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ABORTION AND LEGAL RATIONALITY

Introduction

This article concerns the legitimacy of various legal schemes for dealing with abortion. Legitimacy in one sense is secured simply by complying with the formal criteria for valid law-making: enactment within power and in due form. But jurists have learned (or re-learned) that more can be said about legitimacy, without betraying the purity of their discipline by moralizing and advocacy. From this development in jurisprudential thought emerges the range of questions and criteria deployed in the present study.

Max Weber discerned three types of legal legitimacy: that deriving from the sacredness of tradition; that deriving from the charisma of saviours, prophets or heroes; and that deriving from the rationality of general rules¹. In the last-mentioned case, there stands behind every official and legal act "a system of rationally discussable 'grounds', that is, either subsumption under norms or calculation of means and ends"². Formal rationality is content to subsume particular cases under general norms; but unrestricted rationality demands that the general norms themselves should have more than traditional or charismatic authority, and so subjects all legal material to the substantively rational co-ordination of means with ends³. Now jurisprudence is committed, at the very least, to unrestrictedly rational discussion of legal materials and legal experience. So a society in which jurisprudence is a socially recognised discipline is likely to be or become one in which the principle of legal legitimacy is substantive rationality in Weber's sense. The raising of theoretical questions about law and legitimacy breaks the spell of pure tradition or mere charisma⁴.

In modern Western societies, jurisprudence is a recognised discipline and legal legitimacy is sought to be measured by rationality. Official acts of administration or legislation are questioned, and in response are legitimated by appeal to more general norms and higher ends. These societies exist in a real tension towards the ideal of substantive rationality in law. Jurisprudence, in the pursuit of its own rational questioning, and without imperilling its purity, can examine

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1. Rheinstein (ed.), *Max Weber on Law in Economy and Society* (1954), 336; also xxxix-xlii.
2. *Id.* at 355.
3. On the distinction between substantive and merely formal rationality, see Weber, *op. cit. supra* n.1 at 63-64, 351-356; also Rheinstein's intro., xvii-ix. "Unrestricted rationality" is not a Weberian category.
4. See Eric Voegelin, *The New Science of Politics* (1952), 59. On the inadequacies of Weber's analysis of substantive rationality and charisma, see Talcott Parsons, *The Structure of Social Action* (1937), 658-672.

actual legal material and proposed legal projects in the light of this working ideal. This is not to say that the most general norms and ultimate directive ideals of Western society are derived from, or justifiable by, jurisprudence. It is simply to say that even a jurisprudence which prides itself on rigorously restricted analysis of mature Western legal systems will have absorbed into its account many of the techniques, conceptual structures, distinctions and procedures by which those systems strive to secure a working rationality in the co-ordination of ends and means and in the concretization of general principles and values⁵. Such a jurisprudence can examine actual and proposed schemes for regulating abortion and assess them in terms of that working rationality, if nothing more.

That is our present purpose, and in carrying it out we shall set out in turn three model schemes of legal regulation of abortion. At this point we shall characterize the three only roughly and, as will be seen, insufficiently:

1. the prohibition of all abortions, except where the life of the mother is threatened;
2. the permission of abortion when previously authorised, by independent officials, under defined but ampler categories of medical, psycho-medical or quasi-medical conditions;
3. the permission of all abortions save those performed by persons unqualified to carry out the medical procedures involved.

1. The "rights of the child": strict criteria and ex post facto control by criminal law.

The first scheme of regulation is that which until very recently prevailed throughout the English-speaking world and much of the continent of Europe⁶. In this scheme, the inducing of abortion is prohibited, under penal sanction, except where the life of the mother is in danger, or at most, her health threatened with imminent, grave and lasting impairment⁷. In various jurisdictions the width of these exceptions is uncertain; to interpret them it is necessary to know the accepted objectives of the scheme. These objectives and

5. An obscure sense of this seems implicit in John Austin's doctrine that analytical jurisprudence should concern itself with "the ampler and maturer legal systems". Austin, *The Province of Jurisprudence Determined*, 367 (ed. H. L. A. Hart, 1954). If law were to be regarded simply and solely as sovereign command, it would be difficult to see how it could be more (or less) mature at one time or place than at another.
6. The law under the Abortion Act 1967 (U.K.) and the Criminal Law Consolidation Act Amendment Act 1969 (S.A.) seems to us to be approximate to the third model scheme, for reasons discussed in the text *infra* at nn.59-62 and in nn.59, 78 and Appendix A. For the law in most European states, see Rateau, "Etude de Droit Comparé sur l'Avortement dans Quelques Pays Européens" [1959] *Rev. Int. de Droit Pénal* 265. On the new South Australian legislation, hereafter referred to for convenience as the "Abortion Act" 1969 (S.A.), see Appendix C.
7. Where an exception to the general prohibition is admitted in favour of the *health* of the mother as well as of her life, the first scheme becomes more or less unstable, depending on the strength and content of medical ethics and the interpretation put on the law by the medical profession and the public. In England, a vaguely defined exception was admitted under *R. v. Bourne* [1939] 1 K.B. 687, in favour of the mother's mental health, but the scheme was saved from collapsing into a permissive scheme of the third type by the cautious attitude of the medical profession: see Bernard Dickens, *Abortion and the Law* (1966), 98-100. But when the

values do not appear unambiguously from a mere statement of the formal criteria for lawful abortions. That is why our rough classification of the three model schemes, by reference mainly to the breadth of those formal criteria, needs modification and amplification. Again, in a number of European jurisdictions there exist exceptions in favour, not only of the life and health of the mother, but also of eugenic (i.e. in respect of presumed malformation of the child) and "ethical" (i.e. in respect of pregnancies by rape or incest) indications. If not too many questions are raised about the principle on which these exceptions are based, their existence seems compatible with the first scheme (as well as with the second or third)⁸; but the raising of these questions is liable to make the first scheme seem incoherent in its principles and objectives, and so gradually to topple it over into the third scheme. However, the defined grounds for lawful abortion within a scheme are less directly relevant to a jurisprudential discussion than are the general objectives of the scheme and the appointed techniques of deciding, policing, sanctioning and adjudicating in the light of those objectives. So we shall not here spell out precisely the exceptional grounds for abortion that may or may not be compatible, in a more or less anomalous fashion, with the first of the three model schemes.

To understand any of the three model schemes, and their approximations in actually operative schemes, it is better to proceed straight to the root questions: What is the point of this scheme? Does it secure its objectives in a rational way?

The main objectives of the first scheme seem to be two: (1) the protection of children in the womb from destruction; (2) the protection of the mother from bungling operators. In short, the life of unborn children and the health of mothers are the main values that the scheme seeks to realise; the general principles or norms under which it can be subsumed are that the life of such persons should not be taken, and that people should not be permitted to risk their lives for inadequate cause.

The difficulty of formulating the last-mentioned principle without begging the question immediately reveals that in this scheme the first objective must be primary, and the second objective secondary and in part subordinate and dependent⁹. For people are generally permitted to risk their lives for adequate

exception is judicially defined, as *per* Menhennit J. in *R. v. Davidson* [1969] V.R. 667, 672, as one in favour of honest belief, on reasonable grounds, that abortion is necessary (and "proportionate to the need" [*quaere*: what does this add, or mean?]) to preserve the woman from serious danger to physical or mental health (not being merely the normal dangers of pregnancy and childbirth [*quaere*: could an illegitimate birth present a "normal" danger to mental health?])—then we can say that by judicial legislation, the third scheme has replaced the first.

8. Cf. *infra* n.16. See Rateau, *op. cit. supra* n.6 at 287-88. Not least because of their comparative rarity in practice, the "ethical" and eugenic indications are compatible with the second scheme, but only if not too many questions are raised about their integration into medical ethics, which at present has not perhaps absorbed them: see *Report of the Committee of the British Medical Assoc.* [1966] (2) *British Medical Journal* 40, 42: but cf. *infra* Appendix A, n.111. And in the third scheme they are virtually redundant; the Abortion Act 1967 omits the "ethical" indication because it is catered for by the "mental health" indication: see *Parliamentary Debates (House of Commons)* 13th July 1967, cc.1174-1178; Abortion Law Reform Association, *Guide to the Abortion Act 1967* (ed. Potts, with commentary by Glanville Williams: 1968), 11.
9. Courts and writers who maintain that the primary objective of the first scheme is the protection of the mother misunderstand the scheme; the prevalence in any

reasons; so the postulated inadequacy of abortion as a reason for risking one's life must be explained in terms of the undesirability (at least relative) of killing the unborn child—and this is the undesirability with which the first objective or value or principle is concerned. (Notice that this argument in no way depends on any assumption about the effectiveness or ineffectiveness of this legislative scheme in achieving its second objective).

The primary objective of this first scheme is to be interpreted as a particular modality of a more general principle of mature Western legal systems: that all human life is to be free from deliberate or negligent attack. The assertion that the objective of the scheme has generally been the maintenance of a sufficient birthrate scarcely bears historical examination¹⁰. In any event, a scheme so motivated would be unstable and liable to abandonment in the event of social embarrassments by overpopulation. So here we shall consider this scheme of regulation in its stable form, as motivated primarily by concern for human personality and hence for the person of the unborn.

Now the law can attain its ends in a variety of ways, of which taxation, civil or tortious liability, and criminal or penal liability might conceivably be relevant. In fact, it is always the last-mentioned technique that has been employed in this scheme of abortion regulation¹¹. Is it a reasonable technique?

That jurisprudence can differentiate concepts such as "tax", "tort" and "crime" is a mark of its partnership in Western rationality¹². Indeed, modern

society of such explanations forebodes the collapse of the first into the third scheme. See the comments in Basil Mitchell, *Law, Morality and Religion in a Secular Society* (1967), 81, on the remarks of Goddard L. C. J. in *R. v. Tate*, *The Times* 22 June 1949.

10. See Dickens, *op. cit. supra* n.7 at 11-15. Population policies influenced the growing severity of French law from 1914 to 1945, but abortion was a considerable crime long before the genesis of these policies: Bouzat, "La Politique Criminelle Française en Matière d'Avortement et de Propagande Anticonceptionnelle" in *Les Principaux Aspects de la Politique Criminelle Moderne*, a tribute to H. Donnedieu de Vabres (1960), 183. See also *infra* n.92.
11. The law can grant a civil action in tort to the husband whose marital interest in the life of his child has been invaded by the secret actions of his wife and her abortionist: *cf. Touriel v. Benveniste* 30 U.S.L. Week 2203 (Los Angeles Sup. Ct., 1961); "Comment" 110 *University of Pennsylvania Law Review* 908; 14 *Stanford Law Review* 901 (1962). But it is hard to see what other civil actions would usefully be available in respect of the abortion itself; the child is usually dead, the mother a consenting party. *Cf. George*, "Current Abortion Laws: Proposals and Movements for Reform", 17 *Western Reserve Law Review* 371, 388-390 (1965). Note that J. B. George Jr. also suggests treating abortion "within the framework of civil provisions affecting the medical profession rather than the penal concepts of the criminal code", *id.* at 397. But such a civil scheme would still have to approximate to one or other of our three model schemes, and would still require penal sanctions against abortions performed by persons outside the medical profession. And to try to hold the medical profession to the first scheme only by professional disciplinary proceedings would (a) weaken the symbolic force of the law, (b) place on the disciplinary procedures a rôle they are not structured to discharge either efficiently or with due process, (c) place on the profession an excessive burden in deciding a controverted social question. Note: all the articles on abortion in 17 *Western Reserve Law Review* may now be found in David T. Smith (ed.), *Abortion and the Law* (1967).
12. "Western rationality" is not meant to deny rationality to other cultures, but simply to indicate conveniently a form of thought and culture familiar to us all. On the more general question see Eric Voegelin, *Order and History* (1957), esp. vol. 2, pp.10-24.

analytical jurists, such as H. L. A. Hart, have denounced as inadequate any jurisprudence, such as Hans Kelsen's, that in the name of scientific and value-free purity hesitates to differentiate such concepts because their differentiation turns on value-laden differences of function¹³. For Hart, attention to such functional differences is the very mark of a fruitful jurisprudence. Yet such distinctions were not always drawn, and spring directly from the rational demand for justification in terms of norms and values¹⁴. Now the classical Western notions and justifications of penal action are today commonly declared to be obscure. So if our present question is to be answered jurisprudentially, a few clarificatory remarks and even definitions seem to be in order here¹⁵.

In the fully developed concept of "crime", and act or forbearance will be criminal in a strict sense only if it is taken to manifest an indifference to, and thus publicly to affront, all or some of a considerable set of values upheld by society. "Prosecution" and "punishment" are stages in society's attempt to vindicate those values. "Vindication" is the process by which "good" citizens are encouraged in their habitual readiness to prefer the socially approved values implicit in the law to any competing value. Vindication involves also the instructing of the teachable in the approved ramifications of those values, the deterring of the recalcitrant, and the reform of the amenable. Above all, vindication is the binding-together of this complex of aims and processes into the distinct general form of punishment: a meeting of manifested waywardness of individual will by manifested subjection of that will to the will of those responsible for upholding the values which society prefers but to which that individual has failed to give due weight.

It is not too difficult to discern the range of values with which penal law is concerned. There is the value of the welfare of the individual injured by the crime, and the supporting value of respect for that welfare; there are the values directly or indirectly constitutive of human welfare—life, sociability, property, truth-telling, procreation, etc.; there is the value of doing as you would be done by, and the value of fairness to other members of society who put themselves out to uphold the social values; and there is the general value of giving priority in one's activity to the common good of which one's own good is a dependent component.

