed, people who claimed their desire was to see that every woman could have an abortion came out of the woodwork claiming to be "humanitarian." These were the "business Mafia," as we called them. From April when the legislature acted, the calls began to come in from bright young business entrepreneurs who wanted to build abortion clinics. They said they wanted our CCS "know-how," but what they really wanted was our *clients*. At that time some fifty to sixty thousand women a year were going through our counseling network from Maine to Washington. These businessmen, usually collaborating with a psychiatrist or an Ob/Gyn, were out to make a bundle off a brand-new enterprise. After all, look at what the "illegal abortionist" did for himself in the old days. Now it could be done legally! If you want to understand how "sugar plums danced before their eyes," do a little quick arithmetic: if you performed only 500 abortions a week at \$300 per abortion, that's approximately \$600,000 a month gross or \$7 million a year. You could pay fantastic salaries, buy a building, and still have a phenomenal return on your investment. These entrepreneurs were willing for us to design the facility, set up the services, and be consultants (for a fat fee) all in order that those poor women could get the abortion they so richly deserved!

Then there were all those greedy doctors who, as soon as the law changed, called CCS and Planned Parenthood to volunteer the services they realized would be needed. These doctors were going to perform the first trimester abortions right in their offices. They

had already ordered their vacuum aspirators and were ready to give up their day off if it meant picking up \$3,000 in an afternoon. We knew one doctor who was head of Ob/Gyn at a hospital with stringent rules for an overnight stay and general anesthesia for early abortion cases, but after urging Health Code rules that restricted all abortions to hospital facilities, he offered to do patients in his office for \$300 each. Now there was a physician whose left and right hands were perfectly coordinated! We just had to hang up the phone with loathing for all of these brave, helpful doctors. Where were they when we were begging them to abort a twelve-year-old girl who had been raped and was pregnant? Our bitterness at these doctors was exceeded only by our contempt for them. As far as we were concerned, they were a disgrace to their profession.

The third genre of character that came out into the open when the law changed was the now famous "commercial referral agent," the true entrepreneur of a capitalist enterprise, the middleman who has no skills but doesn't need them because he collects for other people's services. In much of our business world this kind of person is a thoroughly necessary evil whose gains are written into the markup of the prices we pay for that which we consume. One area of professional life where there is no middleman is the medical and health field. Even the hint of such, i.e., fee splitting among doctors, is considered a breach of medical ethics. One of the first such agents was a businessman who started operating charter flights to Europe and who ended up under investigation in New York State for violation of the law. It is rumored that he creamed millions of dollars off the top of the abortion business at the expense of women. This latter group of referral agents became the source of attack by the CCS and Planned Parenthood in New York City. Our efforts resulted in a law which made illegal the operation of commercial abortion referral organizations. Although this effort did not stop them entirely, it did put the law on the right side of the issue.

The story of our struggle against commercial referral agencies is worth setting down because it was an unexpected complication that accompanied the liberalization of abortion. The situation was exacerbated by the differentiation of abortion statutes in different states. In one state, a woman may be completely forbidden to have a therapeutic abortion, except when her life is endangered, but in

a neighboring state the law may have been reformed or repealed. The "middleman" or a commercial referral agency plays the role of helping the woman get from A to Z, terminate her pregnancy, and get back home.

When CCS began its counseling service in 1967 before the laws were changed, one of the tasks was referral, putting a woman in contact with an accredited and competent source of care for terminating her pregnancy. In that sense the clergy acted as a source of information. In the "illegal" days that information was very important, but when the law changed and abortion became simply another elective medical procedure, there was a real question whether there needed to be a person between the woman and the doctor or hospital and clinic.

Soon after the law changed in New York and it could be seen that New York City would be the "abortion capital of the United States," commercial referral services sprang up everywhere. Sometimes they were "front organizations" for a group of doctors running an abortion group practice; other times they were independent agents setting up contracts with abortion clinics and hospitals where the agent was paid so much for every referral. The situation was really no different from when the Mafia offered CCS \$50 per woman for abortion referrals to their "doctors" in New Jersey. Most of the doctors and clinics who went into business had no other way of getting patients except stealing them from each other, which they blatantly did at La Guardia airport by having their driver pick up the other clinic's patient. Many an unsuspecting woman got her abortion in a different place than where she had made an appointment.

When the New York CCS ended referral service, we believed that we were doing the right thing so as not to tie the clergy permanently into the procedure. In retrospect we probably made a mistake in disbanding before we could see what would happen with the growth of the commercial agents in New York. Nevertheless, our decision was to move into advocacy and to turn referral over to Family Planning Information Service, which was nonprofit and which would give free information as well as help arrange abortions for women in New York hospitals.

In the winter of 1971 after the commercial services had been exposed for highly exploitative and brazen fee-splitting arrangements with doctors, the office of the attorney general in New York

State opened hearings on the problem. In our first testimony before his committee, we supported the regulation of the commercial services rather than outlawing them because we were worried about overburdening our Clergy Services across the country; we had no desire to make it more difficult for a woman to find a referral source that was reliable, even if she did not use Clergy Services or Planned Parenthood.

