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History of Abortion Legislation in the United States

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Abstract

In general, demand for abortion services has been consistent throughout U.S. history; what has varied throughout the centuries is a person's ability to access a safe abortion, free from persecution and prosecution. Recent U.S. history has demonstrated that making abortions illegal does not stop people from obtaining abortions. Furthermore, when discussing abortion access in the United States, a recurring theme in our history is how restriction of abortion and antiabortion legislation primarily affects the poorest and most-underprivileged members of U.S. society. This article examines the history of abortion legislation in the United States to promote better understanding of current antiabortion legislation and what these laws mean for patients and providers. (J GYNECOL SURG 38:320)

Keywords: gynecology, abortion, history, legislation

Abortion Law in the Colonial Period and Early America

Abortion in the United States was practiced prior to the colonization of North America—many tribal societies knew how to induce abortions through ingestion of abortifacient agents. Upon the colonization of North America, the legal practices surrounding abortion reflected the attitudes of the governing country and were handled by common-law courts. Prior to 1800, Great Britain's common law only recognized abortion as a crime if the abortion occurred after ''quickening'' or when fetal movement first occurred.[1]

Much of what we know about the enforcement of antiabortion laws in the colonies comes from the case of Sarah Grovesnor, a young woman who died in 1742 from complications of a surgical abortion. Interestingly, the individuals involved were charged with crimes for abortion leading to a person's death, not the act of performing or procuring an abortion.[2] While abortions were viewed as socially unacceptable, prior to the mid-1800s, abortions were not illegal in most states. Prior to 1850, when abortion cases were heard by the courts of individual states, the same conclusion was reached— interruption of pregnancy prior to quickening was not a crime.[1]

The Criminalization of Abortion in the 1800s

Prior to the formation of the American Medical Association (AMA) and the standardization of medical education, abortion and pregnancy care were often performed by midwives.[3] Additionally, women of the early 19th century had access to abortifacient information through home medical manuals, with details on managing ''obstructed menses'' and information on what to avoid during pregnancy. In the mid 1800s, there was a notable increase in abortions procured by married, middle–upper-class Protestant women, which was noticed by physicians in the medical community. In 1847, when the AMA was formed, physicians began to criticize the legitimacy of other health care providers who performed and aided women in obtaining abortions. By 1857, the AMA was advocating against abortions, going as far as encouraging physicians to inquire about abortion laws within their individual states.[1] While evidence supported that death rates following abortions were similar between midwives and physicians, physicians blamed the midwifery field for poor abortion outcomes, and more restrictions surrounding who could practice abortion were created.[4]

Between 1860 and 1880, at least 40 antiabortion statutes were created by state legislatures targeting both persons who

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performed abortions and women procuring abortions. By 1880, most states had criminalized abortions, with laws prohibiting the practice at any point during a woman's pregnancy.[1] Restricting family planning services further, Congress passed the Comstock Act in 1873, which prohibited the sale and dissemination of contraceptives. The Comstock Act was originally spearheaded by Anthony Comstock, a devout Christian who resided in New York City and set out on an ''antiobscenity crusade,'' with his main target being the contraceptives industry.

Following the Comstock Act, individual states proceeded to enact even more restrictive laws; for example, in Connecticut, married couples could be arrested for using birth control and face a 1-year prison sentence if convicted.[5]

Ultimately, the restrictive laws surrounding birth control and family planning of the late 1800s led to the criminalization of abortion and the term ''back-alley abortion.'' By 1910, every state except Kentucky outlawed abortion as a criminal procedure except in cases to save a mother's life.[6]

Illegal Abortions of the 1900s and the Outcomes

Restrictive laws did not stop the practice of abortion; rather, they made abortion more dangerous. According to the Guttmacher Institute, ''one indication of just how common abortions were during the first half of the 1900s was the death toll.'' In 1930, nearly one-fifth of maternal deaths were the results of abortions. The death toll secondary to abortion declined in the 1940s and 1950s secondary to the introduction of antibiotics; however, by 1965 abortion still accounted for 17% of all deaths attributed to pregnancy and childbirth. Specifically, poor and low-income women were disproportionately affected by restrictive laws against abortion. A study of low-income women residing in New York City in the 1960s found that of women who said they had abortions, 77% said that they had attempted self-induced procedures, with only 2% saying that a physician had been involved in any way.[7]

Physicians who performed abortions faced criminal charges and the loss of their medical licenses. Those who continued to practice abortion were referred to as ''physicians of conscience''; these doctors would perform in-office dilation and curettage or utilize biopsy hooks to cause bleeding in early pregnancy, and then send their patients into a hospital for treatment of an incomplete abortion.[8] Patients who could not afford or access an abortion performed by a physician would turn to either a so-called ''back-alley abortionist'' or attempt to perform the procedure themselves.