The criminal law, with the penal process, is the symbolic drama by which the socially preferred range of values is vindicated against indifference and affront. Education is one of its principal aims, from which flows many of its characteristics. Thus it is not every killing of one human being by another that attracts the criminal sanction, but only those killings that are deemed to

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13. H. L. A. Hart, *The Concept of Law* 38-39 (1961). For Kelsen's doubts about the jurisprudential ultimacy of the distinction between tort and crime, see Kelsen, *General Theory of Law and State* 50-56, 207 (1945). Holmes's doubts were less nuanced: "The Path of the Law", 10 *Harvard Law Review* 457, 461 (1897).
 14. The theoretical differentiation of a specifically criminal law within the body of delictual law is perhaps to be ascribed to Plato, *Laws* 862-863; see A. E. Taylor's *Everyman* translation (1960) intro. at xlvi, and text at 250-252.
 15. Elements of the following account will be found in Rodes, "A Prospectus for a Symbolist Jurisprudence" 2 *Natural Law Forum* 88, 105-115 (1957). The background in recent German and American criminology is traced in Eser, "The Principle of 'Harm' in the Concept of Crime: A Comparative Analysis of the Criminally Protected Interests" (1965-6) 4 *Duquesne University Law Review* 345. See also Walter Moberly, *The Ethics of Punishment* (1968), ch. 8.

manifest an indifference to the value of human life (i.e. by intention or negligence). This attention to the value-choices and value-rejections symbolised by individual actions, rather than to the actions simply as movements-plus-consequences, is a classical instance of Western rationality reflecting on the grounds for social reaction to undesired events. Again, the grading of crimes and punishments signifies the approved ranking of the values threatened by crime; and the grading of degrees of culpability recognises that while negligence symbolises little more than human weakness, direct intention and wilfulness are assertions and expressions of available alternative horizons of values. "Evil communications corrupt good manners", and intentional and successful crime tends to "bring the law into contempt".

It is, of course, a main aim of the criminal law to eliminate undesired conduct. But the criminal law is not futile if it succeeds in doing little more than manifesting society's continuing commitment to its preferred values. Examples of such laws are many—laws against speeding, against perjury, against domestic murder, against prostitution, once upon a time against duelling, and now against certain forms of racial discrimination. Such laws are to be contrasted with laws that not only fail to eliminate the forbidden conduct, but also are so widely and publicly flouted by respected men that they lose even the character of symbolising a real societal commitment to the values they purport to uphold. These laws are pointless, and their limping continuance symbolises the impotence not the supremacy of the officially approved values. Prohibition in the U.S.A. was such a case.

The first scheme of abortion regulation, then, is an effort to suppress abortions in all but a few cases, and to witness society's commitment to the value and inviolability of human life. (The very nature of the admitted exceptions¹⁶ witnesses an effort to distinguish between life as such—the life of the mother—and mere qualities of life such as peace of mind, standard of living, avoidance of shame, etc.) The basic commitment, jurisprudence itself cannot evaluate; jurisprudence is a partner in Western rationality, not a summation of it. Nor can jurisprudence itself comment on the minor premise: that early foetal life is simply a modality of human life. Suffice it to say that the fully self-conscious jurist may feel the attraction of both premises. It was no accident that the first great theoretical jurist, Plato, also first elaborated the Western idea of the soul as the centre of what we now call personality¹⁷. For jurisprudence is a sustained and questioning reflection on certain human performances, and a fully reflective jurist will include his own performance as a jurist within the scope of his reflections. So doing, he may well apprehend that the mysterious organizing centre of his life's work, of his concern for truth, of his actual insights and of his will to reflect, lies beyond the capacities of his merely material constitution, however much the latter may be a *sine qua non*. He may conclude that what makes him the person he is, and confers on him any worth he may have, is in the last analysis not a mere

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16. That is, respecting the life of the mother; it is at this point that the compatibility of the eugenic and "ethical" indications with the first scheme is put in question.
17. Of course, it is also true that Plato, like other Greeks, approved abortion on racial eugenic grounds. Western humanism does not fully develop until the equality of all individual souls is grasped, historically as a result, it seems, of Christ.

function or correlate of his size or shape, of the rhythm of his sleeping and waking, growing and fading.

Still, it is schemes of regulation, not their premises, that lie within the competence of jurisprudence, and we have now sufficiently set the stage for a jurisprudential evaluation of the rationality of the first scheme of abortion regulation.

Is this scheme effective in suppressing abortion? An unbiased answer to this question will be very circumspect. On the one hand, there is much reason for saying, No. At this point we must venture on the first of a number of statistical discussions, and it is as well to point out that the figures for illegal abortions are everywhere very unreliable, and inferences from any abortion statistics rather uncertain¹⁸. For example, the great majority of commentators in recent American law journals¹⁹ accept that 1,200,000 is a plausible estimate of the number of abortions *per annum* in the United States. But on examination it appears that this figure has no other basis than a study published in 1934²⁰—according to which it may be assumed that there is one illegal abortion for every 3.55 live births. And this latter figure is simply an extrapolation from the case-histories of 10,000 women who attended the Margaret Sanger birth control clinic in New York City between 1925 and 1929! Another widely accepted figure for the United States is 600,000 *per annum*—this by extrapolation from the case-histories of the women who volunteered the information in Kinsey's famous study of female sexuality (a group which included a negligible proportion of negroes and Catholics, and which was unrepresentative even of urban white women)²¹. Statisticians who study the evidence agree that the number may be between 200,000 and 1,000,000, and that there is no way of determining the number more closely than that²². Similarly, estimates of illegal abortions in the U.K. before the Abortion Act 1967 ranged between 50,000 and 100,000 (250,000 was occasionally mentioned); but on the basis of fairly reliable statistics for maternal deaths, C. B. Goodhart was able to argue plausibly that the figure might in fact be as low as 10,000 *per annum*²³. In South Australia,

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18. See the remarks in Tietze, "Induced Abortion and Sterilization as Methods of Fertility Control" (1965) 18 *Journal Chronic Diseases* 1161.
 19. There is a good bibliography in (1968) 40 *University Colorado Law Review* 297, Appendix B.
 20. M. E. Kopp, *Birth Control in Practice* (1934), quoted by Frederick Taussig, *Abortion Spontaneous and Induced* (1936), 368, and used as the basis of his calculations at 25-26.
 21. See the comments by the Statistics Committee of the 1957 Planned Parenthood Federation of America Conference on Abortion, on the Kinsey Institute's study (i.e. Gebhard *et al.*, *op. cit. infra* n.30), in Mary Calderone (ed.), *Abortion in the United States* (1958), 178.
 22. Comments of the Statistics Committee, *op. cit. supra* n.21 at 180.
 23. Goodhart, "The Frequency of Illegal Abortion" 55 *Eugenics Review* 197, 200 (1964). Criticism in Dickens, *op. cit. supra* n.7 at 79-80. The Minister of Health estimated that in 1964, 75,000 cases of abortion were treated at National Health Service Hospitals, of which 3,300 were therapeutic and 3,000 septic: [1967] (1) *British Medical Journal* 577. Up to 20% of all conceptions result in spontaneous abortion, i.e. miscarriage, and many of these would call for hospital care. (In 1964 there were about 850,000 live births). Sir Dugald Baird, "A Fifth Freedom?" 1966) 58 *Eugenics Review* 195, 204, estimated that the incidence of therapeutic abortion in Aberdeen, with a very liberal medical profession, was about 2% of all maternities; illegal abortions he thought very few, because septic abortions were very rarely seen in Aberdeen. In 1964 legal abortions in Denmark were about 5% of live births; in Hungary they were about 135%: see *infra*, Appendix B.

estimates have ranged between 250 and 10,000; the Abortion Law Reform Association of South Australia estimates that 5,150 to 8,900 abortions are performed on South Australian women each year²⁴. Suffice it to say that even the mean of the latter figures, 7,000 *per annum*, is hard to accept: it would mean that there would be one clandestine abortion for *every* South Australian woman, on average, over her whole life²⁵ (and since many women are not in the market for abortions, it would mean the remainder, many scores of thousands of women, are *averaging* two to three or more abortions each during their lives). Indeed, ALRASA's figures are among the most remarkable ever published; transposed to the U.K., the suggested range of figures would be equivalent to 216,000 to 375,000, which far exceeds the most extreme and unrepresentative estimates made for the U.K. in the polemics preceding the 1967 Act²⁶.

Still, whatever figures are accepted, the fact remains that the numbers everywhere are rather high, not least because of the activities of qualified medical practitioners. On the other hand, before examining other aspects of the phenomenon of abortion, it will be in order to offer a few general cautions about the apparent effectiveness of the criminal law in this age. For in this age "the overflowing of criminality" has affected all parts of Western civilization. In England and Wales both the number *and the rate* of indictable crimes known to the police have multiplied more than tenfold in this century²⁷; yet in 1965 Leon Radzinowicz was willing to hazard that "crime fully brought into the open and punished represents no more than about fifteen per cent of the total"²⁸. But would it not be perhaps a little hasty to declare the criminal law, as a whole, redundant²⁹?

One can accept any of the previously quoted estimates of the incidence of abortion in countries using the first scheme of regulation, and yet find reason to believe that the scheme is effective in suppressing, though not eliminating, abortion. It is agreed that when in 1939 Denmark and Sweden adopted the second scheme (legal abortion by official permission under fairly wide conditions), there was a sharp increase in the number of both legal and illegal

24. See *Report of the Select Committee of the House of Assembly on the Criminal Law Consolidation Act Amendment Bill 1968*, para. 18 (1969), and Appendix B, at 95.

25. This assumes a thirty-year child-bearing period for the 222,900 women between the ages of 15 and 45 (in 1966).

26. In 1969 there were about 42 times as many women between 15 and 45 years old in England and Wales as in South Australia. Note that if 7,000 S.A. women are aborted annually, the rate of illegal abortions per woman of child-bearing age and per live births is as high in South Australia as the rate of legal abortions in Czechoslovakia, Poland and Yugoslavia, where abortion is freely available. This seems unlikely, especially in view of the fact, noted by A.L.R.A.S.A. in their evidence to the Select Committee, that countries such as the afore-mentioned ("less sophisticated countries") are "in a pre-contraceptive era" compared to Australia: *op. cit. supra* n.24 at 101.

27. McClintock and Avison, *Crime in England and Wales* (1968), 23-24.

28. Radzinowicz, *Ideology and Crime* (1966), 64.

29. Professor Packer has said: "We can have as much or as little crime as we please, depending on what we choose to count as crime": Packer, *The Limits of the Criminal Sanction* (1969), 364. As a response to the problem of social order in this age, the slogan is less than adequate.

abortions³⁰. Twenty years later, while the number of live births in Denmark was about twenty-five per cent higher than in 1939, and the population about twenty per cent higher, legal abortions had multiplied tenfold and the number of illegal abortions seemed to be anywhere between twice and fifteen times as high as in 1939³¹. And where the third scheme (virtually unconditional permission of all abortions performed by qualified physicians) has been adopted, as in Eastern European countries during the last decade, the total number of abortions has risen so sharply that the increase is generally agreed to be responsible for at least part of substantial, even dramatic, decreases in the birthrate³². Thus in Hungary, a steady or rising birthrate of 23.0 per 1,000 population in 1954 was converted, after full legalisation of abortion in 1955, to one that dropped about one point each year until in 1962 it was only 12.9³³. In 1964 the number of *lawful* abortions was over 184,000 (in a population of about 10 million!)—far above any estimate of the number of all legal and illegal abortions under the old regime of rigorous regulation³⁴. Similar, though not so marked, effects are observable in countries such as Poland³⁵, Bulgaria, Czechoslovakia and Russia, not to mention Japan³⁶. After nine years under the third scheme, Rumania reverted to a version of the first scheme in 1966, largely (it was said) because of the effect on the birth-rate. The Rumanian legislators certainly knew what they were doing. The birthrate rose from 13.7 in the fourth quarter of 1966 to 38.4 in the third quarter of 1967³⁷! A more striking demonstration of the efficacy of penal law could not be devised. We have set out various statistics relating to some of these countries in Appendix B. Making all allowances for the difficulty of isolating causal factors, it can hardly be doubted that the transition from the first to the second or third schemes of legal regulation is liable to be accompanied by marked increases in the total number of abortions. In this sense, the first scheme of regulation is effective in suppressing abortion, though not in eliminating it.

Is this scheme effective in symbolising society's commitment to protecting the value of human life against deliberate or negligent affront? It seems clear that

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30. See Skalts and Norgaard, "Abortion Legislation in Denmark" (1965) 17 *Western Reserve Law Review* 498, 505; Gebhard, Pomeroy, Martin and Christenson, *Pregnancy, Birth and Abortion* (1958) 221-229. The remarks of the last-mentioned source are played down in Bates and Zawadzki, *Criminal Abortion: A Study in Medical Sociology* (1964), 137, 141.
31. Skalts and Norgaard, *op. cit. supra* n.30 at 519; Glass, "The Effectiveness of Abortion Legislation in Six Countries" (1938) 2 *Modern Law Review* 97, 117, quoting estimates of the Danish Governmental Committee on Abortion (1936). In 1964 there were 3,936 legal and an estimated 12,000 to 15,000 illegal abortions, in a population of just over 4,600,000.
32. Tietze, *op. cit. supra* n.18 at 1167; Mehlan, "Combating Illegal Abortion in the Socialist Countries of Europe" (1966) 13 *World Medical Journal* 84, 87. Competent observers of Japan have come to the same conclusion: Blacker, "Japan's Population Problem" (1956) 48 *Eugenics Review* 31; Samuel, "Population Control in Japan: Lessons for India" (1966) 58 *Eugenics Review* 15, 19.
33. See *infra* Appendix B, table D.
34. See Tietze, *op. cit. supra* n.18; Mehlan, *op. cit. supra* n.32.
35. On Poland, see also Wolinska, "Assumptions Faced with Reality: Marginal Remarks on the Conditions of Permissibility of Abortion Act of 27th April, 1956" 15 *Pansto I Prawo* 282 (Polish Academy of Sciences, 1960) (English summary, 1960 (1), 507).
36. See works cited *supra* n.32.
37. Tietze and Lewit, "Abortion" (1969) 220 *Scientific American* 21, 25. See also *infra* n.92.

the answer must be: Yes. Unless one were to contemplate a prohibition of all abortions whatever, it is difficult to conceive of any other legal treatment of the sphere of maternity that could witness this commitment to the value of human life. One cannot expect empirical sociology to produce estimates of the effectiveness or ineffectiveness of such symbols³⁸—what is at stake is the long haul of civilization, which even in retrospect the cultural historian can assess only by a wisdom that must do without checks or control groups and the apparatus of scientific certainty³⁹.

