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CANADIAN ABORTION LAW
RAYMOND MICHAEL FERRI* AND TERESE FERRI**

INTRODUCTION

Rarely has an issue sustained the level of public controversy that the abortion issue has. Even more rarely has a controversy been as protracted and seemingly irreconcilable as this. Moreover, the controversy appears to be heightening rather than diminishing in public stature.

Abortion is surely an issue of the utmost importance in its own right. But its social impact has been intensified by the fact that it has become a focal point for many other serious social issues. Abortion has become, it seems, the point around which two fundamentally irreconcilable sets of values have begun to crystallize in modern society. Few subjects have provoked such fundamentally divergent responses. As the emerging rift deepens, the ability to remain neutral dissolves.

The implications of abortion in the nature and control of incipient human life, the function of law, the purpose of medicine, the legal and ethical responsibilities of public institutions, touch all of us deeply and personally. These far-reaching implications require that the difficult realities of abortion be honestly confronted and compassionately assessed with an acute awareness of the individual and social consequences. This article is an attempt to present and investigate many of the medical, legal and moral issues at play in the abortion debate.1

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1 This article will address itself specifically to the complex problems which the Kingston General Hospital Task Force on Abortion, Kingston, Canada, has been organized to investigate and report on.

The most recent abortion statistics available from Kingston General are those of 1983. In that year, the therapeutic abortion committee received 704 applications for abortions. Of those, 694 were approved and the remaining 10, initially refused, were resubmitted and approved at a later date. Thus all applications received were ultimately approved. Of those, 675 abortions were actually performed (15 women changed their minds prior to the procedure, 7 aborted at home, 4 were not pregnant, 3 were cancelled as too large and 4 were held over to 1984). Of the 704 abortions approved, 694 were approved on the basis that the
This article will consider hospital practices as well as decision-making of therapeutic abortion committees in order to evaluate: 1) the legality of present abortion policies and practices at Canadian hospitals and, 2) the therapeutic value of abortion. It will be demonstrated that Canadian law governing abortion is actually often misapplied due to misinterpretation or willful disregard of the legal criteria. Moreover, it will be further demonstrated that the vast majority of abortions performed are non-therapeutic, that they do not enhance maternal health, and in fact pose serious physical and psychological dangers to the mother that are for the most part ignored. Present Canadian abortion practices have elicited radical, yet almost imperceptible changes in the ethical principles underlying the practice of medicine. Most importantly, abortion is the destruction of human lives, a fact which cannot be disputed in the face of modern fetology.

THE PRESENT LAW

The present Canadian abortion law is embodied in section 251 of the Criminal Code. It makes the intentional procurement of the miscarriage of a woman an indictable offense which carries a maximum sentence of life imprisonment (§ 251(1)). This provision was amended in 1969 to add an exception to the otherwise general prohibition against abortion in § 251(4). This exception allows qualified medical practitioners to terminate a pregnancy in an accredited hospital without criminal liability if, prior to the commencement of the procedure, a majority of the therapeutic abortion committee of that hospital has certified that the "continuation of the pregnancy of such female person would or would be likely to endanger her life or health . . . ." A copy of the committee's certified opinion must be received by the medical practitioner before he may terminate the pregnancy.

A major impetus in the introduction of this less restrictive law was the argument that pre-1969 abortion law was unclear as to the criminal liability of physicians who intentionally caused the miscarriage of women whose lives were imperiled by pregnancy. In the past, it was recognized
that at times, the death of an unborn child was an indirect and unavoidable consequence of rendering life-saving treatment to the mother. Section 209(2) of the Criminal Code formerly exempted from liability and the sanction of life imprisonment "a person who, by means that, in good faith, [which] he considers necessary to preserve the life of the mother of a child that has not become a [legal] human being, (i.e. has not yet proceeded in a living state from its mother) causes the death of the child." 8

Modern interpretations of the pre-1969 section 209 suggested that it was not intended to deal with the subject of abortion and that it instead envisioned "the performance of some mutilating procedure upon a viable child when the mother's life [was immediately imperiled]." 8 Though this interpretation does not appear to be mandated by the language of the statute, it was argued that the physicians' liability was unclear in the case where he or she, for example, removed an ectopic pregnancy, performed a hysterectomy on a cancerous pregnant uterus or inadvertently caused death to the fetus by the administration of medications essential to save the mother's life. The criminal liability of a physician who induced premature labor resulting in still birth to save the life of the mother was equally unclear under prior law. 7

The purpose of the amendment was, according to Justice Minister Turner, to resolve these lingering doubts. 8 "The fact is the present legislation is not clear and one of the overriding purposes of the legislation is to clarify it." 9 Later, Justice Minister Turner pressed his view that "the substance of these amendments does no more than recognize what has already been happening in a number of hospitals with respect to therapeutic abortions." 10 Turner stated flatly, "[t]he Bill has rejected eugenic, sociological or criminal offense reasons . . . abortion is to be performed only where the health or life of the mother is in danger. [The bill] does not authorize the taking of fetal life; it does not promote abortion." 11

Parliamentary debates over the bill provide the context in which the
originally declared intent of the legislature is manifest. Sociological, eugenic and sexual offense reasons were explicitly rejected as grounds for terminating a pregnancy. Termination was to be permitted only where continued pregnancy "would or would be likely to endanger the life or health" of the mother. Despite numerous recommendations to the contrary, the Minister of Justice refused to define the term "health" as it was used in the legislation, apparently for fear that this would infringe upon good medical judgment. "Health," Turner remarked, "is incapable of definition and this will be left to the good professional judgement of medical practitioners to decide."

He was not as reluctant to interpret the meaning of the word "endanger." That term, he concluded, "imports or connotes the element of hazard, peril or risk. . . . The meaning of the word 'endanger' is every bit as clear and significant as the meaning of the words seriously and directly impair."

One is able to develop from the wording of the amendment and the discussion surrounding its introduction, a fairly precise concept of the legal criteria the legislature envisioned. Criminal liability would be avoided only when it was certified by the therapeutic abortion committee that the continuation of the pregnancy would (or would likely) seriously and directly impair the life or health of the mother. Therefore, regardless of the definition given the word "health," the termination must be demonstrably therapeutic.

LEGAL AND MEDICAL CRITERIA FOR ABORTION

As already noted, the concept of "health" in present criminal code provisions governing abortion has proven to be a particularly elusive one. The Badgley Report on the Operation of the Abortion Law revealed that a very broad interpretation had been adopted by a majority of physicians as grounds for abortion. Ninety three of the physicians surveyed endorsed physical health reasons as justifying abortion. Approximately three-quarters of the physicians surveyed approved of "mental health," "eugenic health" and "ethical health" reasons as grounds for abortion. Fifty-five percent of the physicians surveyed believed that "social health" ought to be considered when determining whether a pregnancy endangered the health of the mother.

The number of "therapeutic" abortions performed in Canadian hospitals has risen from 11,200 in 1970, approximately three abortions per

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13 See Campbell, supra 7, at 226 (quoting Hansard, May 6, 1969, at 8124).
14 Id. at 225 (quoting Hansard, May 6, 1969, at 8397).
15 Cf. Morgentaler v. The Queen, 53 D.L.R. 3d. 161, 207-08 (1975)(Canadian high court's construction of § 251 precludes all defenses save § 251(4)).
every 100 live births, to 66,319 in 1982, approximately eighteen abortions per 100 live births. It is apparent that the interpretation given the concept “health” has continued to expand to accommodate increasing demands for abortion. The vast number of abortions are approved for non-physical reasons, as indicated by the “psychiatric,” “mental health” and “psychosocial” grounds which formed the basis of approval in 694 or 98.5 percent of the 704 applications received at Kingston General Hospital, Kingston, Canada in 1983.