During 1965–1967 The National Opinion Research Center documented commonly used methods to perform abortion by surveying 899 women in New York City; 80% of these women reported that they had attempted to perform the abortions themselves, and the methods utilized ranged from oral medication, douche, placing a tube in the cervix, using other instruments (foreign bodies placed into the cervix), baths, injections, or a combination of these methods. During these years, the most common reason for admission to a gynecologic inpatient service was a septic abortion, and it was common for residents in training to care for women who had complications from these illegal abortions.[9]

Roe v. Wade

In 1965, two Texas attorneys, Linda Coffee, LLB, and Sarah Weddington, JD, decided to take on Texas' restrictive abortion laws. In Texas, abortion was only permitted for saving a woman's life. Norma McCorvery, more commonly referred to as ''Jane Roe,'' was a woman who sought an abortion for an unwanted pregnancy after already placing 2 children from her prior pregnancies up for adoption. In 1970, Coffee and Weddington filed a lawsuit against District Attorney Henry Wade, JD, on behalf of McCorvery and women ''who were or might become pregnant and want to consider all options.'' Initially, a Texas district court ruled that the state's abortion ban was illegal because it violated a constitutional right to privacy. The case was appealed, and on January 22, 1973, the Supreme Court struck down the Texas Law banning abortion citing that a woman's right to abortion was implicit in the right to privacy; this decision effectively legalized abortion in the United States. Additionally, the Supreme Court decision set forth a trimester framework of when abortion could be regulated by states as shown in Table 1.[10]

Abortion Post *Roe v. Wade*

Simultaneous to *Roe v. Wade*, the vacuum aspirator was introduced. The manual vacuum aspirator or ''MVA'' made surgical abortions safer, quicker, and more affordable. With this newer technology, physicians were able to provide surgical abortions in outpatient clinics. In 1973, 81% of abortion providers were associated with a hospital; by 1979, this number decreased to 56%. With abortion being performed in the outpatient setting, a new ''feminist model'' of abortion clinics was born; this model emphasized education on women's health, offering free pregnancy testing and free birth control samples to patients. It is important to note that, while some states saw a rapid increase in freestanding abortion clinics, *Roe v. Wade* did not automatically result in abortion clinics that were easily accessible in all states. For example, in New Jersey, access to abortion remained limited, requiring women to travel to other states.[11] While *Roe v. Wade* legalized abortion in every state, it also nationalized the conversation surrounding abortion.

Before *Roe v. Wade*, Republicans and Democrats voted against abortion at similar rates; it was not until 1979, that Republicans began to vote against abortion at higher rates than Democrats. In order to frame the Republican party as ''profamily'' and mobilize conservative votes, more Republicans began running for office on antiabortion platforms

Table 1. *Roe v. Wade* Trimester Framework for State Regulation of Abortion

Trimester	*Regulation*
First	State governments could not prohibit abortion at all.
Second	State governments could require reasonable health regulations surrounding abortions.
Third	State governments could prohibit abortion as long as laws contained exemptions for cases when they were necessary to save the life or health of the mother.

and introducing laws that restricted abortion access.[12] On September 30, 1976, Representative Henry Hyde, a Republican from Illinois, attached a rider onto an appropriations bill for Medicaid prohibiting the usage of federal funds for abortion services. Over time, Congress multiplied this rider onto other federal health services, including, but not limited to, the Indian Health Services Act and the Veterans Health Administration. Rep. Hyde once stated: ''I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the…Medicaid bill.''[13] Through this rider, abortion access for patients with Medicaid was severely restricted and remains so today, requiring women with Medicaid to pay out-of-pocket for abortion services in many states.

In 1988 and 1989, Republican Governor Robert Casey of Pennsylvania enacted new laws that required:

> a woman seeking an abortion give her informed consent, a minor seeking an abortion obtain parental consent (the provision included a judicial waiver option), that a married woman notify her husband of her intended abortion, and, finally, that clinics provide certain information to a woman seeking an abortion and wait 24 hours before performing the abortion.