It is, however, permissible to wonder whether the lower numbers of abortions under the first scheme than under the second or third schemes are kept down only by the purely deterrent effect of the legal sanctions, so relatively rarely invoked⁴⁰, or whether the symbolic weight of the law's denunciation is perhaps contributing too. One can meditate, too, on the fact that in countries where the first scheme still holds, reformers have to agitate even to create the sense of a problem in the public mind, and people are shocked when they discover the supposed prevalence of illegal abortion⁴¹. The situation is indeed remote from the visible breakdown of the law's symbolic effectiveness under Prohibition. But all these considerations only touch the margin of the problem of symbolising respect for life; further discussion must wait until we come to assess the civilizational implications of the second and third schemes of regulation⁴².

Still, the value of human life may provoke someone to ask, *How effective is this scheme in suppressing the maternal mortality and morbidity caused by bungled abortions?* Again, the answer must be very circumspect. It would be reasonable to suppose that the incidence of maternal death is diminished by adopting the *third* scheme of regulation, which encourages any woman desiring an abortion to approach properly qualified persons⁴³. On the other hand, the diminution is far from complete, since an element of risk pertains to this as to all operations, and the total number of operations tends, as we have said, to increase substantially⁴⁴. As is shown in Appendix B, paragraph 2, the numbers of deaths from abortions (lawful and unlawful) in Poland and Czechoslovakia

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38. Cf. Rose, "Sociological Factors in the Effectiveness of Projected Legislative Remedies" (1959) 11 *Journal of Legal Education* 470, stressing the lack of research, but opining that even widespread violation of law need not, in certain circumstances, diminish respect for law: *id.* at 474. Also Sternquist, "How are Changes in Social Behaviour developed by means of Legislation?" in *Legal Essays: a Tribute to Frede Castberg* (1963) 153-169.
 39. On the Scandinavian debate about the law's effect in creating an "abortion mentality" see Borell and Engström, "Legal Abortions in Sweden" (1966) 13 *World Medical Journal* 72, 74; Ingerslev, "The Danish Abortion Laws" (1967) 7 *Medicine Science & Law* 77, 81; Tietze, "Abortion in Europe" (1967) 57 *American Journal of Public Health* 1923, 1927, and works there cited.
 40. See the analysis of British statistics in Dickens, *op. cit. supra* n.7 at 73-106. In S.A., 17 persons were charged with criminal abortion in the six years ending 30th June 1968: see evidence of Inspector Turner, *op. cit. supra* n.24 at 16.
 41. See Bates and Zawadzki, *op. cit. supra* n.30, at 3, and Guttmacher's Foreword, *id.* at viii.
 42. See text *infra* at nn.84-91.
 43. See the analysis in Tietze and Lehfeldt, "Legal Abortion in Eastern Europe" (1961) 175 *Journal of American Medical Association* 1149, 1151.
 44. The total number of conceptions also rises: *ibid.* It is interesting to note that the rate and proportion of abortions is higher among Japanese women who use contraceptives than among those who do not: Samuel, *op. cit. supra* n.32 at 21. On the risks of the operation see *infra* n.91.

in 1964, after six full years of complete liberalisation, do not significantly differ, when adjusted to population, from those for the United Kingdom under the first scheme of regulation⁴⁵. Swedish commentators on the second scheme of regulation have detected a fall in maternal deaths from abortion, but have been unable to say whether this is due to anything other than the increased availability of anti-biotics⁴⁶.

It is not the business of jurisprudence to offer opinions about the acceptability or unacceptability of a given incidence of maternal mortality and morbidity. But it can offer the following reminders. First, the reduction of maternal deaths from bungled abortions, however desirable, is necessarily only a secondary aim of the first scheme of abortion regulation. Secondly, the number of such deaths, however calculated⁴⁷, is minute compared with deaths from other human and avoidable causes. The feasible reductions in maternal deaths obtainable by abandoning the first scheme of regulation are doubtless only a small fraction of the reductions in deaths obtainable by governing the speed of vehicles to 50 m.p.h. or regulating the consumption of tobacco. Thirdly, no woman need go to her death at the hands of bunglers. To speak of the law driving women to their deaths is none too enlightening. As the studies of Packer and Gampell in California⁴⁸, of the Royal College of Obstetricians and Gynaecologists in England before the Abortion Act⁴⁹, and the evidence of the gynaecologists and other medical practitioners who appeared before the Select Committee of the S.A. House of Assembly⁵⁰ all indicate, no woman whose life is in any way

45. For Poland, see Mehlan, *op. cit. supra* n.32 at 86; for Czechoslovakia, see Potts, "Legal Abortion in Eastern Europe" (1967) 59 *Eugenics Review* 232, 242; for the English figures and an analysis of them, see *Report on Confidential Enquiries into Maternal Deaths in England and Wales 1964-66* (1969, H.M.S.O.), digested in [1969] 1 *The Lancet* 657; also Goodhart, *op. cit. supra* n.23 at 198-200.

46. Borell and Engström, *op. cit. supra* n.39 at 74.

47. Most commentators in American law journals continue to accept a figure for annual maternal mortality from abortion of 5,000-10,000. This figure has been denounced by every competent enquirer as, in Tietze's words, "unmitigated nonsense". Tietze, a statistician for the Population Council of New York and by no means opposed to abortion, estimated that the number was 500-1,000: see *New York Times*, 28 January 1968, 28 col. 3. The higher figures so widely and irresponsibly publicised have no other basis than a claim, itself fancifully arrived at, by Taussig in 1936. In 1934 there were 4,000 registered deaths from abortion *p.a.*; in 1968 there were about 400. See Hall, "Commentary" in Daniel T. Smith (ed.) *Abortion and the Law* (1967) (Hall, passionately in favour of free abortion, thinks 500 a reasonable estimate). See also the careful analyses of deaths in Minnesota, Michigan and Tennessee in (1967) 98 *American Journal of Obstetrics and Gynaecology* 356-370; from these one can conclude that the figure for the U.S. can hardly be higher than 600 *p.a.* and may well be nearer 400. Such a rate corresponds well to the rate of one or two deaths officially reported as probably due to induced abortion *per annum* in South Australia (see *Causes of Death 1965*, Cth. Bureau of Census and Statistics, Bulletin No. 3 (1967) 42, 43). In his evidence to the Select Committee of the House of Assembly, Inspector Turner considered that the death-rate from illegal abortion was only about one every four years: *op. cit. supra* n.24 at 17.

48. Packer and Gampell, *op. cit. supra* n.27.

49. The R.C.O.G. Report, *supra* n.22, begins by saying that "the present situation [i.e. the first scheme as it obtained in England before 1967] commends itself to most gynaecologists in that it leaves them free to act in what they consider to be the best interests of each individual patient . . . We are unaware of any case in which a gynaecologist has refused to terminate pregnancy, when he considered it to be indicated on medical grounds, for fear of legal consequences." As to South Australia, see *infra* n.50.

50. *Op cit. supra* n.24 at 19-20, 22-23, 31, 37, 39, 46, 50-51, 59.

endangered need suppose that her gynaecologist will decline to operate for fear of legal sanctions under the first scheme of regulation. Indeed, even if gynaecologists were even less liberal than they are, it would remain true, as is universally admitted, that the cases where abortion is needed to save life, or to preserve health from serious and lasting impairment, are today remarkably rare⁵¹. A society which has not surrendered to what Maurice Hauriou scathingly called *l'instinct du moindre effort*⁵² would consider measures to alleviate poverty, to disseminate sexual and birth-control information, and to publicise the dangers of amateur abortion, rather than abandon or radically modify the symbolising of its civilizational ideals and norms in order to accomplish a rather small diminution in a category of mortality much less numerous and no more sad, unpleasant or unavoidable than many others.

2. The "rights of the medical profession": broader medical criteria and control by prior authorisation.

The second model scheme of regulation is that which, broadly speaking, obtained until recently in Denmark and Sweden⁵³. In this scheme, abortion is permitted when previously authorised by official medical boards, which must be satisfied that the case falls within one of a number of categories specified by ample but not indefinite criteria of a medical, psycho-medical or quasi-medical nature. Criteria and method of control are in principle, of course, independent variables; but we may say that usually control by boards goes along with criteria wider than in most versions of the first scheme.

This is the place to emphasise that the difference between the three schemes is not to be read off the face of the relevant statute; the accepted interpretation in each jurisdiction is the crucial determinant. If medical boards generally interpret the permitted categories so as to allow abortions in all cases of inconvenience, the scheme must be counted as approximating to the third, not the second, of our categories. One can even conceive a statute intended to effect the third scheme being so interpreted by a united medical profession that it approximated in practice to the first scheme. The only legislative

51. There is an extensive review of medical literature on this point in Quay, "Justifiable Abortion—Medical and Legal Foundations" (1960) 49 *Georgetown Law Review* 173-241. The matter is no longer disputed, even in the polemical literature.

52. Hauriou, *Précis de Droit Constitutionnel*, xi (2nd ed., 1929), commenting on Kelsen's jurisprudence.

53. It should be emphasised that these Scandinavian systems only approximate to the second model scheme, since (1) the medical boards are only partly representative of the medical profession, and (2) some of the grounds for abortion are only partially medical. See Skalts and Norgaard, *op. cit. supra* n.30; Ingerslev, *op. cit. supra* n.30; Hoffmeyer, "Medical Aspects of the Danish Legislation on Abortions" (1965) 17 *Western Reserve Law Review* 529. Norway's system, since 1960, approximates to the British and thus to the third scheme: see Roemer "Abortion Law: the Approaches of Different Nations" (1967) 57 *American Journal of Public Health* 1906, 1914. The evidence before the Select Committee of the S.A. House of Assembly revealed some widespread misconceptions, such as that in Sweden there were boards manned by the village mayor, greengrocer, *et al.* Tietze and Lewit, *op. cit. supra* n.37 at 24, state that in Sweden, where most applications for abortions were referred to the Royal Medical Board, a large proportion of abortions are now performed on the recommendation of two physicians: *i.e.*, the third scheme has virtually been adopted.

guarantee against such a breakdown in the third scheme would be to enact that, where a woman persists in her demand, the physician shall be obliged to perform an abortion. Such appears now to be the law in Hungary⁵⁴. Short of this, legislatures cannot themselves define the limits of their scheme (whichever it is) with complete adequacy and security. Nevertheless, legislation is irrational if its aims are not clear and distinct, and our three model schemes do correspond to distinct sets of aims of abortion regulation.

What are the aims of the second scheme? Three are commonly identified: (1) to preserve the dignity, rights and freedom of action of the medical profession; (2) to recognise the right of the woman over her own body; (3) to suppress unskilled abortions.

Each of these objectives is obviously aimed against a real or supposed implication of the first scheme. Indeed, only hostility to that scheme could prevent intelligent men from seeing that these three objectives cannot all be maintained together. For in the first place, if the woman has the supposed right over her own body, the medical profession (as represented by the board) has no right to deny her the opportunity of getting a lawful abortion: so the first and second objectives do not cohere. In the second place, there is no natural necessity for the medical profession to share the reformers' enthusiasm for reducing unskilled abortions at all costs; medical ethics may be so restrictive that many women will seek out unskilled abortionists: the first and third objectives do not cohere. As we shall see, these observations are not abstract quibbles; they delineate the main features of the Scandinavian experience.

Let us consider the first objective, often rendered as: "setting free the medical profession"⁵⁵. At the outset, an ambiguity must be brought to light. It is one thing to set free the medical profession by giving its accredited representatives, on carefully selected and balanced medical boards, the right to interpret medical criteria in terms of medical science and professional ethics. It is quite another thing to set "the profession" free in the sense of permitting any licensed practitioner (or pair of practitioners) to carry out an abortion when "in good faith"⁵⁶ he considers certain criteria fulfilled. In the former case, one is clearing the ring for the reinforcing of the standards of the profession by the profession, by providing formal mechanisms for authoritative expression of those standards. In the latter case, one is subjecting those standards to a powerful solvent; for if the profession were to attempt to take disciplinary action against a physician who was acting within the penal law but outside the canons of medical ethics and practice, the accused physician could with reason reply that the policy of the law and society was precisely to set him free to act according to his own conscience.

54. Tietze, *op. cit. supra* n.21, at 1149-50; Mehlan, *op. cit. supra* n.32; Potts, *op. cit. supra* n.45.

55. The phrase, with all its ambiguities, is employed in Glanville Williams, "Euthanasia and Abortion" (1966) 38 University of Colorado Law Review 178, 196. Cf. also Sands, "The Therapeutic Abortion Act: An Answer to the Opposition" (1966) 13 U.C.L.A.L.R. 285: "The Therapeutic Abortion Act [Calif.] . . . attempts to allow the medical profession to practice according to its highest standards in spite of restrictive religious views."

56. This is the phrase in the Abortion Act 1967, s.1 (1) (U.K.), for which Professor Glanville Williams must take some credit.