The Badgley Report noted that “most hospitals endorse a broad definition of health, often acknowledging the Charter of the World Health Organization as the basis for their general treatment activities.” These hospitals consider “the complete physical, mental and social well-being, not simply the absence of illness or disease.” Such a broad interpretation is patently inconsistent with the manifest intention of the Criminal Code. The government of Canada, several provincial governments and the Canadian Medical Association have never formally endorsed the World Health Organization’s concept of health. Moreover, determination of the necessity of an abortion is to be made, according to section 251(4) of the Criminal Code, by a “therapeutic abortion committee.” This committee is defined in section 251(6) as consisting of at least three members “each of whom is a qualified medical practitioner, appointed by the board of that hospital for the purposes of considering and determining questions relating to terminations of pregnancy within the hospital.”

That the legislature would entrust this decision-making to physicians alone manifests its intention to allow the determination to be made on the basis of medical expertise. Health, in the very broad sense of total well-being, however, is not exclusively a medical concern. Certainly “[t]he solution of the multidimensional health problem that is abortion is not bounded by the compass of [a physician’s] competence . . . An examination of the suggested grounds for liberalization of abortion, the medical, psychiatric, eugenic, juridical and socioeconomic, reveals a crisis which transcends any one profession.” The only interpretation of health within section 251(4) which is compatible with the intentions of the legislature is that the threat to the mother’s life or health be assessed within the important but limited ambit of the physician’s specialization, usually formulated in terms of physical and mental disease and defect.

Regardless of the interpretation given the word “health,” under current law, termination of a pregnancy is only permitted where the mother’s

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16 See Harris & Tupper supra note 8, at 89-103 (general discussion on requirements, composition and procedure involved in therapeutic abortion committees).
17 D. Granfield, The Abortion Decision 100 (1969). Granfield further elaborated on the liberal justification for abortion: medical, psychiatric, eugenic, juridical and socio-economic. Id. at 100-121.
life or health is, at least on the balance of probabilities, endangered by continuation of the pregnancy. There need be demonstrable evidence: 1) that the continuation of the pregnancy itself poses a substantial risk of harm to the mother and 2) that the termination of the pregnancy will eliminate or at least substantially reduce that risk.

Risks to the life or physical health of the mother represent a very small proportion of therapeutic abortions performed in Canadian hospitals. Granfield, in *The Abortion Decision*, noted:

> To justify abortion on medical grounds, the doctor must answer one of two questions. The traditional question is simply: Is this woman in danger of dying if she does not have an abortion? The liberal question is: Will the continuance of this pregnancy seriously impair the physical health of the mother? These are medical questions, sometimes difficult to determine but certainly within the competence of the medical profession.

Answering either question typically leads to a variety of conclusions. Surveys of randomly selected hospitals in the United States revealed a wide variation in the proportion of abortions performed for physical health reasons. As early as 1951, Dr. R.J. Heffernan of Tufts Medical School stated to the Congress of the American College of Surgeons: “Anyone who performs a therapeutic abortion [i.e., an abortion for the sake of the mother’s life or health] is either ignorant of modern methods of treating the complications of pregnancy or is unwilling to take the time to use them.”

Dr. Henry Morgentaler has also recognized that physical indications are of diminishing concern.

> Medicine has over the last few years, made so much progress that it is now possible for a very sick woman to complete a pregnancy and give birth in spite of serious illness. Thus we see children being born of cardiac and diabetic patients, of women with chronic nephritis, liver disease, hypertension, and so on.

Nevertheless, Dr. Morgentaler goes on to advise women with such problems to terminate their pregnancies which can only lead one to the conclusion that he fits within Dr. Heffernan’s second category.
Managing the high risk pregnancy no doubt presents many problems to the attendant physician. However, even where the risks are substantial, it is by no means clear that abortion is a therapeutic alternative to delivery. Most conditions that pose risks to the mother during pregnancy present only slight danger in the early stages, which increases only as the pregnancy progresses. Usually, it is in the third trimester that significant problems arise. Ideally, management of these pregnancies would enable them to be carried on as long as the woman is not in actual danger, which would in most cases bring the fetus to the point of viability. If premature delivery is threatened due to the deteriorating condition of the mother, such should be (and is) carried out in the best interests of both mother and child.

Severe renal disease is an example of the rather rare situation in which a condition which is exacerbated during pregnancy poses a serious threat in early pregnancy. Nevertheless, close examination of the available data demonstrates that, even in this tragic situation, the alternative of abortion is non-therapeutic. In a 1976 study reported in the New England Journal of Medicine, Jewett described the severe risk posed by abortion (particularly saline abortions) in these cases. Dr. Richard Watson, in his article "Urologic Complications of Legal Abortions," states:

It is true that more serious threats of crisis exist at term and in the postpartum period, but experience indicates that induced abortion is even more dangerous for the patient with lupus (nephritis), regardless of the method used or the stage of gestation. It is probably safer to treat the patient with increasingly large doses of steroids and attempt to deliver a living child than to induce abortion. If the nephritis does progress, it is likely that the fetus will die and abort spontaneously—perhaps the least traumatic course.

There is a far more common condition in which termination of the pregnancy is essential to save the life of the mother. This is the case of ectopic pregnancy. This procedure, which entails the removal of the tube and most frequently the removal of a live embryo is universally recognized as medically and morally proper. Interestingly, the procedure is virtually never brought to the attention of an abortion committee, not only

versy and Dr. Morgentaler). Over the past decade, Dr. Henry Morgentaler has been at the forefront of the Canadian abortion controversy. Id. His pro-choice stance, effectuated through his many abortion clinics, has roused the ire of his equally zealous pro-life opponents. Id. Dr. Morgentaler's ardent views have placed him in the midst of significant abortion litigation in Canada. See, e.g., Morgentaler v. The Queen, 53 D.L.R. 3d. 161, 161 (1975) (Dr. Morgentaler, defendant, in Canadian Supreme Court case concerning crime of abortion).


because of the emergent nature of the condition, but because its acknowledged purpose, to save the life of the mother, only incidentally results in the death of the embryo.

There are other examples of procedures performed to preserve the mother from serious risks but which have the indirect result of causing death to the fetus. Hysterectomies performed to remove a cancerous uterus or a hemorrhaging uterus are cases in which such intervention is necessary. Again, such procedures rarely obtain permission from therapeutic abortion committees. Their moral and medical validity arises from the fact that the intention is not to destroy the fetus, and indeed, nothing in the procedure involves a direct attack on the life of the unborn child as is the case with saline amniocentesis, D&C and suction curettage.

It is evident that there are medically therapeutic and morally valid grounds for terminating a pregnancy. But these cases are not represented in the statistics regarding the therapeutic abortions performed in Canadian hospitals. The figures reflecting abortions performed for “medical complications” pertain to cases which are far more disputable. The available data suggests that there are very few situations in which the fetus cannot be brought to the point of possible viability before a pregnancy must be terminated by premature delivery. Even in those rare instances when this is not possible, the medical evidence suggests that abortion is more dangerous than aggressive treatment of the mother and letting nature take its course with respect to the pregnancy.