Planned Parenthood of Southeastern Pennsylvania sued Governor Casey, culminating in the Supreme Court case, *Planned Parenthood v. Casey*. The final decision on the case upheld *Roe v. Wade*'s decision that women have a right to obtain an abortion but rejected the trimester framework that was previously put forth. Furthermore, the Supreme Court revised how abortion laws would be scrutinized moving to an ''undue burden'' standard. Under the ''undue burden'' standard, a law regulating abortion is invalid if ''its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability.''[14]

Following *Planned Parenthood v. Casey*, many suits were brought forward that centered on the meaning and interpretation of ''undue burden.'' In 2016, the Supreme Court rejected two provisions in Texas that would require doctors at abortion clinics to have admitting privileges at nearby hospitals and abortion clinics to meet the standards of ambulatory surgical centers, citing that these provisions would place a substantial obstacle in the path of women seeking previability abortion.[15] In 2019, after a North Dakota law was passed in an attempt to require that providers inform patients receiving medical abortions that the procedure was reversible, the AMA filed suit, noting that the law would put ''physicians in a place where we are required by law to commit an ethical violation.'' This was the first time the AMA took an active role in abortion advocacy. Previously, during *Roe v. Wade*, the AMA stated that ''abortion decisions'' were to be between ''a woman and her doctor'' but declined to submit a friend-of-the-court brief to the high court during its consideration of *Roe v. Wade*.[16]

During the presidency of Donald J. Trump, a Republican, 3 conservative justices were nominated to serve on the Supreme Court, leading to a conservative court that was primed to overturn *Roe v. Wade*.[17] In 2021, state legislatures enacted a record 108 abortion restrictions in 19 states. Policies focused on 3 ban types: (1) 15-week abortion bans; (2) ''Texas Style'' bans that rely on bounty-hunter enforcement, and (3) ''trigger bans'' that would be in effect if *Roe v. Wade* were to be overturned.[18] Up until 2022, the Supreme Court had consistently upheld *Roe v. Wade*. However, on June 24, 2022, in a 6–3 decision, via the *Dobbs v. Jackson Health Organization* decision, the Supreme Court returned abortion legislation to the states and held that the Constitution of the United States did not confer a right to abortion.[19]

The Post *Dobbs v. Jackson Health Organization* Landscape

Since the *Dobbs v. Jackson Women's Health Organization* decision that June, several trigger bans and new abortion bans went into effect. At the time of this publication, 13 states currently have complete or 6-week bans, although that number is changing rapidly, and with states calling for special legislative sessions for the sole purpose of passing abortion bans now that *Roe v. Wade* has been overturned.[20] The current authors suspect that history will repeat itself, and now that abortion is illegal in many states under all or most circumstances, a rise in maternal morbidity and mortality is anticipated. A preview of this has already been seen in Texas, where a study from two hospitals showed maternal mortality almost doubled following the passage of SB8 (the Texas legislation) in September 2021, which banned abortions after 6 weeks.[21]

While there will be a likely rise in the incidence of maternal morbidity and mortality as a result of *Roe v. Wade* being overturned, the situation may not be quite as dire as occurred in the septic abortion hospital wards of the 1960s and early 1970s. This is largely in part due to the availability of medication abortion, something that did not exist prior to *Roe v. Wade*. Medication abortions, consisting of a combination of mifepristone and misoprostol, now account for more than half of all abortions performed in the United States and appear set to change the face of self-managed abortion.[22] Today, there is less worry about unskilled people placing objects into women's uteri to end their pregnancies, and more concern about people being criminalized after taking abortion-inducing medications.

Conclusions

Legislation surrounding abortion in the United States has varied greatly since the formation of the United States. It is unclear what the future will hold for legal abortion here; however, history has shown us that criminalization of abortion does not stop abortion from occurring, and, instead, makes abortion less safe, and impacts the health and well-being of patients negatively. Only once abortion is seen within the context of standard medical care can there be a decrease in antiabortion legislation and improvements in maternal morbidity and mortality rates.

Authors' Contributions

Michelle Whittum MD was the primary author of this article with Rachel Rapkin MD as the secondary author.

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