These broadly opposed tendencies, corresponding to the two broadly distinct senses of the ambiguous notion of "professional freedom", will remain effective, though in varying degrees as complicating components are added to one legal set-up or the other. For example, one could settle for medical boards and thus for the maintenance of general professional standards; but the strengthening effect on those standards would vary according as the boards were exclusively or only partly obstetrical, exclusively or only partly medical, centrally or locally selected, representative of State commissions or representative only of hospital managements, and according as the criteria for decision were exclusively medical, or partly psychiatric, or partly "social", and according as the decisions were required to be unanimous or only by majority. On the other hand, one could settle for setting free individual physicians or hospitals; but the solvent effect of this on professional standards would vary according as the decision was left with individual physicians, or pairs of physicians, or committees of hospitals, exclusively gynaecologists and obstetricians, or generally all practitioners, and according as a "reasonable" or only "good faith" decision was required, and according as the onus of proving conformity with the legal criteria rested with the prosecution or with the defendant physician⁵⁷.

But since, as we said, the broad tendencies to maintain or dissolve professional standards persist throughout the foregoing ranges of variations, it is fair to say that any scheme⁵⁸ (such as that of the "Abortion Act" 1969 (S.A.) or the Model Penal Code⁵⁹) which leaves the decision (in ordinary as well as emergency cases) to anything other than centrally appointed medical boards, by unanimous decision on substantially medical grounds, is a scheme which

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57. On onus of proof, see George, *op. cit. supra* n.11 at 392; Moore, "Antiquated Abortion Laws" (1963) 20 *Washington and Lee Law Review* 250, 259; Quay, *op. cit. supra* n.51, at 241; Louisell, "Abortion, the Practice of Medicine and the Due Process of Law" (1969) 16 *U.C.L.A.L.R.* 233.
58. Provided that it is introduced specifically to liberalize the first scheme. As to uses of the second scheme to tighten up a sagging first scheme, see text *infra* at nn.73-75.
59. The Abortion Act 1967 (U.K.), the "Abortion Act" 1969 (S.A.) and the Model Penal Code s.230.3 all leave everything to the good faith of two doctors. This similarity is more important than the difference which appears from the fact that the Model Penal Code authorises abortion only where there is substantial risk of grave injury to the mother (*infra* n.72), whereas the Abortion Acts specifically distinguish between grave injury and other injury, and expressly authorise abortion in the latter as well as the former case: see *infra* Appendix A, para. 1. Packer and Gampell's scheme for requiring authorization by hospital committees is announced as an attempt to substitute "the institutionalized exercise of responsible medical judgment for the hit-or-miss application of the criminal law": Packer and Gampell, "Therapeutic Abortion: A Problem in Law and Medicine" (1959) 11 *Stanford Law Review* 417, 455. The hospital committee scheme has been adopted in the 1967-8 abortion legislation in Colorado, Maryland, North Carolina and California: see Annotated Code of Maryland, art. 43 s.149E; Colorado Revised Statutes, 40-2-50 to 53; Calif. Health and Safety Code ss.25950 to 25954; and *cf.* N. Carolina, General Statutes s.14-45.1; see also "Survey of Abortion Reform Legislation" (1968) 43 *Washington Law Review* 644; "Colorado's New Abortion Law" (1968) 40 *University of Colorado Law Review* 297; Survey (1968) 43 *Notre Dame Lawyer* 684; Sands, *op. cit. supra* n.55. But the institutionalization is basically feeble, in that the authorizing committees are subject to no central appointment, direction or control; a hospital out to make money would need to do no more than constitute itself a committee with "humane and progressive" standards. Note that the great Japanese liberalization of 1952 was effected not by extending the grounds for abortion in the Eugenic Protection Law of 1948, but by removing the control of the District Eugenic Committees over individual doctor's decisions: Blacker, *op. cit. supra* n.32 at 35.

approximates to the third rather than the second of our three model schemes. For the brute fact is that standards *within* the medical profession⁶⁰ (not to mention the psychiatric profession)⁶¹, as distinct from the representative standards *of* the profession, vary so widely in relation to the relevant questions of medical and ethical propriety that getting an abortion will depend on no more than a woman's eye for the liberal practitioner or hospital, and her persistence in seeking an "authoritative" consent to her request after any number of refusals (since unlike consents, refusals can never be authoritative or final in such a scheme). Or perhaps the determining factor will be no more nor less than a woman's wealth⁶².

Scandinavian experience in these matters may now be considered. Skalts and Norgaard have testified that under the 1937 Danish legislation (which came into force in 1939), hospital physicians, gynaecologists and surgeons often considered that the decisions of the official boards were too liberal, while many women and their families and doctors considered the boards too restrictive. This was ascribed to the fact that the physicians, gynaecologists and surgeons saw only the cases in which consent was given by the boards, and not the cases in which consent was refused; the tension is said to have disappeared since the introduction of regulations requiring the submission of all cases to the boards, including those cases ending in a refusal⁶³. This explanation, which is not free from ambiguities, must be taken along with the fact that in 1964, for example, only 54 per cent of applicants were granted their request for abortion⁶⁴. Indeed, during the later nineteen-fifties, there is evidence of "a more restrictive practice of authorization"⁶⁵, presumably reflecting changing assessments of medical and psychiatric realities in relation to the permitted categories of indication⁶⁶. Moreover, Henrik Hoffmeyer has recognised that the liberalizations

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60. When Packer and Gampell put eleven hypothetical case histories to California hospitals, in only four did a majority of hospitals say that they would approve an abortion, but in nine a majority of the hospitals thought that other reputable hospitals would approve. On the difference in standards between family doctors and gynaecologists, see Skalts and Norgaard, *op. cit. supra* n. 30 at 506. For the difference between psychiatrists and gynaecologists, compare the Report of the R.C.O.G., *op. cit. supra* n.22, with the *Report of the Royal Medico-Psychological Assoc.* (1967) 199, *Journal American Medical Association* 199.
 61. On the alarming differences among psychiatrists, see Niswander, "Medical Abortion Practices in the United States" (1965) 17 *Western Reserve Law Review* 403, 414; Rosenberg and Silver, "Suicide, Psychiatrists and Therapeutic Abortion" (1965) 102 *California Medicine* 407, 410, concluding that when a psychiatrist recommends abortion, he is probably considering "socio-economic factors" rather than psychiatric indications. For the effect of putting psychiatrists and social workers on authorizing boards, see Ingerslev, *op. cit. supra* n.39, at 78.
 62. H. L. A. Hart has attacked the unfairness of the first scheme, under which the obtaining of an illegal but skilful abortion depends on one's wealth: *The Morality of the Criminal Law* (1965) 47. How much more galling would be the system under which the obtaining of a legal abortion depended on wealth!
 63. Skalts and Norgaard, *op. cit. supra* n.30 at 506, 511; Ingerslev, *op. cit. supra* n.39 at 81.
 64. Skalts and Norgaard, *op. cit. supra* n.30 at 513.
 65. Tietze, *op. cit. supra* n.18 at 1163.
 66. Thus Hoffmeyer, *op. cit. supra* n.53 at 536, comments on the development during the nineteen-fifties of "a more objective and sober attitude on the part of officials . . . adopted as it was realized that suicides and the development of chronic psychopathology were rare" in many cases once supposed to provide indications for abortion.

he desires meet with "the problem . . . that doctors are not specifically qualified to apply them ["social criteria"] and would certainly refrain from participating . . . and many surgeons and gynaecologists certainly would refrain from performing the operations"⁶⁷.

In short, the Scandinavian concern has to some extent been to set free the medical and psychiatric professions to apply representative (not individual or merely local, however conscientious) standards of judgment; and change in the law is feared because it would involve the division of the profession and a clear threat to the maintenance of those very standards.

Clearly, the Scandinavian legislation does not recognise any distinct "right of women to dispose of their bodies as they see fit". The boards' refusals to terminate pregnancy are authoritative, and the criteria do not include the wishes of the woman. So we can turn to the implications of the Scandinavian experience for the third of the objectives commonly proposed for the scheme of regulation: the suppression of unskilled abortions.

It is not generally denied that during the first ten years after the introduction of an approximation to the second scheme in Sweden and Denmark, the number of illegal and presumably unskilled abortions rose appreciably⁶⁸. No-one asserts that during the subsequent decade there was any greater decline in the number of such illegal abortions than was experienced during a similar period in countries, such as Holland, under the rigorous first scheme⁶⁹. Nor is this surprising. The strict application of medical and psychiatric professional standards by the medical boards must be well known in Denmark and Sweden; it cannot escape the notice of women that only about a half of those who apply will be granted an abortion. The formalities necessary to secure a sound judgment according to national standards are not trivial; there is red tape⁷⁰. So a great many women do not apply, and of those who do so unsuccessfully, it is known that over 15 per cent subsequently obtain illegal abortions, despite the general aid and dissuasive counsel which they have received from the Mothers' Aid Centres in connection with their application⁷¹.

It is as well to be realistic here. The conception of an unwanted child represents a failure for the woman and is a source of humiliation to her. Studies in Amsterdam indicate that failures in birth-control methods frequently result from lack of communication between the spouses, manifesting a disturbed family structure⁷². It is in this context of failure, mental isolation, shame and dilemma that many women will decide to act. Formalities, the requirement of

67. *Id.* at 551.

68. *Supra* n.30.

69. Skalts and Norgaard, *op. cit. supra* n.30 at 519, opine that the number of illegal abortions may have declined by 10-14% between 1954-1964; but a similar decline seems to have taken place during the post-war period in Amsterdam, where the first scheme is in force: Treffers, "Abortion in Amsterdam" (1966-7) 20 *Population Studies* 295, 299-300. Tietze doubts whether there has been any reduction in illegal abortion in any Scandinavian country: *op. cit. supra* n.39 at 1927.

70. On Swedish red-tape, see Tietze, *op. cit. supra* n.26 at 1152.

71. Skalts and Norgaard, *op. cit. supra* n.43 at 516.

72. Treffers *op. cit. supra* n.69 at 308-309, contains a very detailed analysis and demonstration of these facts by way of a variety of statistical *indicia*. On the contraceptive practice of British women having lawful abortions in 1968, see *infra* Appendix A, para. 4.

informing the husband, and fear of being "talked out of it" by professionals⁷³—all these must weigh in favour of an approach to unauthorised abortionists.

So the use of the second scheme to protect representative professional standards is incompatible with the aim of reducing unskilled abortions, and indeed may well increase such abortions and the consequential mortality and morbidity. The second scheme, therefore, stands or falls with its aim of setting the profession as a whole, through its representatives, free from all legal restrictions save those generated by the representative professional conscience. To use this scheme for other ends as well would be irrational, since it would in all probability follow that none of its ends would be secured and all would be prejudiced. The scheme often attracts favor as a moderate, pragmatic compromise between the "extremes" of the rigorous first scheme and the permissive third scheme. But the compromise is illusory; the essence of the scheme is to set aside all the aims of the first and third schemes, and to replace them with the distinct aim of preserving representative medical and psychiatric standards. If this point is not firmly grasped by legislatures, the resulting schemes will simply get the worst of all worlds. The point was not grasped by many of the British and S.A. legislators of 1967 and 1969, and has eluded academic American commentators, who have almost all proposed schemes which structurally approximate the second model scheme (in more or less unstable versions), but which cheerfully profess all the aims of both the first and third schemes as well⁷⁴.

Moreover, it is not clear that even a regulatory scheme which firmly and precisely sought to liberate and strengthen representative medical ethics would succeed—at least if it were adopted expressly as an alternative to a functioning first scheme. For the primary object of the first scheme is the protection of innocent human life against deliberate or careless attack. So the adoption of the second scheme might be taken to represent a judgment that the free operation of professional standards is to be preferred to the foregoing objective of the first scheme. (This judgment would be particularly undisguised if society continued to impose its own standards on the medical profession in respect of life other than foetal life, and operations other than abortions.) What would be the effect of such a judgment on the professional standards themselves? At present, those standards happen to include the objective of the first scheme. Would not some members of the medical profession be tempted to conclude that society, in seeming to prefer the liberty of the medical profession to the protection of foetal life, was willing to follow professional ethics however they developed, even if they abandoned concern for foetal or other categories

73. The Danish Mothers Aid Centres are said to talk a number of women out of getting an abortion; see Skalts and Norgaard, *op. cit. supra* n.30 at 516-17.

74. On Packer and Gampell's scheme see *supra* n.59. Compare the scheme in Moore, *op. cit. supra* n.57 at 259. On the Model Penal Code scheme, see M.P.C. s.207.11 (Tent. Draft No. 9, 1959); s.230.3 (Prop. Off. Draft, 1962); Barnard, "An Analysis and Criticism of the Model Penal Code Provisions on the Law of Abortion" (1967) 18 *Western Reserve Law Review* 540. The principal M.P.C. criterion is "substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother". This weakens without clarifying the principle of the first model scheme, provides none of the institutionalized safeguards or advantages of the stable versions of the second scheme, and on the admission of the draftsmen themselves does not meet the problem of illegal amateur abortions to which the third scheme is a plausible answer. On the confusion of the South Australian legislators see *infra* n.110.

of human life? Would not such conclusions (whatever their justifiability) be likely, and might they not inspire attempts to revise medical ethics, not in the light of the immanent norms of those ethics, but in accordance with presumptions about "social opinion". Would not such attempts threaten the very value which the second scheme seeks to realise, namely, the orderly development and functioning of an autonomous and respected body of medico-ethical standards? All this is quite distinct from the further question, which we shall not here pursue: Would society be happy with a medical profession that held itself free to dispose of human life according to shifting and disputed criteria of professional ethics, or that was encouraged to believe it had a general right to develop its standards in these matters without any legal restrictions imposed from outside the profession?