**Psychiatric Indications For Abortion**

In 1983, at Kingston General Hospital, Kingston, Canada, 694 (or 98.5%) out of 704 abortion applications were approved on the basis of “psychiatric,” “mental health” and “psychosocial” indications. The distinction between these categories is not self-evident since mental health simply means “health of the mind,” while psychiatry is defined as “medical treatment of the mind.” Presumably, the distinction is based on the severity of the condition: “psychiatric” being restricted to disorders associated with physical conditions, psychoses, and long term neuroses while the “mental health/psychosocial” category covers anxiety, reactive depression, socioeconomic and other factors.

Regardless of the category, the legal requirements for termination of pregnancy are the same: the therapeutic abortion committee must certify that the life or health of the mother is (or likely to be) endangered by continuation of the pregnancy. This requires that the committee have demonstrable evidence that (1) the continuation of the pregnancy itself poses a substantial risk of harm to the mother, and (2) that termination

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**Stealman's Medical Dictionary.**
of the pregnancy will eliminate or at least substantially reduce that risk.

The demands of medical ethics are no less rigorous than those of the law. Any medical intervention must be systematically evaluated to determine its safety, its possible side effects and its test validity. In other words, like the legal requirements, it is only justifiable if it is a verifiable remedy which significantly improves the health of a patient otherwise endangered.

The therapeutic value of abortions performed for "mental health" reasons of varying severity would, like all other grounds, require evidence that the abortion would relieve a danger to the life or health of the mother posed by the pregnancy. "Psychiatric" reasons accounted for 20 (or 2.8%) of the 704 applications approved for abortion at Kingston General in 1983. This group included both chronic (18) and acute (2) cases and presumably represents those most seriously affected by mental health problems in conjunction with or due to their pregnancies.

Upon investigation of the available data, one is immediately struck by the lack of methodologically sound studies and substantiation for clinical diagnoses and prognoses. Little data exists to compare the consequences of abortion with non-intervention alternatives to abortion in mental health cases. The validity of much research is questionable due to serious problems, such as small sample size, shortness of study periods, poor or non-existent follow-up and lack of control groups. The bias of those conducting the research has also been the subject of frequent comment and criticism. Often the researchers are those referring for and performing abortions. It has been suggested that they therefore have a vested professional and ethical interest in results which validate their previous decisions.

The inadequacy of these studies is compounded by the fact that their conclusions are inconsistent and often diametrically opposed. The Badgley Report and other investigations reflect a profound lack of consensus within the medical profession on the issue of mental health reasons for abortion. This in itself gives reason for pause since one would expect that a procedure involving such serious legal and ethical implications would only be undertaken where the evidence of its therapeutic value was reasonably well-established. Such is not the case.

Despite the inadequacies and inconsistencies of the available data, there are a number of emerging trends which have particular importance with respect to claims that abortion is therapeutic for the seriously psychiatrically ill.2

See generally D. Granfield, supra note 17, at 106-07 (objection to abortion as therapeutic to psychiatrically ill). Granfield listed 3 general objections to the therapeutic value of abortion to the psychiatrically ill. Id. He asserted that the standards by which we gauge the psychological difficulties of pregnancy and abortion are too vague to warrant abortions. Id.
Abortions for psychiatric reasons (as opposed to mental health grounds) are generally rationalized on the basis that the pregnancy poses a substantial risk of deterioration in the woman with pre-existing illness. Alternatively, abortion is recommended where the woman is so distraught over her pregnancy that she becomes suicidal.

Kaplan, Freedman and Sadock summarized the conclusions of psychiatric literature, stating that there are no neurotic or psychotic conditions for which abortion is beneficial. Moreover, study after study, regardless of the authors' allegiances on the abortion issue, indicate that the procedure is contraindicated for women with a history or presence of severe psychiatric illness.

Termination of a pregnancy is frequently posited as a method of avoiding the risk of postpartum psychosis in the psychiatrically ill mother. Dr. Sim, Clinical Director of the Forensic Psychiatry Clinic, Victoria, B.C., pointed out that:

[A]s the condition occurs in approximately 1 per 1,000 live births, only a bold person would predict history of breakdown—whether postpartum or from other causes—the risk is increased, but these are the very patients who should not have an abortion, for they are at even greater risk if they do.

The incidence of post-abortion psychosis has not been established with any certainty due to methodological problems inherent in the studies conducted. These have been particularly criticized for low sample size and poor follow-up. The well-known study of Dr. Brewer showed a post-abortion psychosis rate of 0.3 per 1,000, compared with a postpartum psychosis rate of 1.7 per 1,000. This conclusion was based, however, on a mere 25% reply to questionnaires sent to area psychiatrists. Many of those who abstained from answering were reluctant to assist Dr. Brewer, who was then psychiatrist for the area's largest abortion clinic and who had publicly declared his bias.

Other more reliable research indicates a higher incidence of both puerperal and post-abortion psychosis. Jansson's Swedish study reported a much higher rate of post-abortion psychosis (19.2 per 1,000 abortions)

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at 106. He also mentioned the uncertainty in diagnosis and prognosis attendant to abortion. *Id.* at 106-07. His third objection concerned the training of the decision maker stating that the narrow ambit of the physician's training in relation to the pervasive ramification involved in the decision to abort should disqualify the medical practitioner as the sole arbiter. *Id.* at 107.


compared to puerperal psychosis (6.8 per 1,000 deliveries). Brewer himself notes that, in Jansson’s study, a significant proportion of those aborted had a history of psychiatric disorder. Brewer recognized that such women are at far greater risk of developing post-abortion psychosis.

In 1979, Sim and Neisser discovered an even more alarming fact. The prognosis for post-abortion psychosis was far worse than the prognosis for women with postpartum psychosis. 99.3% of the postpartum group showed a good response to treatment, with full remission of symptoms and restoration to the premorbid level of functioning in an acceptable period of time, without the problem of a relapsing course. Only 50% of the post-abortion group, however, showed this level of recovery.

Numerous attempts have been made to identify factors which might influence adverse effects after an abortion. Time after time, a history of or concomitant psychiatric illness has been associated with unfavorable psychiatric sequelae. One such study demonstrates that approximately 10% of women who have abortions for any reason will subsequently suffer psychiatric illness. Among the several factors they have identified as having predictive value for post-abortion difficulty is previous psychiatric illness. Another study found that the psychiatric condition of women with psychiatric problems prior to abortion was worsened in the post-abortion period.

The threat of suicide is another factor which may weigh heavily in the decision to recommend abortion. The rationale is that a woman seriously distraught over her pregnancy and actively seeking abortion is at high risk for suicide if the pregnancy is not terminated.

