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CRISTINA'S WORLD: LESSONS FROM EL SALVADOR'S BAN ON ABORTION

Michelle Oberman*

INTRODUCTION

It has been forty years since the U.S. Supreme Court forbade states from restricting women's access to abortion during the early months of pregnancy, and if one thing is clear about abortion law today, it is that most Americans do not like the decision. The reason for *Roe v. Wade*'s unpopularity is obvious: most Americans reject the position that early abortion should be legal for all women, regardless of their circumstances. Polls consistently show that approximately three in four Americans would use criminal laws to restrict access to abortion. Of those, twenty percent would make abortion illegal under any circumstances and the majority—fifty-two percent—believes abortion should be legal only under some circumstances. Of that fifty-two percent, the great majority believes that abortion should be legal under only a few

^{*} Professor of Law, Santa Clara University. I owe a debt of gratitude to many who helped me in this project. First, there are my friends in El Salvador, Morena Herera, Dennis Muñoz, Cristina Quintanilla, and members of La Agrupación Ciudana, without whom I could not have undertaken this research. Second, my colleague Brian Buckley, a philosopher and lawyer, read and critiqued earlier versions of this Article, helping me to understand the deep sources of disagreement as well as the rhetorical excesses that corrode our ability to converse about abortion. In addition, I thank my friends and colleagues David Ball, Michele Goodwin, Marina Hsieh, and Ariella Radwin for their generous comments, my reference librarian, Ellen Platt, for being my right hand, and my research assistants, Sita Kutiera (Santa Clara Law, Class of 2013) and Katarina Peña (Santa Clara Law, Class of 2014), for their unflagging support. Many thanks to Melissa Hughes (Stanford Law School Class of 2013), for excellent and thought-provoking editorial assistance. Finally, my deepest gratitude to Dean Donald Polden and Santa Clara University School of Law for enabling me to engage in this work.

^{1.} Lydia Saad, *Pro-Choice Americans at Record-Low 41%*, GALLUP (May 23, 2012), http://www.gallup.com/poll/154838/Pro-Choice-Americans-Record-Low.aspx.

^{2.} Gallup polls show approximately 26% of Americans believe abortion should be legal under all circumstances. *See* Lydia Saad, *Plenty of Common Ground Found in Abortion Debate*, Gallup (Aug. 8, 2011), http://www.gallup.com/poll/148880/Plenty-Common-Ground-Found-Abortion-Debate.aspx.

circumstances.⁴ These numbers have not changed much over the past forty years, although recent years have seen an increase in persons identifying as pro-life.⁵

Obscured by contemporary pro-life/pro-choice discourse are the differences among those who identify as pro-life. For instance, sixty-nine percent of Americans who identify as pro-life favor legal abortion when pregnancy endangers a woman's life; fifty-nine percent would permit legal abortion in cases of rape or incest. Likewise, there are distinctions among the twenty percent who believe abortion should always be illegal. For example, the American Association of Pro-Life Obstetricians and Gynecologists' official position permits the termination of non-viable pregnancies, such as ectopic pregnancies. Others organizations, such as the Catholic Church and the Association of Pro-Life Physicians, assert that because it is impermissible to intentionally kill the embryo, the only morally justified response to ectopic pregnancy is to remove the fallopian tube in which the embryo is located. Still other pro-life voices disagree with this position, disputing the actual threat to human life posed by such pregnancies, and asserting that humans should never intervene in the reproductive process.

With the exception of those who believe humans should never be permitted to intervene in the reproductive process, those who identify as pro-life take for granted both the idea that limiting access to legal abortion will save fetal

^{4.} *Id.* 39% favor limiting abortion to "only a few circumstances," as opposed to keeping it legal under "most circumstances." *Abortion*, GALLUP (2012), http://www.gallup.com/poll/1576/abortion.aspx/#2. Circumstances typically invoked include rape, incest, fetal abnormality, and threats to maternal life or health.

^{5.} Between 1996 and 2012, the number of people identifying as "pro-life" has risen from 33% to 50%. *Id.* These numbers do not surprise me. My "pro-choice" students are increasingly uncomfortable articulating absolute support for "choice," and confess to horror at the slaughter of girl fetuses in far off cultures. Closer to home, they hedge their support for choice in (hypothetical) cases in which women allegedly use abortion as a "method of contraception." By contrast, my "pro-life" students continue to identify as such, even when many acknowledge their intention to rely upon prenatal testing and, if necessary abortion, in the event tests showed a significant fetal abnormality.

^{6.} Saad, supra note 2.

^{7.} What is AAPLOG's Position on Treatment of Ectopic Pregnancy?, AM. ASS'N OF PRO-LIFE OBSTETRICIANS & GYNECOLOGISTS (July 2010), http://www.aaplog.org/position-and-papers/what-is-aaplog%E2%80%99s-position-on-treatment-of-ectopic-pregnancy.

^{8.} Are There Rare Cases When an Abortion Is Justified?, ASS'N OF PRO-LIFE PHYSICIANS, http://www.prolifephysicians.org/rarecases.htm (last visited Feb. 24, 2013).