The symbolic significance, and hence the consequences, of the second scheme would be quite different if it were adopted in order to prevent a development observable in many Western societies: an uncontrolled drift from the first scheme to the third by a process of official and unofficial interpretation and practice together with a breakdown in the unity of medical ethics. In such a situation, the second scheme would be an attempt, not merely to support medical ethics against the wayward consciences of individual physicians, nor merely to liberate respectable practitioners from fear of the variable rigour of non-medical prosecutors, but also to strengthen a particular tenet of existing medical ethics, namely respect for foetal life. In other words, the second scheme could conceivably be adopted specifically to strengthen, rather than to depart from, the primary objective of the first scheme. In this case, to ensure its success, the adoption of the scheme would have to be generally recognized as clarifying and tightening up "the law", and not as liberalizing or "humanizing" it. The boards would have to be selected largely from those representatives of the medical profession known to favour the traditional medical standards; more weight would have to be given to gynaecologists than to psychiatrists and social workers, and decisions to abort would have to be unanimous. The point could be reinforced by appointing a public defender of the unborn child's interests, whose duty would be to present to the board those facts about the applicant's circumstances which otherwise might be suppressed by the woman's anxious advocacy of her own cause. The consent of the husband would need to be required⁷⁵, in order to stress the point that the law was not dealing with a mere adjunct of the woman's body, but with the living human fruit of a familial enterprise. Emergency operations without the permission of a board would, of course, need to be lawful—but to prevent abuse of this facility, it might perhaps be necessary to put the onus of proving reasonable belief in the existence of such an emergency on the doctor or hospital concerned.

Whether the second scheme were adopted as a liberalization of the first or as a tightening up, many of the foregoing technical questions would need careful resolution. Given clear and coherent aims, technicalities are the law's means of securing substantive rationality. The symbolic and practical significance of technical devices is immense; most people see the aims and significance of the law only through its technical operations. Onus of proof, unanimity of decision,

75. As it is not under the Abortion Act 1967 (U.K.) or the "Abortion Act 1969 (S.A.). Cf. *supra* n.11. It is required under, for example, the Colorado statute of 1967, *supra* n.59.

representation of competing interests, verification of *ex parte* assertions, consent of interested parties—these are the factors whose determination one way or another will govern the efficacy of any version of the second scheme. One may add that, if the liberalizing version of the second scheme (or, indeed, the third scheme) be adopted, some further technical questions will need clear solution: Will it be an implied term in a medical practitioner's contracts with his employers (if any) and his patients that he will perform abortions in all situations where the law permits abortion? Will it be actionable negligence not to suggest to a patient the possibility of an abortion in those situations where a considerable number of practitioners would be willing to perform an abortion? Should, for example, a surgeon be entitled to plead conscientious objection to the performing of any authorised abortion, for purposes of criminal, professional *and civil* liability⁷⁶? If the first scheme is somewhat hard on medical practitioners because of its want of precision (in some versions) and its uncertain application in the hands of police and prosecutors, is there not as great injustice in any version of the other schemes which, through failing to distinguish between the permitted and the compulsory, leaves the practitioner who has a firmly traditional conscience uncertain of his legal right to act according to it?

3. The "right of the woman": uncontrolled application of indeterminate criteria.

The third scheme of regulation obtains, broadly speaking, in South Australia, the United Kingdom, Japan⁷⁷, Russia and Eastern Europe. Here, abortion is either formally or in practical effect permitted whenever it is performed by a qualified physician⁷⁸. The limiting case is where the physician or authorising board must perform or authorise an abortion if the woman persists in her demand (Hungary). But there are many variants short of this. The first scheme is liable, as we said, to change gradually into the third wherever qualified

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76. The Abortion Act 1967, s.4 (1) (U.K.) and the "Abortion Act" 1969 (S.A.) both contain a conscience clause which extends only to "participation in any treatment authorized by this Act", but which does not protect a physician in respect of any duty to advise his patient nor in respect of "any duty to participate in any treatment which is necessary to save the life or to prevent any grave permanent injury to the physical or mental health of a pregnant woman": s.4 (2). In both these respects the conscience clause in Moore, *loc. cit. supra* n.74, is preferable. The Model Penal Code has no conscience clause. The proposed Humane Abortion Act of 1967 (New York) would, it seems, have required courts to order abortion in certain cases. "Comment" (1967) 31 Albany Law Review 290, 294. Could a judge plead conscientious objection? In England, Geoffrey Howe Q.C. suggested to the Medical Protection Society that the safe rule for members of the Society seeking to avoid civil liability might be: "If in doubt, terminate!": "The Abortion Act in Practice" British Medical Journal 14th February 1969, 437.
77. The Japanese Eugenic Protection Law 1948, as amended, provides that an abortion can be performed whenever in the judgment of a single physician "it is feared that continued pregnancy or childbirth will for physical or economic reasons markedly injure the health of the mother's body". This is formally much stricter than the U.K. and S.A. Acts: see *infra* n.110, and Appendix A, para. 1.
78. Since Parliament expressly rejected any special qualifications for the required second opinion, it must be regarded as the merest formality. Note that in East European countries, abortions must be approved by a board, and in some countries about 10% of applications are refused; but the fundamental fact remains that "medical reasons for termination are uncommon, contributing 6% of cases in Slovenia, 10% or under in Czechoslovakia; approximately 4% in Hungary and only 1% in Rumania": Potts, *op. cit. supra* n.45 at 239.

physicians are in practice permitted to perform abortions at will without fear of prosecution or professional disciplinary proceedings. The second scheme is liable to be converted into the third by extension of the grounds on which the boards may authorise abortion, so as to include considerations remote from medical or psychiatric indications. Within the third scheme it is possible for there to be central boards, or no boards; permissive or mandatory indications; fee-paying requirements, or free service⁷⁹; stipulations of authorized hospitals, or no such stipulations; compulsory sterilization as a condition of first, second, third or subsequent abortions, or no such requirement; compulsory instruction in birth control procedures, or no such provision; and other similar variations, including many of those already mentioned in discussing versions of the second scheme.

The aims of the third scheme are two: (1) to give effect to the rights of the mother over her own body; (2) to eliminate unskilled abortions⁸⁰. Neither of these aims need be regarded as primary or secondary; each is by itself a sufficient explanation of the scheme.

What is the meaning of the first aim? In both the first and the second model schemes, recognition is given to the rights of the mother as against any rights which the unborn child may have. But these schemes preserve the impression that the problem is one of balancing competing rights; it is only where the mother is medically gravely threatened that her rights are given precedence. In the third scheme, on the other hand, the foetus has no rights as against the mother, since its existence is strictly by her sufferance or at her will and pleasure, subject only to her finding compliant physicians. Indeed, under the third scheme the foetus is likely to be less protected as against the mother than are other portions of the mother's anatomy. For by the Anglo-American common law, no-one may consent to an assault upon himself; consent is relevant only as a pre-condition of the lawfulness of physical interventions within the context of lawful games or of medically indicated treatment⁸¹. To ask a surgeon to cut off one's leg for no reason other than that one wants it off, for example, to win a bet or to beg, does not legally entitle the surgeon to perform the operation. This is not in itself a criticism of the third scheme, but underlines its novelty and scope.

Sometimes it is argued that to adopt the third scheme would contradict the common law rules recently developed in many American States, conferring conditionally enforceable rights upon unborn children, even non-viable

79. If abortions are cheaper than contraceptives the results are predictable: on the Japanese experience, see Blacker and Samuel, *op. cit. supra* n.32. Moreover, effective contraception requires continuing effort: see *infra* Appendix A, para. 4. In 1964, one third of the 184,000 Hungarian women legally aborted had had two or more previous legal abortions: Klinger, *op. cit. infra* n.80, at 471.

80. An orthodox but nuanced account of current doctrine in Communist states is Solnar, "Contribution à la Question de la Criminalité de l'Avortement Provoqué" in *Tribute to de Vabres, supra* n.10 at 171. Also Tietze and Lehfeldt, *op. cit. supra* n.43 at 1149; Wolinska, *op. cit. supra* n.35; Potts, *op. cit. supra* n.45, and Mehlan, *op. cit. supra* n.32 at 87, both citing the preamble to the Russian legislation of 1955; Klinger, "Abortion Programs" in *Family Planning and Population Programs* (Proceedings of the International Conference on Family Planning Programs, Geneva, 1965) (1966), 465.

81. Devlin, *The Enforcement of Morals* (1965) 6; Perkins, *Criminal Law* (1957) 853; *Fairclough v. Whipp* [1951] 2 All E.R. 834.

foetuses, in respect of negligently caused ante-natal injuries⁸². The argument, as it stands, is mistaken. The law can, without contradiction or legal-logical absurdity, confer legal personality on whatever it wishes, human or non-human, and under whatever restrictions and conditions it sees fit. For example, the law could coherently confer a right of action upon a child as against its parents for conceiving it in face of known risk of malformation. To say that legally the child had a right not to be conceived would in no way carry the implication that the child had in any sense existed prior to its conception. Similarly, it would not be legal-logically absurd for the law to say that a non-viable foetus had no right, as against its mother and her physicians, not to be aborted, but did have a right, as against third parties, not to be negligently injured⁸³. Of course, legal-logical coherence and legal legitimacy are to be distinguished—the latter concept, unlike the former, involves considerations of the law as a project for social order, as a scheme of living, of co-ordinating human ends, and ends with means. Even so, to point to the developing common law civil rights of the unborn child does not of itself establish that the third scheme lacks substantive legal legitimacy.

But the recent American developments of the law on ante-natal injuries by third parties are not irrelevant. For the developments have been provoked by a growing sense of the arbitrariness of the distinction between viability and non-viability. To more and more judges it has seemed that there is no meaningful stage, in the development of the child after conception, at which the child could in commonsense be said to change from a "part" into something more than a part of the mother⁸⁴. We have already said that legal rights and personality could be conferred on the non-viable foetus for any reason or none; what we are saying now is that, as a matter of fact, the conferment of these rights and personality has in large measure been due to a judicial sense that, again as a matter of fact (not of legal logic), the non-viable foetus is as distinct from the mother as the viable foetus. It is this cultural fact about educated opinion, not the question of legal coherence, that is important here.

82. On these developments see Gordon, "The Unborn Plaintiff" (1965) 63 Michigan Law Review 579; Note: "A New Theory in Prenatal Injuries: The Biological Approach" (1957-8) 27 Fordham Law Review 684; Note, "The Impact of Medical Knowledge on the Law Relating to Prenatal Injuries" (1962) 110 University Pennsylvania Law Review 554. All the authors predict the general triumph of the new extension of tort and other civil rights to the non-viable foetus. The condition on which the rights in tort are enforceable is, of course, that the child should be born alive; but in *Raleigh Fitkin-Paul Morgan Memorial Hospital v. Anderson* (1964) 201 A.2d 537 the Supreme Court of New Jersey held unanimously that a mother could be compelled to submit to blood transfusions in order to save her unborn child, despite her religious objections.

83. Indeed, the law which grants a child an action in respect of negligent injuries caused while it was still non-viable, need not be expressed in terms of "rights of the non-viable foetus" at all. It can be expressed, after the fashion of the civil law systems in this matter, in terms of nothing more than a causal link between the plaintiff child's condition and the defendant's wrongful act: see Gordon, *op. cit. supra* n.82 at 590-91. Similarly, under existing law, the young foetus is protected against abortion, but has no right to legal interment, can be handled as a pathological specimen, and its untimely birth need not be registered: in South Australia it is thought that these legal disabilities end at the 20th week of pregnancy: see evidence of the Director-General of Medical Services, Adelaide, *op. cit. supra* n.24 at 18.

84. In *Smith v. Brennan* 157 A.2d 497, 502 (1960), the Supreme Court of New Jersey said: "The third reason for the rule denying recovery was the theory that an unborn child was a part of the mother, and therefore not a person in being to

For this fact provokes the question: What are the implications, for society at large, of adopting the third scheme in preference to the first or second? Such an adoption seems symbolically to devalue the primary objective of the first scheme: the unconditional protection of human life, inside as outside the womb, save where another human life is involved. Now this objective has two components: the major premise is that human life is to be protected unconditionally, save where other human life is involved; the minor premise is that foetal life is human life. One or other of these premises must be undermined by adoption of the third scheme. Which will it seem to be? Will it not be the major premise? For the minor premise is protected by the strong trend of modern thought, in the light of improved biological knowledge of ante-natal development and of the chromosomal determination of human characteristics at the moment of conception, in favour of recognising the distinct humanity of the foetus after conception, and in favour of denying the relevance (long-since denied by medical science)⁸⁵ of "viability" or "quickening" or any other notional stage in ante-natal growth. It is to this trend that the developments in the law about ante-natal injuries bear witness.

The symbolic form of Western civilization is in large part what we have called Western rationality, in which the generality of rules is highly valued. We see this form of thought in the following passage from the influential contemporary American moralist Joseph Fletcher:

There are common exceptions to the rule against medical homicide. If one can be made at the beginning of life (abortion) why not also at the end of life (euthanasia)? The one situation is no more absolute than the other. There is no more stigma in the one than in the other⁸⁶.

It so happens that the Rev. Mr. Fletcher is arguing in favour of euthanasia; but the symbolic form and movement of his argument is what is of interest here. The dialectic moves in the ambit of the rationalist symbols: "rules"—"exceptions"; "if this, why not that?"; "the one, so the other". Once Western rationality had differentiated itself from the traditional and charismatic symbolic forms, it became a dynamic system with a keen sense, and low tolerance, of the arbitrary and anomalous. "Common exceptions" must be restated as a new

whom a duty of care could be owed. All the courts that have permitted recovery for prenatal injuries have disagreed with that theory. They have found that the existence of an infant separate from its mother begins before birth . . . Medical authorities have long recognised that a child is in existence from the moment of conception, and not merely a part of its mother's body . . ." See also, e.g., *Sylvia v. Gobeille*, 220 A.2d 222, 223 (R.I. 1966). In *Sinkler v. Kneale* 164 A.2d 93, 94 (1960) the Supreme Court of Pennsylvania said of Holmes J.'s doctrine in *Dietrich v. Inhabitants of Northampton* 138 Mass. 13 (1884): "Judge Holmes's real point d'appui for decision was that the unborn child was part of its mother. This was undoubtedly the medical view accepted by the law at the time, and it is precisely the view that has altered since." The court approved *Bennett v. Hymers* 147 A.2d 108, 110 (1958), in which the Supreme Court of New Hampshire said that "the foetus from the time of conception becomes a separate organism and remains so throughout its life." Holmes's doctrine was overruled in his own State, in respect of a non-viable foetus, in *Torigian v. Watertown News Co.* (1967) 225 N.E.2d 926.