A number of recent studies have compared the emotional impact of women who procured abortions with that of women who were refused them. None of the researchers reported suicides among those who were

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33 See D. Granfield, supra note 17 at 104 (citing Jansson, Mental Disorders After Abortion, 41 Acta Psychiatrica Scandinavica 87, 110 (1965)).
30 See Brewer, supra note 30.
34 See Friedman, Greenspan & Mittleman, The Decision-Making Process and the Outcome of Therapeutic Abortion, 131 Am. J. Psychiatry 1332 (1974). The Article discussed a case study of a woman with a history of psychopathology who developed new psychiatric symptoms post-abortion. Id. at 1334 [hereinafter Friedman].
35 See, e.g. Ford, Castellnuovo-Tedesco and Long, Abortion: Is it a Therapeutic Procedure in Psychiatry? 218 J. A.M.A. 1173, 1176-77 (1971) (severity of psychological distress pre-abortion indicative of greater likelihood of negative psychological response post-abortion). The clinical research revealed that abortion could alleviate certain less severe psychological disturbances, yet further indicates that the therapeutic value of abortion is suspect where the patient suffered from more serious psychological disorders. Id. at 1177. This revelation contradicts the traditional approach taken by therapeutic abortion committees, which are more apt to certify abortions for patients with severe mental disorders under the notion that the patient’s mental condition would be aggravated by the continuation of the pregnancy. Id.
refused. Two earlier Swedish studies provided additional data. Linberg investigated 304 women who had been refused abortions. Of the sixty-two out of the 304 who threatened to commit suicide if their pregnancies were not terminated, none did.86 Jansson’s findings were even more startling. In his study, three of fifty-seven mothers who procured legal abortions subsequently committed suicide. Of 195 mothers who were refused abortions, however, there were no suicides.87

The above data is further substantiated by the investigations of coroners which indicate that suicides among pregnant women are rare and occur with greater frequency among women of childbearing age who are not pregnant.88 Moreover, the fact that a woman is unmarried and pregnant does not increase the likelihood that she will commit suicide.89

Moreover, the evidence overwhelmingly indicates that abortion is not only often non-therapeutic, it may be even injurious to some women in comparison with non-intervention. As Dr. Gluckman, psychiatrist for the National Women’s Hospital in Auckland, noted, “few would dispute with Sim (1968) that any procedure in medicine designed to avert a situation should not result in the same or a worse situation.”90

It is apparent that abortions performed for psychiatric conditions are decisively non-therapeutic. Certification of these abortions by therapeutic abortion committees reveals either a profound ignorance of the scientific data, or a deliberate disregard of both legal and medical criteria for intervention.

Mental Health and Psychosocial Justifications for Abortion

The vast majority of abortions authorized and performed in Canadian hospitals are done for neither psychiatric nor physical reasons. At Kingston General Hospital, Kingston, Canada, 674 (or 95.7%) of the 704 abortion applications approved in 1983 were on the basis of “mental health and psychosocial” reasons. The speculative and variable nature of this category has been the subject of much criticism from both sides of the abortion debate. It has been denounced as being both too narrowly and too liberally construed, as imposing restrictions on access to abortions

87 See D. Granfield, supra note 17, at 104 (citing Lindberg. 45 SVENSKA LAK-TIEN 1381 (1948)).
88 Id. (citing Jansson, Mental Disorders After Abortion, 41 ACTA PSYCHIATICA SCANDINAVIA 87, 110 (1965)).
89 Id. (citing Guttmacher, The Influence of Fertility Control Upon Psychiatric Illness 115 AM. J. PSYCHIAT. 683 (1959) and Sim, Abortion and the Psychiatrist, 2 BRIT. MED. J. 145, 147 (1963))
90 D. SIM, NEW PERSPECTIVES ON HUMAN ABORTION 156 (T. Hilger 1981).
and as responsible for abortion on demand. Since the therapeutic abortion committee at Kingston General did not refuse a single abortion application in 1983, it is appropriate to assume that the notion of “mental health” is indeed broadly construed at this hospital.

The “mental health/psychosocial” category, as distinct from the “psychiatric” category, refers to those cases in which pregnancy-termination is authorized because anxiety, reactive depression, socioeconomic and other factors allegedly pose a serious threat to the mental health of the mother. As noted above, the law allows the termination of a pregnancy only when the therapeutic abortion committee has demonstrable evidence that the continuation of the pregnancy itself poses a substantial risk of harm to the mother and which termination of the pregnancy will eliminate or at least substantially reduce. Moreover, it is the professional responsibility of committee members as well as recommending and performing physicians to assure themselves that the procedure is safe and verifiably remedial.

A recent Canadian study sponsored by the Canada Council surveyed women who had procured “therapeutic” abortions performed in Canadian hospitals, on why they had an abortion. Sixty-four percent gave “social” reasons, including financial factors, age, poor relationship with the father and problems related to having and raising an illegitimate child. Twenty-nine percent reported “not wanting (another) child” and “psychological health” reasons.\(^4\)

In a well-published study funded by the Family Planning Division of Health and Welfare, Canada, entitled “The Abortion Choice: Psychological Determinants and Consequences,” women who received therapeutic abortions in Canadian hospitals were asked by the interviewers: “What is your main reason for your decision to have an abortion?” The reasons given were classified into five categories: (1) family size, (2) financial, (3) physical, (4) psychosocial, and (5) timing. The reasons given were as follows: (1) 211 did not want children at this time, did not want children at all or said that their family size was complete. (2) 101 said they could not afford a child or that they did not have the money to move to larger accommodations. (3) 97 said they were too old or too young to have a child, that they were afraid the child would be abnormal or that they feared the pregnancy would pose risks to their health. (4) 69 said they were not married, did not want friends or family to find out about the pregnancy, that the child was not their partner’s, that the partner did not want a child or that the pregnancy threatened their mental health. (5) 76 said they were alone and did not want to raise a child, would have to quit school or a job

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or that it would interfere with their career plans.\textsuperscript{42}

The findings of the Family Planning Division stand in sharp contrast to the declared intentions of Justice Minister Turner who introduced the present abortion law. The reasons given by women who had abortions sharply conflict with the intent of the abortion law’s sponsors who rejected eugenic, sociological or criminal offenses as justifications for abortion.\textsuperscript{43}

The vast majority of justifications do not begin to meet the legal criteria. Such reasons as the size of one’s accomodations, already having the number of children one wanted, not wanting parents or partner to find out about the pregnancy and interference with career plans, are not matters intended to enter the legal considerations of eligibility for abortions. In these cases, it is not the continuation of the pregnancy at all that allegedly threatens the mother, but the threat of an unwanted child.

Of 704 abortions performed at Kingston General in 1983, three were for “obstetrical/fetal” reasons. They represent eugenic reasons (congenital anomalies) or risks of fetal abnormalities due to other causes. Again, these reasons are not the legal criteria for abortion under the current legislation since they do not bear on any risk in the pregnancy to the mother.

Eugenic criteria are often sought to be grounded on the “mental health” of the mother. The distress experienced by the mother in response to the possibility or likelihood that her baby will be deformed, retarded or otherwise handicapped is frequently posited as the grounds for abortion.\textsuperscript{44} It is evident in such cases that it is not the continuation of the pregnancy that so distresses the mother, but the fear that the child will be handicapped.

Still, it is argued there are many cases in which a woman may experience such intense anxiety and depression as a result of an unwanted pregnancy, that it threatens her normal functioning. Such experiences, it has been suggested, may truly jeopardize the woman’s total mental health. One must not trivialize the intense emotional impact that an unwanted pregnancy may have. For almost all women, pregnancy, childbirth and the responsibilities of parenthood exert great physical and emotional strain. The burden of that strain is magnified considerably when the pregnancy, for whatever reason, is unwanted.

It is an unfortunate fact that the inequities and pathologies of society are often responsible for many of the factors which coerce women to seek

\textsuperscript{42} J. Greenglass, Abortion: Reading and Research 82 (P. Sachdev ed. 1981).

\textsuperscript{43} See Campbell, supra note 7, at 224-25 (quoting Hansard, May 6, 1969, at 8397) (legislative intent to create restrictive abortion law).

\textsuperscript{44} See, e.g., Dickens, Eugenic Recognition in Canadian Law 13 Osgoode Hall L. J. 547, 562-65 (1975) (discussion of eugenic justification for abortion in Canada).
abortions. Perhaps, if the current inequities in distribution of resources and opportunity were eliminated, many pressures to seek abortions would also disappear. In a society which, through its media and entertainment and in its promotion of contraception, encourages sexual activity among its young adults there should be a showing of greater support and compassion for women who suffer the consequences of having responded to its solicitations. The immediate problems remain, however, and their solutions must be sought within the scope of what is ethical, what is legal and what is medically therapeutic.