But we changed our minds in the next two weeks and gave written testimony to the attorney general's office of that fact. We said that the commercial services should be outlawed, not regulated, because, given the way they functioned, they usurped the prerogatives and responsibilities of the medical profession in regard to the patient/physician relationship; if they were made legal, even with restraints, the practice would set a dangerous precedent for commercial middlemen in all areas of health care. The major argument *against* outlawing them was that women would not be able to get abortions. But that was a spurious argument since the women we were concerned about were out-of-state women and for the most part the white, middle-class people who have always found their way to help. Other women, the marginally poor, ghetto women, were not being helped by these commercial referral services anyway. The poor had to rely on the clergy who could care for a limited number because they referred largely to a nonprofit clinic which willingly accepted as patients a certain number of poor women.

The final resolution of this matter came with the passage of a bill which banned profit-making commercial referral services operating in the state of New York. CCS and Planned Parenthood were allowed to continue making referrals because they did not charge women a fee for information and had no kickback arrangements with any clinic or hospital.

The law struck at the heart of every enterprise making money by charging a fee for information about the source of medical assistance. Section 4501 of Article 45 stated:

No person, firm, partnership, association or corporation, or agent or employee thereof, shall engage in for profit any business or service which in whole or in part includes the referral or recommendation of persons to a physician, hospital, health related facility, or dispensary for any form of medical care or treatment of any ailment or physical condition. The imposition of a fee or charge for any such referral or recommendation shall create a presumption that the business or service is engaged in for profit.

We believe the example set by the experience of hundreds of clergy and lay counselors who gave thousands of hours of uncompensated time resulted in passage of that law which cannot help but abound to the benefit of consumers of medical services.

The narrow and unrelenting stand we had taken requiring that Clergy Services be free of any but voluntary contributions was clearly exonerated by the distinction the New York law made between clergy and other referral services. Once abortion was legal, some persons in our Clergy Services believed it was only fair to charge a fee for counseling women. The question was understandable. After all, the clergy weren't paid for this counseling, and their own expenses for telephones and running their local CCS many times came out of their pockets; so, to defray their own expenses, it was natural for them to consider asking for a surcharge on patients sent to Women's Services. Although the request seemed reasonable, we were adamantly opposed to the clergy charging women or getting what would amount to a "kickback" from the clinic, and the idea was never pursued.

This issue was deep at the heart of what CCS had been about since its origin. We did not believe that any counseling that was a part of the ministry of the church ought to be paid for by the recipient, except voluntarily. This conviction was particularly true in regard to abortion counseling, as in this instance women were forced to go to clergy who had information they needed and couldn't get elsewhere. To place a price on the service smacked of the "sale of indulgences," especially to those outside of the church. The church had made a lot of theological talk over the past decade about servant-people serving the world as well as the church, but when it came right down to practice, the temptation was there to charge some money for counseling those who weren't part of our churches.

One reason that Clergy Services attained the reputation they did around the country, particularly in the days in which abortion was illegal, was that there was a high level of professional counseling and no money passed hands. In all the times that we were making arrangements with "illegal" abortionists, though they were charging unscrupulous prices to women, we never accepted any offers of money. We easily could have rationalized in those days that the doctors should pay for the running of CCS because of the excellent job of screening that our counselors were doing. When we

were offered money, which was not all that often, we always suggested to the doctor that he could keep it and apply it against lowering the price of abortions.

A further ethical consideration related to the new law which was passed in New York State against commercial referral agencies was the precedent that information and/or arrangements for medical assistance and services is not a salable commodity. Otherwise, why not such arrangements for all medical services? These entrepreneurs saw in the abortion referral business the possibility of making a fast buck during a transitional period in medical practice. They were charging a woman anywhere from \$10 to \$100 for information; one of the *real* distinctions between Clergy Services and other referral groups was that the clergy did not charge any fees.

Finally another important consideration in arranging "kick-backs" for referrals from a clinic has to do with the conflict of interest. For example, if CCS had an arrangement to receive money for its operation from a clinic like Women's Services, and a few months later the price went up and the quality went down, would not our freedom to pull out of that facility be curiously hampered by our dependency on the money that made our operation possible? The integrity of our decision would be seriously jeopardized by such a monetary understanding.

Another unexpected problem met us with passage of the reformed abortion law in New York State. The new law made abortions legal up until the twenty-fourth week. Our experience with second trimester (thirteen to twenty-four weeks) abortions had been minimal during the three years of our operation. We sent all late pregnancies, when the women could afford it, to London or Tokyo. Dr. David Sopher in London performed abortions for several years using the laminaria procedure under general anesthesia. This procedure involved the use of instruments to remove the fetus. Then when our law changed, CCS counselors began sending a fair number (about 200 a week) of late terminations to New York City. The only accepted procedure for late termination in this country is known popularly as the saline method. Briefly, the procedure is as follows: A needle is put through the abdomen into the amniotic sac, and several ounces of fluid are removed and replaced with an equal amount of a highly concentrated salt solution. The salt solution kills the fetus and

stops the release of placental hormones. The patient within a twenty-four-hour period undergoes labor similar to a live birth, and the fetus and placenta are then expelled with the help of labor-producing medication.