85. See "Note" (1962) 110 University of Pennsylvania Law Review 554, 556 n.17. On the minor premise generally, see the debate between O'Connor and Noonan in (1968) 13 Natural Law Forum 127-140.
86. Joseph Fletcher, *Morals and Medicine* (1955) 205. Compare the title of Glanville Williams's article, "Euthanasia and Abortion", *supra* n.55.

“rule”, even if the old rule fares rather badly in the process. So, given the increasingly apparent humanity of the foetus, it must be assumed that the consequence of shifting to the third system of abortion regulation will be the gradual displacement of the old rule, often expressed in the Christian humanistic symbolism (which together with rationality comprises the symbolic form of Western civilization) as “the sanctity of human life”⁸⁷. The eventual content of a stabilised new rule, no-one can predict.

Some, preferring not to draw attention to the question of rights (which, however, arises whether one likes it or not), rely on the alternative objective of the third scheme: the elimination of unskilled abortions. Indeed, of all the schemes the third seems best fitted for attaining this end. But quick results and complete satisfaction, as we have seen⁸⁸, are not to be expected. Nearly a decade after adoption of the third scheme, the hospitals of each Eastern European state are filled with thousands of cases consequential on illegal abortions⁸⁹. Mortality and morbidity are probably⁹⁰ lowered; but they are far from eliminated, not least because the total number of abortions is considerably increased, and the operation is not free from risk of complications and sequelae⁹¹.

Advocates of the third scheme must consider a further issue: How great is their devotion to the rights of the mother or the elimination of unskilled abortions, or both? The unrestricted availability of abortion may well lead, as it has in Hungary, to a fall in the birthrate so great that the population begins to decline quite rapidly. At a certain point such a fall in population brings hardships and threatens the common economic and social good⁹². Is the availability of abortion then to be restricted, with consequential limitations on the rights of the mother and probable increases in the number of unskilled abortion? Does the abortion question ultimately involve no more than shifting considerations of social welfare, or does it involve human rights—and if so, whose? On the answer to these questions, too rarely pressed, depends the clarity of aim, and consequential precision of means, which are the essence of legal rationality.

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87. Giannella raises the sensible (rationalist) question how it can be consistent (i.e. just) to allow the destruction of three or four healthy foetuses in order to prevent one defective, while convicting the doctor who kills an unexpected defective after birth: “The Difficult Quest for a Truly Humane Abortion Law” (1968) 13 Villanova Law Review 257, 271. It is not clear why a full-blooded exponent of the third scheme, like Glanville Williams, should purport to wish to use the criminal law to prevent abortions after the first 16 weeks of pregnancy: *op. cit. supra* n.55, at 196.
88. *Supra* at n.45.
89. See Appendix B.
90. Not certainly: see the comment in Appendix B.
91. Report of the Royal College of Obstetricians and Gynaecologists, *op. cit. supra* n.22 at 851; Müller, “The Dangers of Abortion” 13 World Medical Journal (1966) 78; Yoshio Koya, “The Harmful Effects of Induced Abortion” (1966) 13 World Medical Journal 170.
92. The Report of the Inter-departmental Committee on Abortion (1939: U.K.) recommended against extension of the grounds for abortion not least for fear that it would lead to under-population (see s.232). In October 1966, Rumania repealed its liberal abortion law of 1957; the preamble to the law of 1966 referred primarily to “the great prejudice to the birth rate and the rate of natural increase”, secondarily to “severe consequences for the health of the woman”: see Tietze, “Abortion in Europe” (1967) 57 American Journal of Public Health 1923, 1931.

4. The proper scope of penal law

"He who violently bloweth his nose bringeth forth blood"⁹³. To the proverbial wisdom of Israel were added the words of Christ: "Neither do men put new wine into old bottles, else the bottles break, and the wine runneth out, and the bottles perish"⁹⁴. With a fanciful but vivid sense of relevance, the Christian legal philosopher drew from these sayings support for the conclusion that the law should not lay too severe a moral burden on weak men⁹⁵. Crime should not be coterminous with vice. I do not think that any of the three model schemes of abortion regulation conflict with this jurisprudential canon. In the current phase of Western mores, a criminal law which forbade abortion in all circumstances whatever would perhaps offend against the maxim; but the form of the first scheme operative in the law and practice of all relevant countries now permits abortions whenever the life of the mother is in danger. Of course, this scheme is too severe for many women, and they break the law. But there is no evidence of widespread resentment against the law, spilling over as a result into more general lawlessness. There seem to be no general criminal rackets flourishing on the basis of illegal abortions and extending into other areas of crime⁹⁶. Unlike Prohibition, the abortion law, while undoubtedly causing some of the wine to ferment in the bottle to the extent of many thousands of violations of that law, has not led to any split in the wineskin of the criminal law as a whole.

Are there any further jurisprudential doctrines, considerations or debates relevant to the problem of legally regulating abortion? There seem to be two candidates: (1) the doctrine of the American Law Institute (recently made use of by the Abortion Law Reform Association of South Australia) that to use the criminal law against a substantial body of decent opinion is contrary to basic American traditions⁹⁷; (2) the questions raised in the "Hart-Devlin" debate about the proper scope of the criminal law⁹⁸.

This is not the place to offer a full discussion of the American Law Institute's opinion: on its face it is a proposition within the ideology of American democracy, not within jurisprudence. However, a few questions may be raised in passing. Which is the body of decent opinion referred to, in the context of abortion? Is it the representative opinion of the medical profession? Or is it the

93. *Proverbs* 30:33.

94. *Matthew* 9:17.

95. Both the texts were cited by Thomas Aquinas, *Summa Theologiae* I-II, q. 96, a. 2, to support the view that the law should not suppress all vices.

96. The reasons for this lack of connection between abortion and organized crime are analysed in Schelling, "Economic Analysis and Organized Crime" in *Task Force Report: Organized Crime* 114, 124 (1967: ed. The President's Commission on Law Enforcement and Administration of Justice).

97. *Model Penal Code* s.207.11 at 151 (Tent. Draft No. 9, 1959); also Leavy and Kummer, *op. cit. supra* n.10 at 138. This view seems to lie behind another very popular, but weak and obscure, argument: that the law should not "make hypocrites of law-abiding citizens": see Trout, "Therapeutic Abortion Laws Need Therapy" (1964) 37 *Temple Law Quarterly* 172, 173; "Psychiatric Implications of Abortion: A Case-Study in Social Hypocrisy" (1965) 17 *Western Reserve Law Review* 435, 453.

98. Devlin, *op. cit. supra* n.81 (which contains a bibliography of the debate to 1964); Hart, *op. cit. supra* n.62; Mitchell, *op. cit. supra* n.9; J. R. Lucas, *The Principles of Politics* (1966) 172-75, 344-51.

opinion of those women and practitioners who consider they have a basic human right to demand and perform abortions at will? If it is the latter, why does not the Institute's Model Penal Code contain a straightforward version of the third scheme? If it is not the latter opinion, what is indecent about the body of opinion? But more important, how conscientiously is the American Law Institute willing to apply its principle in other areas? Would it have eliminated the law against duelling, during the centuries before the law's eventual triumph? Is the opinion of decent racialists to be protected by the principle? Looking at the Bill of Rights, we are inclined to believe that American democratic principles are somewhat richer than the American Law Institute would have us believe; as Edmond Cahn remarked of the desegregation decision in *Brown v. Board of Education*: "Here we see again the falseness of the popular belief that, with regard to moral values, the law imposes only 'minimum standards' "⁹⁹.

As a useful principle, more than merely a culturally effective slogan, the American Law Institute principle seems rather ramshackle. The same is true, it must be confessed, of the "Hart-Devlin" debate, despite the fact that this was sought to be conducted within the realm of jurisprudence proper. At the beginning of the debate, the principle that society has the right to punish immorality as such was opposed to John Stuart Mill's principle that "the only purpose for which power can be rightfully exercised over any member of a civilised community, against his will, is to prevent harm to others"¹⁰⁰. At the end of the day, Lord Devlin's advocacy of the former view had been reformulated¹⁰¹:

Whether society should have the power to restrain any activity depends on the nature of the activity. Whether it should exercise the power at any given time in its history depends on the situation at that time and requires a balance to be struck between the foreseeable danger to society and the foreseeable damage to the freedom and happiness of the individual.

Meanwhile, Professor H. L. A. Hart's advocacy of the other view had been shifting, too: for him, Mill's principle comes down to little more than¹⁰²:

that the issue should be calmly viewed as one to be decided by consideration of the balance of harm done by the practice and the harm done by the existing law.

Between this "principle" of balancing and the "principle" of balancing quoted from Lord Devlin, we find it difficult to see any difference. In the absence of critical clarification of the concept common to both—namely, danger, damage or harm—we feel free to say that the debate has neither strengthened nor weakened our own analysis of the functions of the criminal law.

John Stuart Mill himself was able to recognise that the problem is not as simple as some of his uncritical followers have supposed. One hundred years ago, progressive and humanitarian thinkers in England were agitating for State

99. Cahn, "Jurisprudence" (1955) 30 *New York University Law Review* 150, 156.

100. Mill, *Essay on Liberty* (Everyman ed., 1910) 72-73.

101. Devlin, *op. cit. supra* n.81 at 113.

102. Hart, *op. cit. supra* n.62 at 47; also 48-49.

registration and certification of prostitutes¹⁰³. The primary object of this scheme was analogous to a main aim of the third model scheme of abortion regulation: the prevention of venereal disease. But in his evidence to the Royal Commission on Contagious Diseases¹⁰⁴, in 1871, it was Mill who said that a licensing law¹⁰⁵:

facilitates the act beforehand, which is a totally different thing, and is always recognised in legislation as a different thing, from correcting the evils which are the consequences of vices and faults. If we were never to interfere with the evil consequences which persons have brought upon themselves, we should help one another very little. Undoubtedly, it is true that interfering to remedy evils which we have brought on ourselves has in some degree the same bad consequences, since it does in the same degree diminish the motive we have to guard against bringing evils on ourselves. Still, a line must be drawn somewhere, and a marked line can be drawn there. You may draw a line between attacking evils when they occur, in order to remedy them as far as we are able, and making arrangements beforehand which will enable the objectionable practices to be carried on without incurring the danger of the evil. These two things I take to be distinct and capable of being kept distinct in practice. As long as hospitals are not peculiarly for the class of diseases, and do not give that class of disease any favour as compared with others, they are not liable to objection, because their operation consists in remedying the effects of past evils; they do not hold out a special facility beforehand to practising illicit indulgence with a security which it would not otherwise enjoy. The interference is not preventive but remedial.

And then Mill was asked: "You think that the tendency of the Act¹⁰⁶ is to do moral injury?" He said¹⁰⁷:

I do think so, because I hardly think it possible for thoughtless people not to infer, when special precautions are taken to make a course which is generally considered worthy of disapprobation safer than it would naturally be, that it cannot be considered very bad by the law, and possibly may be considered as either not bad at all, or at any rate a necessary evil.

103. Sheldon Amos, *Laws for the Regulation of Vice* (1877); Ann Stafford, *The Age of Consent* (1964).

104. State-controlled facilities or licensing provisions obtained in almost every European country and, in practical effect, in English military districts. In 1870 a Royal Commission was appointed to inquire into the possibility of extending the quasi-licensing provisions to all parts of England. At the outset, most of the Commissioners, who included T. H. Huxley and F. D. Maurice, were in favour of such an extension. But at the end of the day the Chairman was to say: "So far as the medical testimony was concerned, there can hardly be a doubt that the system of the periodical examination was the most efficacious for the restriction of diseases. On the other hand, there were many considerations of morality and decency which rendered the Commission unwilling to recommend it." Amos, *op. cit. supra* n.99 at 16, 47. For the conclusions of the Commission, *id.* at 478-496. On the Contagious Diseases Act 1864, *id.* at 423-471. On the Royal Commission, Stafford, *op. cit. supra* n.99 at 43-51.

105. Quoted Amos, *op. cit. supra* n.103 at 53-54.

106. *I.e.*, the Contagious Diseases Act 1864, 27 and 28 Vic. c.85, providing for medical inspection of prostitutes in military districts in England.

107. Amos, *op. cit. supra* n.103 at 53-4.

It is this more supple and far-seeing conception of harm that is relevant in jurisprudence.

The problem of prostitution, like that of abortion, is not to be solved by any legislative scheme alone; but throughout Europe experience of the progressive and humanitarian scheme for regulating prostitution showed that if society regards something as a vice, it will generally be better to treat it as a vice and not merely as a problem of health regulation like the sale of milk¹⁰⁸. If the law speaks with a clear voice, it is easier to set in motion the educative and alleviative programmes which are essential if the vice is to be checked at its root.

To anyone who shares what have hitherto been the fundamental values of Western society, an abandonment of the universal respect for the value of human life must seem a harm—a change for the worse—not only to those whose lives are lost as a result, but also to those who are persuaded to commit the unjust killings: at the roots of Western moral thought is the conviction of Socrates that the man who does an injustice harms himself more than he harms his victim; he makes himself less of a man, and thus altogether worse off¹⁰⁹. On the other hand, to someone who disputes these values in their application to abortion, the first and even the second scheme of abortion regulation must seem pointless and harmful. Between the two ranges of opinion there need be no further jurisprudential issue; it is simply that the calculations or balances of harm are drawn up with different weights.