The medical criteria for assessing whether termination of pregnancy is justified where its continuation is exerting a great deal of stress proceeds upon the same course as the legal criteria: Is the abortion therapeutic? Is it a verifiable remedy which significantly improves the health of a patient otherwise endangered?

As noted earlier, studies in this area are startlingly scant or unreliable due to serious methodological flaws. There is no agreement within the medical profession with respect to the therapeutic efficacy of abortion in the treatment or avoidance of mental health and psychosocial problems. The observations of "Psychological Reaction to Therapeutic Abortions" appear to represent the current state of opinion:

The effect of abortion on the emotional life of the patient aborted is an unsettled issue. Those favoring the increased availability of abortion insist that abortion has few psychological ill effects and that far greater emotional damage results from the unwanted pregnancy which is carried to term. The opponents of liberalized abortion argue that psychological damage is usual following abortion and that, no matter how socially disastrous the continuation of pregnancy is, the long-term effect on the mother is substantially less injurious without abortion. Unfortunately, neither point of view has sufficient reliable data to prove its case.

The fact that the therapeutic value of abortion has not been established for these purposes militates against its authorization by a committee which, under the law, must be able to demonstrate such an efficacy in order to justify its exception from the general prohibition against abortion.

Despite the lack of data in this area, certain findings have important implications in assessing the therapeutic value of abortion when it is alleged that a mother's mental health is endangered by continued pregnancy. Several studies have compared the outcome of women who were refused abortions with other women who had babies. In a recent article

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45 Niswander, Singer and Singer, Psychological Reaction to Therapeutic Abortion, 114 AM. J. OBSTET. GYNECOL. 29 (1972) [hereinafter Niswander].
46 Id. at 29.
47 See e.g., Binken, Mhango, Cates, Slovis & Freeman, Women Refused Second Trimester
in the Canadian Medical Association Journal, Dr. Delcampo surveyed current literature and concluded that, "[it] shows a generally comparable outcome of pregnancy, delivery and puerperium between women who were denied abortion and controls: no evidence that a continued unwanted pregnancy will endanger the mother’s mental health; good acceptance of the infant, especially if she has the father’s support . . . ."48

It is generally agreed that some post-abortion depression, including feelings of self-reproach and guilt, is extremely common and perhaps universal. Dr. Paul MacKenzie of Kingston General Hospital, in a 1975 study of abortion patients, expressed surprise at the prevalence of these subjective aftereffects which, he advised, "should not be lightly regarded and should be explained to the woman in advance."49 There is no similar consensus regarding the prevalence of more profound and intractable symptomatology. Friedman, Greenspan and Mittleman determined that approximately ten percent of women develop severe post-abortion psychiatric complications.50 Since it is generally the case that severe morbidity represents only a small proportion of significant complications, it may be assumed that many more women experience psychological problems which are as yet unstudied. Dr. Gluckman, psychiatrist for the National Women’s Hospital in Auckland, New Zealand, suggests that significant ongoing psychoneurosis occurs in some twenty-five percent of patients following abortion.61

A study of objective Minnesota Multiphasic Personality Inventory Test Scores data compared a group of abortion patients with matched maternity patients both before and after abortion and delivery, respectively. Preoperatively, the abortion patients’ scores indicated that they were less “normal” in overall adjustment, anxiety, depression and impulsiveness than the maternity patients. Both groups showed slight “improvement” six months after abortion and delivery, respectively. However, the authors noted that, “[p]ostoperative tests showed a significant reduction in stress for the abortion patients but still indicated that this group was more depressed and generally less adjusted than the control group.”62

Studies which have attempted to assess the long-term psychological

Abortion: Correlates of Pregnancy Outcome, 145 AM. J. OBSTET. GYNECOL. 279, 282 (1983) (comparing pregnancy outcomes of 316 low income women denied abortions to outcomes of the rest of the hospital’s maternity population) [hereinafter Binken].
48 DelCampo, supra note 36, at 362.
50 See Friedman, supra note 34, at 1334. Several factors are suggested as having predictive value for post-abortion difficulty including severe psychiatric illness, lack of familial support and coercion by family of physician. Id.
61 See Gluckman, supra note 41, at 77.
62 See Niswander, supra note 45, at 32.
and social well-being of women who have had abortions are notorious for their very low rates of participation and response. Dr. Adler suggests that this failure to participate is, in itself ominous. In the first place, it may invalidate the studies which are conducted on the basis of data contributed only by those who willingly participate. It is precisely those who are experiencing difficulties with respect to the abortion who will be reluctant to participate in studies which require them to focus on what may be a painful reality. Thus, those without easily recognizable sequelae are selected out as the only participants. Secondly is the fact that a very large proportion of women who abstain from participating in spite of the persistence of the researchers, suggests that there are very large numbers who experience shame, regret and depression of such significance that it inhibits their ability to express their feelings on the issue.

Dr. Gluckman of the National Women's Hospital has noted a strong correlation between certain psychiatric symptomatology and abortion. "Regardless of specific psychiatric diagnosis, psychiatric and neurotic reactions do occur as post-abortal phenomena." He feels that "post-abortal neurosis and psychosomatic disorders are likely more common than is realized and are often disguised in terms of the presenting symptomatology." Dr. Gluckman has observed a number of symptoms, particularly gynecological symptoms, in women subsequent to therapeutic abortion. The most prevalent are: frigidity (in each instance the sexual response had been much more adequate prior to abortion), dyspareunia (painful intercourse which is most often of emotional origin), amenorrhea (absence of menstruation which is psychosomatically induced and often associated with the expressed wish to be pregnant), menometrorrhagia (excessive, irregular bleeding which is usually emotionally determined), leucorrhea (excessive vaginal/cervical secretions which may be associated with post-abortion cervicitis but have a high correlation with suppressed erotic desire and premenstrual syndrome where none existed prior to abortion), ill-defined pelvic discomfort and unexplained sterility.

Every physician is aware of the prevalence of the above symptomatology among women. However, its close association with abortion may be overlooked, according to Dr. Gluckman, because patients unfortunately prefer to discuss symptoms rather than causes or emotions associated with symptoms:

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88 See generally Adler, Sample Attrition in Studies of Psychological Sequelae of Abortion: How Great a Problem?, 6 J. APPLIED SOC. PSYCHOLOGY 240 (1976) (on the possibility of understated negative reactions to abortion due to the correlation between survey participation and abortion reaction).
84 Gluckman, supra note 41, at 77.
85 Id. at 78.
Any patient with ongoing unexpressed resentments, fears, guilts or anxieties, may develop a chameleon syndrome . . . a chronic illness in which symptoms are treated with no attention to the patient . . . . Induced abortion is common but most doctors know how rarely this is mentioned when past history is being investigated. Many such patients retain a sense of shame or embarrassment about the previous abortion. The unmentioned may also be the unmentionable.\textsuperscript{56}

Although Dr. Gluckman is not sure what connections there are between abortion and subsequent psychological disturbances, he points out that "it is not rare for such women to be firm in their view that such gynecological symptoms were minimal or absent prior to abortion . . . [and that they] were the indirect result of it."\textsuperscript{57}

The clinical experiences of Dr. Gluckman and his perceptions of the association between abortion and psychiatric and neurotic symptomatology appear to be documented in the Badgley Report, which studied the use of hospital and physician's services by abortion versus non-abortion patients.