Clearly, most women did not voluntarily wait that long to decide to terminate their pregnancies. However, if a woman was ten or eleven weeks pregnant when she was initially examined, the task of getting to a counselor, receiving information, getting together her resources, and making arrangements to travel some five hundred to a thousand miles distance meant that she would be past the twelve-week period during which abortions could safely be performed in a clinic using vacuum aspiration. This meant then that she must wait until the sixteenth week before she could obtain a saline abortion. The psychological pressure upon the woman who had to carry the fetus another month after her decision was a traumatic one. If you add to that pressure the nature of the later procedure which was more dangerous and difficult, one can understand what happened to women.

We got our first inkling of trouble when the reports from clergy across the country began to indicate some bad psychological and emotional reactions to the late termination. What we discovered was that in this medical procedure the woman literally had to go through a "mini-birth" in which she passed the fetus in bed. Often she saw the fetus and was highly disturbed. A woman who had a miscarriage but was forced during the D & C to look at the products of conception would have a similar reaction. For most women who had the fears and anxieties of having to wait so long, it was an extremely disturbing situation.

It became clear to us that this method of evacuation, the only common procedure used by the medical profession in this country, was highly undesirable and worked an inordinate hardship on women. The contrast between our experience with late terminations in England with Dr. Sopher was so striking that we began to raise questions about why the American medical profession did not use the laminaria method which seemed so much more humane and satisfactory for the patient. We were told by every doctor we asked that laminaria was a very unsafe and even dangerous procedure. These reports were not borne out by the complication rate on late abortions in England or Japan where the laminaria technique is practiced, and we were highly puzzled. However, we were

left with no alternative but to suggest that all counselors prepare counselees with late pregnancies for a very taxing and difficult time in order to be sure they understood what lay ahead and would be able to decide on that basis whether to have an abortion or to carry the pregnancy to term. Unfortunately, most of these patients were teenage girls, who had been afraid to tell their parents, or ghetto women who simply didn't know that they were pregnant until very late, and had difficulty locating a source of help.

In order to understand the nature of the operation and its emotional effect upon women, National CCS employed Sonja Hedlund to spend three months as an observer in hospitals where saline abortions were being done. At the end of that time she issued a report on her findings and made recommendations for pre-abortion counseling. Copies of this report were sent to all CCS counselors around the country for use as a guide. We did not find out until almost a year later the real reason why the saline method is the only generally approved late termination technique in this country. A physician using laminaria on an experimental basis in a West Coast hospital spoke to us about the sharp contrast between the two methods. In the saline method, the burden is on the woman to pass the products of conception; so she thereby has to deal with a sixteen- to twenty-four-week fetus, while with laminaria the doctor must remove the fetus with instruments. Such a procedure would probably be almost as traumatic for many doctors as the saline procedure is for women. This explanation seemed more plausible than any other we had heard and confirmed our feelings that doctors develop prejudiced practices and justify them with statistical mendacity that makes the layman believe that a particular procedure is used in order to save life when, more probably than not, it is used to save the doctor time, unpleasantness, or money. In that sense the medical profession is no different from others; lawyers give professional advice that lands clients in jail because it concludes a case more quickly; clergy use theology to justify a course of ethical behavior to a parishioner. One could swallow the phony explanations from doctors more easily if one did not have to endure the high and mighty medical pretensions, couched in jargones.

Women would be greatly benefited if the medical profession could develop a new procedure that is both safe and humane for late termination of pregnancy. Such an effort would seem only fair

if doctors do not have the stomach for dealing with the "products of conception."

The changing of law is simplicity itself compared with the complexity of its implementation. Every state where reformers, clergy and lay alike, are fighting for change needs to have a group whose sole task is to lay the groundwork for what will happen when the law changes. Some states have liberalized abortion laws but women still cannot get abortions because of excessive price, red tape, or simply lack of planning for medical facilities and doctors to perform services. The laws on abortion in Alabama and Kansas, for example, allow extensive freedom for abortion procedures, but the women of those states are still traveling thousands of miles to obtain a medical service which the laws of their own state allow. They have to do so because no group of people planned for what would happen when the law changed. For example, a first trimester abortion in a hospital in Topeka, Kansas, costs \$500; so many Kansas women fly to New York City and get an abortion for \$125. Even allowing for air fare, the cost is far less than the termination would cost a woman in her own hometown.

The experience of CCS was a hard but valuable teacher for all of us, and the abortion issue provided a testing ground for a great variety of rhetoric and strategies that have grown up around social change. Some of those lessons may be profitable for other fields of social reform.