The jurisprudential questions remain, whatever the fundamental values in balance. Ends must be carefully clarified, and means related strictly to mutually compatible ends, not to vague hopes, nor to compromises which in pursuit of the immediately attainable lose sight of both the ultimately and the immediately desirable¹¹⁰. It is ominous that the most popular schemes in current discussion happen to be compromises that muddle together aims and elements of all the three model schemes, and so more or less obviously diverge from the jurisprudential ideal of rational co-ordination of means with clear and coherent ends. "Pragmatism", "codification of current practice" and "moderate reform" are not synonyms for rationality; in much recent thought, they are substitutes.

108. Registration of Prostitutes is condemned by the Convention for the Suppression of the Traffic in Persons and of the Exploitation of the Prostitution of Others, approved by United Nations General Assembly Resolution of 2nd December 1949. The Contagious Diseases Act 1864 was repealed in 1875, 38 and 39 Vic. c.66.

109. Plato, *Gorgias*, 469B and *passim*.

110. In South Australia, the Select Committee of the House of Assembly, reporting in favour of reform along the lines of the Abortion Act 1967 (U.K.), said (*op. cit. supra* n.24 at para. 24): "Even though the general rule may be that there should be no interference with a pregnancy, there are and always have been qualifications for various reasons. The difficulty is to define them. The members of the Committee are agreed that *any qualifications must be treated with the very greatest of care*. For the same reasons, they could not accept abortion on request . . ." (emphasis added). For the reasons given below in Appendix A, para. 1, the Committee must be said to have deceived itself: the language of the Bill (as of the Abortion Act 1967) in respect of "greater risk of injury to the physical or mental health of the pregnant woman . . . than if the pregnancy were terminated" is such that no medical practitioner need regard the Act as in any way "qualifying" his right to terminate pregnancies on request (subject to some casual paper-work). And this is the case quite apart from the "social clause" (*scil.* "greater risk to the physical or mental health of . . . any existing children of her family

Appendix A

NOTES ON THE ABORTION ACT 1967 (c.87. U.K.)

1. The Act draws a sharp distinction between two types of lawful abortion. Emergency abortions are lawful when performed by a medical practitioner who is of the opinion, formed in good faith, that an abortion is immediately necessary to save the life or to prevent "grave permanent injury to the physical or mental health" of the pregnant woman: section 1 (4). Other abortions are lawful when performed by a medical practitioner, if any two medical practitioners are of the opinion, formed in good faith, that the continuance of the pregnancy "would involve risk to the life of the pregnant woman or any existing children of her family, greater than if the pregnancy were terminated", or that there is "substantial"¹¹¹ risk that if the child were born it would suffer from such physical or mental abnormalities as to be seriously handicapped": section 1 (1).

Not only (i) may the medical practitioners take into account a risk to the health of persons other than the pregnant woman (and the unborn child), but also (ii) in determining such risk to health, "account may be taken of the pregnant woman's actual or reasonably foreseeable environment": section 1 (2). When people speak of "the social clause" they may be referring to either (i) or (ii) and very often to both.

It is the existence of the so-called "social clause" that perhaps more than any other feature of the Act gives the average citizen, doctor and parliamentarian the impression that the Act considerably relaxes or liberalizes the law on abortion. This impression is of great social significance, and no doubt of itself profoundly affects the working of the Act's scheme of abortion regulation. But the fact is that in the first 13 months of the Act's operation, only 3.9 per cent of lawfully notified abortions were stated to be on the grounds of risk to the health of existing children¹¹². Far more significant than the "social clause" in this sense, is the fact that the Act, by drawing the sharp distinction already mentioned, sanctions abortion where the anticipated injury to health¹¹³ is not grave and permanent but slight and transient, and where the risk of such injury is not substantial or serious but merely "greater than if the pregnancy were terminated". This fact is emphasised by the printed form provided for certification in accordance with the Abortion Regulations 1968¹¹⁴. The certifying

than if the pregnancy were terminated", and "account shall be taken of the pregnant woman's actual or reasonably foreseeable environment.")—this clause (or clauses) is less significant than the Committee (para. 20) seems to suppose.

111. In considering the meaning of "substantial", and the effect of the Act on medical ethics, one will note that an editorial in *The Lancet* for 12th July 1969, p.89, commended abortions at the 24th week of pregnancy in certain cases wherever the risk of congenital abnormality is 1 in 10 or greater.
112. Sec. of State for Social Services, *Parliamentary Debates* (House of Commons), 16th June 1969, col. 9-13.
113. Note that in 1960, the World Health Organization defined "health" as "a state of complete physical, mental and social well-being, not simply the absence of illness and disease". Note also the looseness of the English requirements as against those in the California legislation of 1967, where what is in question is "mental illness to the extent that the woman is dangerous to herself or to the person or property of others, or is in need of supervision or restraint": California Health and Safety Code section 25954 (1967).
114. S.I. 1968 No. 390, Schedule 1.

'doctors need do no more than sign the form, having ringed a number, for example; "2. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the pregnant woman greater than if the pregnancy were terminated"; or "3. the continuance of the pregnancy would involve risk of injury to the physical or mental health of the existing child(ren) of the family of the pregnant woman greater than if the pregnancy were terminated".

As C. B. Goodhart has said: "Since the almost non-existent risk to the life of a healthy woman in an abortion properly performed early on in pregnancy is indeed likely to be less than the present very low, but not wholly negligible, risk in childbirth, it is hard to see how any doctor could justify a refusal to give such a certificate. Whatever Parliament may have intended, this is in effect abortion on demand, subject only to a doctor's right to refuse to participate if he can prove a genuine conscientious objection"¹¹⁵.

2. The Act (which does not apply to Northern Ireland) came into force on 27th April 1968. From time to time since then, Ministers have supplied Parliament with statistics based on the notifications required by the Act. These statistics relate to England and Wales; Scottish figures are issued separately, and are not included in the following table and commentary.

TABLE A¹¹⁶

I Period	II Cumulative total at end of period	III Notifications within period	IV Average daily rate within period	V Equivalent annual rate
1968				
27th April - 24th June	3,863	3,863	65	24,000
24th June - 8th October	13,042	9,179	87	32,000
8th October - 31st December	22,256	9,214	110	40,000
1968 - 1969				
31st December - 25th February	28,849	6,593	118	43,000
1969				
25th February - 27th May	41,496	12,647	139	51,000
27th May - 1st July	46,714	5,218	149	54,000

115. British Medical Journal 4th May 1968, 298.

116. The table is based on figures supplied by Ministers: see Parliamentary Debates (House of Commons) vol. 767, col. 184; 770, col. 84; 771, col. 192; 776, col. 137; 780, col. 10; 781, col. 199; 785, col. 9; Parliamentary Debates (House of Lords) vol. 304, col. 252.

1st July - 30th September	60,585	13,871	151	55,000
30th September - 31st December	76,269	15,684	170	62,000
(2nd November - 29th November	—	5,171	185	67,000)

It is possible that some of the notable increase in the rate of lawful abortions observable during the first 20 months of the Act's operation has been due to an increased influx of women from outside the United Kingdom. However, it seems unlikely that this is the major cause of the increase. In the period from 27th April to 31st December 1968, 5 per cent of women aborted in England and Wales gave a place of residence outside the United Kingdom¹¹⁷. In the period from 1st January to 1st July 1969, the number rose, but only to 7.3 per cent of the total¹¹⁸. Perhaps more significant (since it is impossible to estimate how many women give false addresses) is the fact that the proportion of abortions performed in National Health Service hospitals has remained virtually constant at about 60 per cent of all abortions being performed in England and Wales. Indeed, while the proportion of National Health Service abortions fell from 60.8 per cent in mid-1968 to 59.2 per cent in mid-1969, in the last quarter of 1969 (in which the number of foreign women aborted rose to about 10 per cent of all lawful abortions) the National Health Service proportion actually rose to 69.0 per cent. Since it is certain that only a negligible number of foreign women are aborted in National Health Service hospitals, one would expect any considerable, but otherwise hidden, increase in the influx of foreign women to be reflected in a fall in the proportion of National Health Service abortions. Such a fall has not occurred¹¹⁹.

3. It is commonly supposed that the majority, even the great majority (the most popular figure is 80 per cent), of women seeking abortion in modern Western societies are married women living with their husbands. Many supporters of reform use this supposition to support an argument that reform would not occasion sexual promiscuity and a change in sexual mores¹²⁰. Whatever the merits of this argument, which is not in question in this article, the supposition has not been borne out by the evidence available, for the first time, since the Abortion Act 1967 came into force.

During the first nine weeks of the Act's operation, only 45 per cent of women aborted were married and living with their husbands. During the 13 weeks

117. Parliamentary Debates (House of Commons), 16th June, 1969, col. 12.

118. Calculation based on ministerial figures in Parliamentary Debates (House of Lords), 15th July 1969, col. 252.

119. Parliamentary Debates (House of Commons), 16th June 1969, col. 12; 4th February 1970, col. 159; 9th March 1970, col. 898.

120. See, e.g., Taussig, *op cit. supra* n.20, 388; Dickens, *Abortion and the Law* (1966), 111; Lowe, *Abortion and the Law* (1966), 8; Lucas, (1968) 46 North Carolina Law Review 730; Comment (1968), 14 Wayne Law Review 1006, 1019; Moore (1963), 20 Washington and Lee Law Review 250, 256; Note (1967), 7 Journal Family Law 496; etc. Note that the *Report of the Inter-Departmental Committee on Abortion* (1939; H.M.S.O.) stated, in para. 37, that "both the mortality statistics and the figures of cases treated in hospital show that the overwhelming majority of abortions occur among married women".

ended 31st December 1968, the proportion had fallen to a little over 43 per cent, and over 47.5 per cent of the women aborted were single (the remainder being widowed, divorced or separated)¹²¹.

4. In a letter to *The Lancet* in 1968, Frederiksen and Brackett stated: "From data presented for countries in which contraception is already practised by a substantial proportion of the population, it appears that permissive abortion laws may contribute more to a diminution of the effective practice of contraception than to a reduction in the birthrate beyond the level already obtained by contraception before the enactment of liberal abortion legislation"¹²². Be this as it may, since the Abortion Act came into force a good deal of evidence has become available concerning the birth-control practices of women seeking abortions.

Of one series of 1,000 women between 1964 and 1969, 30 per cent normally used no method of birth-control and 48 per cent used none on the occasion of unwanted conception¹²³. In a recent study of women who obtained lawful abortions through the Birmingham Pregnancy Advisory Service, 45.8 per cent normally used no method and 73.5 per cent used none at the time of conception¹²⁴. Of the first 500 women aborted through the offices of the London Pregnancy Advisory Service, 42 per cent normally used no method and 70 per cent used none at the time of conception¹²⁵. In the last-mentioned study, the Hon. Medical Secretary of the Service stated that 60 per cent of the women were single, but "only 8 per cent of the pregnancies resulted from a casual union. Many an intelligent young unmarried woman has admitted that she viewed taking oral contraceptives as a degree of commitment she was not prepared for"¹²⁶. Nearly 12 per cent of the first-mentioned series of 1,000 women were doctors or nurses, a further 11 per cent were students or teachers, and only 4 per cent were schoolgirls who might, perhaps, be expected to be more ignorant of birth-control methods¹²⁷. The President and Hon. Secretary of the Royal Society of Obstetricians and Gynaecologists stated in July 1969 that "evidence is accumulating that contraception among the young is an irrelevance"¹²⁸.

5. Under a scheme of abortion regulation as relaxed as that adumbrated by the Abortion Act, it might be expected that mortality (and morbidity) from unlawful abortion would decline appreciably. This decline has been slow to appear, as the following table indicates:

121. See Registrar-General's *Quarterly Returns for England and Wales* for Quarter ended 31 December 1968 (H.M.S.O. 1969), 23; Parliamentary Debates (House of Commons), 16th June 1969, col. 12.

122. [1968] 2 *The Lancet* 167.

123. Diggory, "Some Experiences of Therapeutic Abortion" [1969] 1 *The Lancet* 873, 875.

124. *Id.*

125. Abels [1969] 1 *The Lancet* 1051.

126. *Id.*

127. Diggory, *loc. cit. supra* n.123.

128. Letter to *The Times*, 23rd July 1969.

TABLE B¹²⁹

Deaths notified as due to abortions induced for reasons other than medical or legal indications (England and Wales)

1961	23
1962	29
1963	21
1964	24
1965	21
1966	30
1967	17
1968 January to April	6
May to December	16

The total number of notified deaths from all forms of abortion for the period 1st April 1968 to 31st March 1969 was 42, as against 36 for the same period in 1967-8¹³⁰.

As for morbidity occasioned by unlawful abortion, no strong evidence is available yet. The sponsor of the Abortion Act stated in the House of Commons on 15th July 1969 that admissions to the London Emergency Bed Centre for spontaneous or incomplete abortions (a category which includes bungled criminal abortions) were 870 in the first quarter of 1968 as against 1,363 in the first quarter of 1966¹³¹. However, the Emergency Bed Service Annual Report for 1964 indicated that many hospitals had a prejudice against abortion admissions, preferring to leave them to the Emergency Bed Service¹³². So the decline since 1966 may reflect a change in hospital attitudes now that hospitals are ready to perform twenty times as many abortions as in 1966.

6. Early in 1969, an unmarried student was aborted in a Scottish hospital. The certifying doctors ringed the clauses on the certificate which concern "greater risk to the mental or physical health of the pregnant woman . . ." and "substantial risk of abnormality". In fact the foetus was more than 28 weeks old, and after the abortion lived for nine hours, being discovered to be alive when the porter carrying it to an incinerator in a paper bag heard its cries. At a public enquiry into the affair, the procurator fiscal, representing the Crown, suggested that, while the Act gave doctors a right to terminate pregnancy, it did not take away from them the duty to take every step to revive a child who might be viable. Not surprisingly, various medical witnesses opined that, since the object of abortion normally is to prevent the child's survival, resuscitatory

129. See figures supplied by the Minister of Health, Parliamentary Debates (House of Commons) 18th October 1968, col. 192; Registrar-General, *op. cit. supra* n.121 at 21. All these figures exclude a category of deaths due to abortion notified to the Registrar-General without specifying whether induced or spontaneous. The triennial *Reports on Confidential Enquiries into Maternal Deaths*, *supra* n.45, confirm the substantial accuracy of the Registrar-General's figures.