In a Saskatchewan investigation which reviewed before-and-after use of health care services by women who had deliveries, spontaneous abortions, therapeutic abortions and sterilizations for 1970 and 1971, statistics demonstrated that, in the year following their operation, woman who had therapeutic abortions were diagnosed by their physicians 40.8\% more often as having mental disorders and were treated 25.0\% more often for accidents of conditions resulting from violence than women who had deliveries. Interestingly, the women who had therapeutic abortions, spontaneous abortions and sterilization all subsequently consulted physicians twice as often for mental-health related reasons as women who had term deliveries.\textsuperscript{58}

A five year study in Alberta compared the use made of health services by a group of one hundred women who had therapeutic abortions, to a group matched who had not. The hospitalization experiences of the groups differed in significant ways. Sixty-four percent of the abortion patients were subsequently hospitalized as compared to fifty-two percent of the control group. Seven of the abortion patients versus two of the control group had gynecological problems. The incidence of intermenstrual bleeding was more than twice as high among abortion patients. Thirteen percent of the group who had abortions were subsequently hospitalized with psychological problems (four of which involved an overdose of drugs)

\textsuperscript{56} Id. at 77. See also Richardson & Dickson, \textit{Effects of Legal Termination on Subsequent Pregnancy}, 1 Brit. Med. J. 1303, 1304 (several patients undergoing abortions requested that their general practitioners not be informed).

\textsuperscript{57} Gluckman, \textit{supra} note 41, at 77.

\textsuperscript{58} See Badgley, \textit{supra} note 15, at 319.
while only four percent of the control group were subsequently hospitalized for psychological reasons (one of whom was an alcoholic).86

The Alberta study also compared the two groups for their use of the services of physicians over the same five year period. Women who had abortions saw physicians over the same five year period. Women who had abortions saw physicians with much greater frequency than the control group (29% and 72 follow-up visits versus 13% and 47 follow-up visits, respectively). The abortion group also made more subsequent visits to psychiatrists (25%) than the controls (3%).87

Despite all of the foregoing data, there have been studies which still report that a good percentage of women who had abortions show little immediate guilt or remorse and no long-term psychological sequelae. These studies assert that these women frequently respond to termination of the pregnancy with a significant reduction in anxiety and report a general sense of relief and well-being. These reactions are often cited as evidence that the procedure is harmless and genuinely therapeutic. However, a closer examination of this data provides insight into the psychological dynamics which are at play and reveals that these allegedly healthy responses are in fact indicative of serious emotional/psychological disorders.

Two studies have investigated the effects of abortion on the basis of the Minnesota Multiphasic Personality Inventory (MMPI) test scores.61 Each reported a post-operative "improvement" in abortion patients but, as already noted, a similar, if less significant improvement was experienced by the maternity control group post-delivery. Although these studies are frequently cited as evidence of the therapeutic effect of abortion, they disclose other remarkable findings which assist in explaining the apparently unaffected responses of some women to abortion.

The MMPI scores of both studies indicated that, as a group, the abortion patients had specific deviations which reflect a classic pattern of narcissistic and psychopathic personalities. Preoperatively, they had abnormally high scores for hysteria, depression, hypochondria, psychopathic deviance, psychasthenia and schizoid tendencies. Post-operatively, most of these scores came down in the high-normal range, but the depression and psychopathic deviance score remained on the borderline of deviance.62 Thus, the abortion group appeared to contain a much higher proportion of narcissistic and psychopathic personality disorders than the female population at large. These test scores accurately reflected the

86 See id. at 320.
87 Id. at 322.
61 See generally Ford, supra note 35 (comparing women's pre-abortion MMPI scores to their post-abortion test scores); Niswander, supra note 45 (comparing MMPI test scores of 65 abortion patients to 20 maternity patients' scores).
62 See Ford, supra note 35, at 1176 (graph comparing deviations before and after abortion).
maladaptive defenses of the narcissistic and psychopathic personalities which responded to the stress of the unwanted pregnancy as reflected in the very high scores. When the source of anxiety diminished, so did their display of maladaptive behavior.

The characteristics of the narcissistic and psychopathic personalities described by the *Harvard Guide to Modern Psychiatry* correspond to the high scores on the MMPI. These individuals have a low tolerance for anxiety, and show poor impulse control (an inability to delay gratification) both in the degree of tolerable delay and in the amount of organization and flexibility available in the pursuit of goals. They exhibit defects in self-management and in self-esteem as well. “Patients with narcissistic character disorders have come into increasing prominence recently . . . The patient is often free of conspicuous symptoms, and the problem may not be identified without rather extensive familiarity with the patient’s history and pattern of living . . . Nevertheless there are signs of serious inadequacy in ego development.”

The authors note that “[p]atients with narcissistic character disorders are likely to be successful and to appear normal when their work, personal relations and activities are superficially examined.” This may explain why, as a group, women who seek and obtain abortions have higher income and more education than women who do not seek abortions. The real pathology of the narcissistic and related psychopathic personality is evidenced in the manner in which they govern relationships with others and the way in which they deal with situations of stress.

As already observed, the narcissistic personality has a low tolerance for anxiety, but this condition is often not obvious. She may, in fact, behave with:

[U]nusual equanimity . . . because she has developed, in response to the anxiety, ideas of omnipotence, of invulnerability, of special persecution or withdrawal, and, often, of dismissal of the anxiety-provoking person or situation . . . Self-esteem is maintained only precariously. If successes seem to dissolve into vanity, closeness into threat, and if others are always seen as trying unpredictably to ‘escape,’ the usual social reinforcements of self-esteem are no longer effective, and isolation or denial of much experience becomes necessary.

Similarly, the psychopathic personalities may respond to her own antisocial acts by displacing blame and denying wrongdoing or guilt. “[S]he may experience intense feelings of guilt, but that emotion is fleeting and

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69 *Id.*
70 *Id.*
soon repaired without basic alterations in behavior."

Thus these personalities characteristically employ denial, fantasies of omnipotence and the assumption of unquestioned entitlement as mal-adaptive mechanisms to protect a precarious self-esteem, self continuity and self cohesiveness. Their responses to both the unwanted pregnancy and to the abortion incorporate these defenses, providing the illusion of a conflict-free decision and sequelae. Ironically, what has been held out by some investigators as evidence of the therapeutic value of these abortions, is, in reality, a classic manifestation of serious psychopathology. The abortion not only permits but perpetuates the self-deception. The ultimate ineffectiveness of these defenses is only hinted at in the persistently high depression scores on the MMPI.

Once again, Dr. Gluckman's clinical experience at National Women's Hospital provides some verification of these psychodynamics. He has found that psychopathic personalities (including narcissists) who have had abortions, like congenital mental defectives, "rarely suffer long-term [psychoneurotic] sequelae of abortion. The ability to evaluate realistically the intellectual, emotional and moral; and some would add spiritual implications is a prerequisite for conflict. Without such conflict, there can be no anxiety."

Claims that abortion is therapeutic in the treatment or avoidance of mental health or psychosocial problems are tenuous. Studies of women denied abortion have demonstrated that continuation of an initially unwanted pregnancy will not endanger the mental health of the mother. There is mounting evidence that serious psychoneurotic illness follows abortion with unanticipated frequency. Also emerging is a pattern of response to abortion which indicates that serious psychopathy is perpetuated by the "treatment." Furthermore, the vast majority of reasons given by women for "choosing" abortions cannot possibly provide the basis for a certification that her life or health is endangered. As noted by Dr. Sim, "[s]uicide is rarer in the pregnant than in the non-pregnant, serious mental breakdown is virtually unpredictable and does not occur more frequently than one in a thousand live births and carries an excellent prognosis."

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66 Id. at 290.
67 Gluckman, supra note 41, at 76.
68 See, e.g., Ford, supra note 35, at 1177 (abortion has little, if any, therapeutic effect on the mental health of women suffering from neuroses of psychoses).
69 See, e.g., DeCelles, Conservatives and Liberals on Prolife Issues, 144 America 365, 367 (1980) (women choose to abort because they are driven by the uncontrollable).
The Risks and Complications of Abortion

In determining whether a procedure is therapeutic in a particular situation, one must weigh the risks and complications that may accompany it against its foreseeable benefits. This has proven to be an impossible task in the case of abortion because the innumerable complications which accompany abortion cannot be established with any certainty. Indeed, many long-term sequelae are only now being recognized, studied and documented. It is clear that abortion is not without risk. But the collection of reliable data, particularly regarding later complications, is fraught with difficulty.

Many studies which attempt to assess the physical complications of abortion are rendered unreliable by their flawed methodology. Follow-up study is often handicapped by the refusal of women undergoing abortions to participate initially, or later inability to locate these women for subsequent investigation. Assessing the complication rate of those lost to follow-up studies is extremely difficult. As noted by Dr. Gluckman, women who experience problems after an abortion are very often reluctant to confide the fact that they had an abortion when their history is being investigated. Physicians, therefore, may not be able to connect the current problem with the earlier abortion. Even when the physician knows of the woman’s previous abortion, he may not attribute the present problem to the abortion because of the remoteness of the two events. If the physician treating the current ailment was the one who originally recommended the abortion or in fact performed it, it may be all the more likely that he will be reluctant to make the association.

Very few studies of complication rates have extended longer than a year past termination. Most are restricted to the stay in hospital and, therefore, document only the most immediate effects. In spite of the scantness of current data, women are assured that the procedure is safe, particularly in the early stages of pregnancy. New findings have begun to question safety, giving the cautious individuals reason to pause on the issue of the physical after-effects of abortion.

The 1983 statistics of the Kingston General Hospital, Kingston, Canada, indicate that the early complications of abortion carry a morbidity rate of approximately 3%. This rate is confirmed by a review of 352,000 Canadian abortions in the 6 year period of 1975-1980.

The incidence of later complications is far less understood. It has not

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71 See Wodhera, Early Complication Risks of Legal Abortions, Canada 73 CAN. J. PUB. HEALTH 396, 396 (1982).
73 See id.
been the subject of serious study until fairly recently. So far, the data suggests that therapeutic abortion is associated with the following conditions as post-abortion phenomena: infertility or decreased fertility; preterm delivery; cervical incompetence; urinary stress incontinence and urinary tract infections. At the present time, studies are conflicting and often unreliable, which makes assurances of safety in the procedure uncertain.

ABORTION AND THE UNWANTED CHILD

An increasingly common argument in favor of abortion of unwanted pregnancies seeks its rationale in considerations of the welfare of the child. Dr. Morgentaler, Canada's leading abortion advocate, is convinced that unplanned and unwanted pregnancies contribute to a "wide range of serious and psychological disturbances in these children" and feels that abortion is a "highly responsible choice, not only to avoid damage to the child, but also to safeguard the emotional and physical health of the woman."

In a lecture at Queen's University, Dr. Morgentaler took his argument a step further by suggesting that these unwanted children eventually account for much of the criminal and dangerously psychiatrically-ill elements of society. The view that abortion offers a solution to the social burdens and alleged dangers posed by those as yet unborn, is not new. It has been the subject of comment by several justices who participated in the famous, precedent-setting American abortion case, Roe v. Wade.

They have considered the consequences of state denial of abortion upon indigents and the state itself, citing the "welfare costs that will burden the State for the new indigents and their support in the long, long years ahead." Pro-abortionists assert that "not only is the quality of life of

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75 H. MORGENTALER, ABORTION AND CONTRACEPTION 52 (1982). For some interesting background on Dr. Morgentaler's pro-abortion crusade, see Morgentaler's Crusade Moves East, McLean's, June 27, 1983, at 44. See also Morgentaler v. The Queen, 53 D.L.R. 3d. 161 (1975) (Morgentaler's appeal of conviction for performing an illegal abortion dismissed).
76 410 U.S. 113 (1973). In Roe, the U.S. Supreme Court held a Texas criminal statute unconstitutional for proscribing all abortions which were not necessary to preserve the mother's health without regard to the stage of pregnancy. Id. In another Supreme Court decision, a Georgia statute was found unconstitutional for requiring hospital accreditation by a private organization, approval by a hospital abortion committee, and in-state residency of applicants. Doe v. Bolton, 410 U.S. 179 (1973). For a discussion of the Roe and Doe decisions' impact on Canadian abortion law, see Comment, The Abortion Decision - A Qualified Constitutional Right in the United States: Whither Canada?, 51 Can. B. Rev. 643, 654-58 (1973).
77 Beal v. Doe, 432 U.S. 438, 463 (1977) (Blackmun, J., dissenting). In a separate dissent, Justice Marshall argued that an indigent woman who was denied a state funded abortion
those born worthy of enhancement, but there is also some need for prebirth termination of the lives of those whose projected quality of life is low,"79 such as those who, if born, would be "relegated to lives of poverty and despair."79

One may be skeptical about the genuineness of this self-declared compassion for the quality of life of the unborn, especially when there exists such powerful vested interests in rationalizing their destruction. One may be struck by the inherent paradoxes of a solution which offers to those it claims to perceive as in danger of being victimized and deprived, the answer of extermination.80 Apart from the problem of internal inconsistencies, this social theory is suspect because the "solution" it advocates depends upon the parents' wish for an abortion to justify termination of the pregnancy. If the rationale for abortion is the defense of society from children who may become a danger or financial burden to it, state intervention could conceivably be authorized over parents' protests.81 Like compulsory sterilization laws which still exist in the United States,82 society could presumably adopt Mr. Justice Holmes argument that it has the right "to prevent . . . our being swamped with incompetence"83 and "to prevent those who are manifestly unfit from continuing their kind."84 This language and reasoning is chillingly reminiscent of Nazi Germany's master-race theory.85 History has demonstrated, with terrifying lucidity, that such logic never stops with the unborn.

Arguments favoring liberal abortion regulations often rely on the belief that an unwanted child may become a victim of cruelty or suffer more in terms of mental health than "unwanted" children. This rationale has received its major impetus from a 1966 Swedish study which compared the children born to women denied abortions with wanted children.86 The

would be "forced into full-time child care for years to come; [and] unable to work so that her family [could] break out of the welfare system or the lowest income brackets." Id. at 458 (Marshall, J., dissenting).

80 Id. (citing Beal v. Doe, 432 U.S. 438, 462 (1977) (Marshall, J., dissenting)).
82 Id. at 785.
83 See Parness, supra note 78, at 495 n.37.
85 Id.
86 See Parness, supra note 78, at 498.
authors concluded that the test group (the children of women denied abortions) showed significant social and psychological handicaps when compared to the control group. The study suggested, in particular, that the test group showed a greater propensity for anti-social and delinquent behavior than the control group.