130. Secretary of State for Social Services, Parliamentary Debates (House of Commons), 16th June 1969, col. 12.

131. Parliamentary Debates (House of Commons), 15th July 1969, col 414. For more complete figures, revealing a continuous decline in abortion admissions to the Service since 1964, see Parliamentary Debates (House of Commons), 13th February 1970, col. 1658.

132. Dickens, *op. cit. supra* n.120, 116.

measures might not be in place. But the jury unanimously recommended, not only (i) that legislation should be introduced prohibiting abortion when the foetus is approaching or has reached the stage of viability, but also (ii) that in all cases where an infant of or approaching or about viable age or apparently or possibly viable is to be delivered by abortion, all facilities and resuscitatory measures applied in cases of ordinary birth should be adopted¹³³.

The oddity, not to say downright absurdity, of this well-meaning recommendation may help to indicate how far the scheme of the Abortion Act 1967, as concretely understood in the society to whose order or disorder it contributes, diverges from substantive rationality.

Appendix B

ABORTION STATISTICS FOR SOME EUROPEAN STATES

1. In Table D there is a category named "other abortions". This term refers to official figures for hospital admissions for all forms of incomplete, spontaneous, septic or missed abortion. Thus it includes a certain number of bungled illegal abortions, but also a number of spontaneous abortions (i.e. miscarriages). A very thorough recent study¹³⁴ of births and abortions in Belfast (where, it was concluded, a negligible number of conceptions—at the outside, 1 per cent—ended in illegally induced abortions) indicates that not less than 12 per cent nor more than 17 per cent of all conceptions result in spontaneous abortion (miscarriage) detectable by the woman concerned. In this population, urban and well-serviced with state hospitals, just under 12 per cent of all conceptions resulted in an abortion for which medical treatment was given. In 91 per cent of cases, this treatment was in hospital, even though of the women treated in hospital only 25 per cent passed any part of the foetus itself in the hospital. From this study, and others, it is reasonable to conclude, therefore, that *not more* than about 12 per cent of all conceptions could (on account of spontaneous abortion or miscarriage) call for hospital treatment of any kind¹³⁵.

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133. "Death of a Baby—Inquiry in Glasgow", *British Medical Journal* 14th June 1969, 704, 705. In a letter to *The Times* after the inquiry (2nd June 1969), Professor Glanville Williams suggested that abortions after the 24th week of pregnancy should not be lawful except in real emergency. Cf. *supra* n.87. The 1967 California law draws the line at 20 weeks: California Health and Safety Code sec. 25953. Note that in the first seventeen months of the U.K. Act's operation, 63.1 per cent of the fetuses aborted were aged 12 weeks or less, and 35.4 per cent were aged 13 weeks or more: see Parliamentary Debates (House of Commons), 10th February 1970, col. 336.
134. Stevenson et. al, "Observations on the Results of Pregnancies in Women resident in Belfast" (1959) 23 *Annals Human Genetics* 395, 396. See also Warburton and Fraser, "Spontaneous Abortion Risks in Man" (1964) 16 *American Journal Human Genetics* 1, 2; Tietze, Guttmacher and Rubin, "Unintentional Abortion in 1,497 Planned Pregnancies" (1950) 142 *Journal American Medical Association* 1348, 1349.
135. In England and Wales in 1964, there were about 850,000 live births, an unknown number of illegal abortions (not less than 10,000) and 75,000 cases of abortion (of all kinds) treated in National Health Service hospitals, plus a small number treated in private clinics. These figures tally well with the Belfast depth-study, and suggest that the figure of 12 per cent (conceptions ending in hospital treatment for non-induced abortion) is a high maximum which in many areas and populations might be (as in Czechoslovakia and Poland it is known to be) considerably lower.

This enables a rough calculation to be made of the proportion of the "other abortion" cases, reported in the East European statistics, which should be ascribed to illegally induced abortions. The number of conceptions which might have ended in spontaneous abortion is calculated by adding to the number of births the whole of the number of "other abortions". (Conceptions ending in induced abortion, legal or illegal, can be ignored because, in the event, these cannot have ended in spontaneous abortion). The proportion of this number of conceptions that might be expected to have ended in spontaneous abortion calling for hospital treatment is, as a maximum, 12 per cent. (The resulting figure may in fact overstate the expected number of spontaneous abortions calling for hospital treatment, since the number of conceptions used as the basis of the calculation in fact includes conceptions which ended in illegally induced abortion calling for hospital treatment.)

Thus, in Hungary in 1964, for example, with 132,100 live births and 34,300 "other abortions", one would expect that no more than 19,000 women would have spontaneous abortions calling for hospital treatment. So it is not unreasonable to suppose that the other 15,000 women who had hospital treatment for abortion (other than legally induced abortion) were victims of illegal abortions.

In Czechoslovakia and Poland, no calculation can be made on this basis, since the figures for "other abortions" show that it has never been the case, in these countries, that 12 per cent of all conceptions resulted in spontaneous abortion resulting in hospital treatment, and there is no way of determining the relevant lower proportion from the figures available. One can, however, observe that in neither country has the proportion of "other abortions" to conceptions (i.e. to conceptions other than those known to have ended in induced abortion) fallen significantly, if at all, between 1953-54 and 1963-64, despite the falling birthrate and the legalisation of abortion.

2. What about deaths registered, in these countries, as due to illegal abortion? Mehlan's figures are often cited¹³⁶:

Poland 1959, 76; 1965, 26
 Czechoslovakia 1959, 53; 1962, 11
 Hungary 1959, 83; 1964, 24.

These figures cannot, however, be relied on. Potts, a passionate advocate of free abortion, has cited the analyses of the Czech figures made by Lukás¹³⁷ and by Cernoch¹³⁸: Potts states that Cernoch's are based on the more thorough analysis¹³⁹. Where Mehlan states that deaths from illegal abortion in Czechoslovakia in 1959 numbered 53, and in 1962, 11, Lukás puts the figure for 1959 at 14, and for 1962 at 15, while Cernoch puts them at 10 and 9 respectively. The contrast drawn by Mehlan thus evaporates. It will also be noticed that in Czechoslovakia in 1962 the ratio of those deaths to live births was (assuming only 9 deaths) about 1:24,000 and in England about 1:28,000.

136. Mehlan, *op. cit. supra* n.32 at 86; Roemer, "Abortion Law: the Approaches of Different Nations" (1967) 57 *American Journal Public Health* 1906, 1912.

137. Lukás, "Abortion in Czechoslovakia" in *Sex and Human Relations* (International Planned Parenthood Federation Conference, 1965) 93.

138. Cernoch, "Les Autorisations d'interruptions de grossesse en Tchécoslovaquie" (1965) 160 *Gynaecologia* 293.

139. Potts, *op. cit. supra* n.45 at 242.

TABLE C¹⁴⁰
LEGAL ABORTIONS IN SWEDEN AND DENMARK

Year	Legal abortions per		Legal abortions per	
	Legal abortions	1,000 live births	Legal abortions	1,000 live births
	SWEDEN	SWEDEN	DENMARK	DENMARK
1939	439	5	484	7
1940	506	5	522	7
1941	496	5	519	7
1942	568	5	824	10
1943	703	6	977	12
1944	1,088	8	1,286	14
1945	1,623	12	1,577	17
1946	2,378	18	1,930	20
1947	3,534	28	2,240	24
1948	4,585	36	2,543	30
1949	5,503	45	3,425	43
1950	5,889	51	3,909	49
1951	6,328	57	4,743	62
1952	5,322	48	5,031	65
1953	4,915	45	4,795	61
1954	5,089	48	5,140	67
1955	4,562	43	5,381	70
1956	3,851	36	4,522	59
1957	3,386	32	4,023	53
1958	2,823	27	3,895	52
1959	3,071	29	3,587	48
1960	2,792	27	3,918	51
1961	2,909	28	4,124	54
1962	3,205	30	3,996	51
1963	3,528	31	3,971	48
1964	4,671	38	4,527	54
1965	6,245	51	5,190	60
1966	—	—	—	—
1967	9,600	79	—	—
1968	11,350	100	6,123	84

TABLE D¹⁴¹
BIRTHS AND ABORTIONS IN CZECHOSLOVAKIA, POLAND
AND HUNGARY

Year	Live Births	Birth-rate per		Legal abortions	Other abortions
		1,000 population			
CZECHOSLOVAKIA					
1953	271,700	21.2	1,500	29,100	

140. See Tietze, "Induced Abortion and Sterilization as Methods of Fertility Control" (1965) 18 *Journal Chronic Diseases* 1161, 1163; Tietze, "Abortion in Europe" (1967) 57 *American Journal Public Health* 1923, 1928; Tietze and Lewit, *op. cit. supra* n.37 at 24; *The Lancet*, 7th February 1970, 291.
141. See Tietze and Lehfeldt, "Legal Abortion in Eastern Europe", (1961) 175 *Journal of the American Medical Association* 1149, 1150; Tietze, *opera cit. supra* n.134 at 1928 and 1166; *Rocznik Statystyczny 1964* (Warsaw, 1964), 41; Klinger, *op. cit.*

1954	266,700	20.6	2,800	30,600
1955	265,200	20.3	2,100	33,000
1956	262,000	19.8	3,100	31,000
1957	252,700	18.9	7,300	30,200
1958	235,000	17.4	61,400	27,700
1959	217,000	16.0	79,100	26,400
1960	217,300	15.9	88,300	26,300
1961	218,000	15.8	94,300	26,000
1962	217,500	15.7	89,800	26,100
1963	236,000	16.9	70,500	29,400
1964	241,300	17.2	70,700	28,500
1965	231,600	16.4	79,600	26,200

POLAND

1953	779,000	29.5	1,200	69,500
1954	778,100	29.1	—	—
1955	793,800	29.1	1,400	100,200
1956	779,800	28.0	18,900	85,400
1957	782,300	27.6	36,400	85,400
1958	755,500	26.3	44,200	82,200
1959	722,900	24.7	79,000	82,500
1960	669,500	22.6	150,400	73,400
1961	627,600	20.9	143,800	72,800
1962	599,500	19.6	140,400	70,300
1963	583,700	19.0	146,500	113,800
1964	560,900	18.1	177,500(?)	—

HUNGARY

1950	195,600	20.9	1,700	34,300
1951	190,600	20.2	1,700	36,100
1952	185,800	19.5	1,700	42,000
1953	206,900	21.5	2,800	39,900
1954	223,300	23.0	16,300	42,000
1955	210,400	21.4	35,400	43,100
1956	192,800	19.5	82,500	41,100
1957	167,200	17.0	123,400	39,500
1958	158,400	16.0	145,600	37,400
1959	150,800	15.2	152,400	35,300
1960	146,500	14.6	162,200	33,800
1961	140,400	14.0	170,000	33,700
1962	130,100	12.9	163,700	33,900
1963	132,300	13.1	173,800	34,100
1964	132,100	13.1	184,400	34,300
1965	133,000	13.1	180,300	33,700

Appendix C

NOTES ON THE SOUTH AUSTRALIAN "ABORTION ACT"

1. This Act, the Criminal Law Consolidation Act Amendment Act 1969 (No. 109 of 1969), is substantially identical to the Abortion Act 1967 (U.K.).

supra n.80 at 475; Potts, *op cit. supra* n.45; Mehlan, "The Socialist Countries of Europe" in *Family Planning and Population Programs* (1966), 207, 209.

So the comments on that Act in Appendix A, para. 1, are applicable to the South Australian statute.

There are two significant differences of detail between the South Australian and the English provisions. (i) Unlike its model, the South Australian statute specifies that the two medical practitioners whose opinion is a condition precedent to a lawful abortion, must have formed this opinion "after both have personally examined the woman". This is a clear improvement on the English statute. (ii) In the English statute, an emergency abortion by a single medical practitioner is authorised "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* . . ." (s.1(4)). Correspondingly, the conscientious objection clause (s.4) does not "affect any duty to participate in treatment which is necessary to save the life or to prevent grave permanent injury . . ." These provisions are adopted in the South Australian statute, but the phrase we have italicised is in both cases watered down to "grave injury". This appears to weaken the scope of the protection afforded by the conscience clause, and is regrettable. The Parliamentary Draftsman defended his deletion of "permanent" by suggesting that "grave permanent injury" might exclude the case where the injury might cause death. But even if death is not to be counted as a "permanent injury" (*sed quaere!*), the case of risk of death is amply covered by the conjoined phrase "to save the life".

2. At the time of writing, three sets of figures had been published¹⁴², covering the first 88 days since the Act came into force in 8th January 1970. On the basis of these figures and on the assumption that the number of women of child-bearing age in England and Wales is about 42 times greater than in South Australia¹⁴³, the following table can be constructed.

TABLE E

I	II	III	IV	V
Period	Notifications within Period	Average Daily Rate within Period	Equivalent Daily Rate for Population of the size of England and Wales	Equivalent Annual Rate for S.A.
1970				
8th January - 25th February	64	1.33	56	485
20th February - 22nd March	54	2.16	91	788
23rd March - 7th April	44	2.75	115	1,004

Column IV is included to facilitate comparison with Table A, column IV. This comparison shows the remarkable similarity between the South Australian and the English experience, as regards both the absolute rate of lawful abortions and the increase in this rate. The increase has, so far, been more rapid and marked in South Australia.

142. See *The Advertiser*, 26th February and 24th March 1970; *The News*, 8th April 1970.

143. See *supra* n.26.