The Swedish study is still cited by advocates of abortion despite the fact that subsequent studies have completely discredited it because of serious methodological flaws. Critics of the study have shown that its researchers failed to carefully match the two groups, and as a result that test group contained a significantly higher proportion of children of lower socio-economic status. This fact explains the discrepancies in profiles between the two groups since poorer children generally suffer from the lack of opportunities and advantages afforded the more affluent.

A more recent study (1971) conducted by Dytrych in Czechoslovakia attempted to assess the outcome of children of mothers denied abortions nine years after birth. In this investigation, the test group of 220 children whose mothers were denied abortions was carefully matched to the control group on the basis of age, grades in school, sex, birth order, number of siblings, mother's marital status and father's occupation. The research did not bear out the discrepancies found in the Swedish study. No gross maladjustment or maladaptation problems were indicated. The study did suggest, however, that as compared to the control group children, the test children were acutely ill more often, were more often described as bad tempered or naughty by their mothers, were felt to be less conscientious and more excitable, did slightly worse in school and were regarded as having less desirable personality traits by their mothers, teachers and peers.

Although the Dytrych study made some interesting findings with respect to the children of women denied abortions, the study does not prove that these children are disadvantaged because they were unwanted.

As previously noted, studies which have investigated the personalities and psychological profiles of women seeking abortion have established that, as a group, these women exhibit a higher proportion of narcissistic and psychopathic personality disorders than that of the general female population. It was also noted that people with these character dis-

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87 Zemlick & Watson, Material Attitudes of Acceptance and Rejection During and After Pregnancy, 23 A. J. Orthopsychiatry 570, 582-83 (1953) (rejection expressed in post-partum overprotection may handicap a child).
89 Id.
orders have a very low tolerance for anxiety and are impulsive. Such women are, therefore, more likely to seek abortion for less "critical" reasons. They would, therefore, be the least likely, within the abortion group, to have for example, medical, eugenic, or other serious grounds for seeking abortion. Thus, these women would also be the most likely to be denied abortion. The women denied abortion in these studies were the likeliest to suffer from narcissistic and psychopathic personality disorders. Therefore, it is not at all surprising that the children of such women might also have personalities that are susceptible to this particular pathology. It is even less surprising that the mother's pathology would have a detrimental effect on their children regardless of their original "wanted-ness." To conduct a valid study of the outcome of "unwanted" children, one would have to compare the children of women denied abortion with the planned children of women who had previously been aborted on the same grounds as those denied. It is suggested that the two groups will not only be indistinguishable, but that both will share social and psychological deficiencies as compared to a group of children whose mothers never sought abortions, regardless of whether their pregnancies were "wanted" initially.

A number of subsequent studies, however, have demonstrated that the initial response to and acceptance of a pregnancy is not an important factor determining the outcome of the child. On the contrary, it has been indicated by studies that 90% of children who were battered by their parents were actively planned and "wanted" and that there was more deviant behavior among women who had planned their pregnancies than those who had not.

The arguments in favor of abortion when the pregnancy is unwanted base their rationale on the defense of society from future "criminals and mental incompetents" or on considerations of the quality of life of these children as yet unborn. Neither survives scrutiny.

**CONCLUSION**

It is evident that a serious discrepancy exists between the law governing abortion and its actual application in Canadian hospitals. Whether this is due to misinterpretation or willful disregard of the legal criteria is a matter of speculation. In either case, therapeutic abortion committee

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81 *Cf.* Zemlick & Watson, supra note 87, at 581 (there is a significant increase in accepting attitudes toward babies after parturition).
82 *See* Campbell, supra note 7, at 249 n.164 and accompanying text.
83 *Id.* at 243 n.165 and accompanying text.
84 *Id.* at 243 n.166.
85 *See, e.g.*, Buck v. Bell, 274 U.S. 200, 207 (1927) (advocating abortion to prevent the birth of imbecils and degenerates).
members ought to be informed about the accumulating evidence which
militates against abortion as a therapeutic procedure.

Hospital boards, charged with the responsibility of appointing thera-
pic abortion committee members, are ultimately responsible for abort-
ion practices at their hospitals. They have a duty to insure that the com-
mittee members are aware of the legal requirements and criteria and that
these members are not abusing the authority with which they have been
vested by the board. Hospital boards cannot escape legal and ethical re-
sponsibility for abortion decisions which make a mockery of the law sim-
ply by washing their hands of the issue or maintaining ignorance of the
decision-making process. They are responsible for those they appoint.
They are responsible for formulating hospital policy on abortion and for
insuring that committee members understand the limits of their
authority.

This article has attempted to demonstrate that the vast majority of
pregnancy terminations are medically non-therapeutic. They do not en-
hance maternal health, but on the contrary, pose serious physical and
psychological risks which are to a large extent ignored. In this respect, the
approach to abortion is a radical departure from traditional medical
practice.

Dr. Delcampo considers this discrepancy:

Few interventions are accepted without systematic evaluation. Drugs shown
to be effective in the laboratory are evaluated in clinical trials, and surgical
procedures are constantly criticized and revised. Even diagnostic tests must
be shown to be safe, to cause only minor side effects and to have adequate
test validity. Therapeutic abortions appear to be a major exception; they
apparently have been privileged to bypass evaluation. Why are they being
done without clinical validation, even in the face of mounting evidence that
they are not necessary for the prevention of maternal disease or the birth of
unwanted children? . . . Physicians must take a more scientific approach to
unwanted pregnancies and realize that abortion is not the answer to social
ills. Legislators should base their decisions on clinical reviews rather than
succumb to public pressures.**

Present abortion practices are eliciting a radical, if almost im-
perceptible, change in the ethical principles underlying the practice of
medicine and the provision of health care.

The change has not come in the unborn child which still develops the same
way; not in the uterus which contains it. Rather it has come in what doctors
do and why they do it. The change has come in the ethic which now regards
as commendable something which for a doctor was previously forbidden to
practice. And the reason the doctor has changed is not medical but pressure

** DelCampo, supra note 36, at 362.
from the patient community who have changed their standards and requests. To accede to such requests is, I believe, to subordinate surgical judgement to social dictation. In more ways than one legalized abortion is a form of tyranny.\textsuperscript{77}

Present abortion practice is making a mockery of the law and a mockery of medicine.\textsuperscript{88} It is, in itself, symptomatic of a hypocritical and narcissistic society which seeks its immediate gratification but has neither the courage nor the psychological stamina to face up to the realities of its own violent actions. In a manner characteristic of narcissistic denial, there exists a pervasive conspiracy of silence with regard to the reasons for, and consequences of abortion, and with regard to unborn victims of abortion.

The significance of the abortion issue in modern society cannot be underestimated. It has become the point around which two fundamentally irreconcilable sets of values have begun to crystallize. The division it represents is perhaps more profound than any other. It implies opposing views about such fundamental issues as the function of law, the purpose of medicine and the very nature and value of human life. One view offers a society caught in the web of its own narcissistic tyranny, which frantically seeks immediate gratification in a futile attempt to sustain its fantasies of omnipotence and invulnerability; fantasies which will ultimately crumble under the weight of a reality it refuses to face. The other holds hope for a future society which is compassionate and rational, which protects its most vulnerable and has the fortitude to sacrifice immediate gratification for the sake of the values and principles that will insure its long-term survival and betterment. The choice is ours.

\textsuperscript{77} Bergrin, \textit{supra} note 28, at 770.

\textsuperscript{88} See D. Sim, \textit{supra} note 40, at 1062 (abortions are being recommended on psychiatric grounds, not because they are justified, but to circumvent the law to accommodate those who don't wish to bear children).