^{9.} See, e.g., id. As in the famous trolley hypothetical, the claim is that it is immoral to turn the trolley off its tracks, even if it means that five people will die instead of only one. See Judith Jarvis Thomson, The Trolley Problem, 94 YALE L.J. 1395 (1985) (summarizing and analyzing the problem originally posed by Philosopher Phillipa Foot in Phillipa Foot, The Problem of Abortion and the Doctrine of the Double Effect, VIRTUES AND VICES AND OTHER ESSAYS IN MORAL PHILOSOPHY 19 (1978)).

lives, ¹⁰ and the faith that the law will identify and permit access to the subset of cases in which they believe that the pregnant woman deserves to terminate her pregnancy. ¹¹

Perhaps because of the line-drawing inherent in the notion that abortion is mostly, but not always, wrong, the post-*Roe* U.S. struggle over the morality of abortion takes place in the legal setting. ¹² Our disputes over abortion are not confined to philosophical or theological realms, but rather, have become central features in our political discourse, occupying the attention of candidates, lawmakers, and courts. As such, it is essential to consider the validity of these assumptions about the practical consequences—the efficacy—of abortion laws.

10. See, for example, the manner in which Eric Scheidler, of the Pro-Life Action League, describes the accomplishments of the pro-life movement since 1973:

Every state in the union has enacted some kind of restriction on abortion, from parental involvement laws (38 states) to waiting periods (26 states) to conscience protections for health care workers (46 states). Not only do these kinds of laws enjoy broad public support, they are saving babies from abortion.

Eric Scheidler, Accomplishment #6: Pro-life Laws Have Been Enacted at the Federal, State and Local Level, Pro-Life Hotline Blog (Jan. 16, 2013, 1:54 PM), http://prolifeaction.org/hotline/2013/topten06.

11. Numerous cases illustrate the problem of inadequate mechanisms for accessing abortion under qualifying circumstances. For example, in *K.L. v. Peru*, a woman was forced to carry to term her anencephalic fetus, in spite of the fact that Peruvian abortion law permits abortion when the life or health of the mother is in danger. *K.L. v. Peru (United Nations Human Rights Committee)*, CTR. FOR REPROD. RIGHTS (Dec. 10, 2008), http://reproductiverights.org/en/case/kl-v-peru-united-nations-human-rights-committee. The United Nations Human Rights Committee found that K.L.'s pregnancy severely compromised her life by endangering her physical and psychological health and that the second half of her pregnancy (during which she desired but was denied an abortion) was a clear violation of international standards prohibiting violence against women, and constituted cruel, inhuman, and degrading treatment by state officials. K.N.L.H. v. Peru, Communication No. 1153/2003, Rep. of U.N. Human Rights Comm., 85th, 86th, & 87th Sess., Oct. 17-Nov. 3, 2005, Mar. 13-31, July 10-28, 2006, ¶¶ 6.3-6.6, U.N. Doc. A/61/40, GAOR, 61st Sess., Supp. No. 40 (2006), *available at* http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G06/444/57/PDF/G0644457.pdf?OpenElement.

12. The tension between morality and legality complicates the abortion debate, particularly in the case of anti-abortion absolutists, whose objection to taking prenatal life under all circumstances tends to invoke notions of God, and as such, to trigger conflicts with the First and Fourteenth Amendments. See, e.g., David M. Smolin, The Religious Root And Branch Of Anti-Abortion Lawlessness, 47 BAYLOR L. REV. 119 (1995) (describing the role of God-rhetoric in anti-abortion legislation). I found it difficult to describe the position taken by those who oppose abortion even in cases of non-viable fetuses or when a mother's life is at stake without using the word "God," and to the extent that I succeeded in wording non-intervention as a secular rather than a divine obligation, I found myself running afoul of common law doctrines governing bodily autonomy and affirmative duties to act, as well as into the basic guarantees in our Bill of Rights. For a detailed discussion of the manner in which normative approaches to abortion law belie the authors' moral beliefs, neglecting to take into consideration conventional modes of legal analysis, see Margaret G. Farrell, Revisiting Roe v. Wade: Substance and Process in the Abortion Debate, 68 IND. L.J. 269, 306-317 (1993).

In seeking to explore the nexus between abortion laws and abortion in practice, one could turn to the rich body of pre-*Roe* abortion history in the United States Beginning in the nineteenth century, state laws sought to police abortion via the criminal law.¹³ Numerous historical accounts conclude that, although the laws likely led at least some women to carry unwanted pregnancies to term, they had a far greater impact on the circumstances under which abortion was provided than they did on the frequency with which women terminated their pregnancies.¹⁴

However, a comprehensive review of our own history will not serve to inform a contemporary consideration of how and whether abortion laws shape abortion practices. Too many relevant factors have changed since the days when abortion was a crime in United States. Single motherhood is now commonplace; women and men enjoy access to numerous forms of effective contraception; and one may procure an abortion medically, by prescription drugs, as well as surgically.

A more relevant source of information to deepen our understanding of the impact of endeavors to restrict abortion via the criminal law may be found in countries around the world whose laws make abortion a crime. In looking to their experiences, we may observe the practical impact of the law on women's lives, noticing factors such as the mechanisms needed in order to successfully enforce laws against abortion and endeavoring to assess whether criminalizing abortion lowers the rate at which women terminate unwanted pregnancies. To be sure, it is hazardous to assume the experiences of a given country or culture will have any predictive bearing on our own. That said, it would be folly to assume that the United States has nothing to learn from the experiences of other countries that have outlawed abortion.

In an effort to understand how abortion laws work in practice, I chose to study abortion in El Salvador, which in 1998 changed its penal code from a law permitting legal abortions in cases of rape, incest, or threat to maternal health or life to a law banning abortions in all cases. ¹⁵ It was an extreme move,

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^{13.} Steven Graines & Justin Wyatt, *The Abortion Right, Originalism, and the Fourteenth Amendment*, 47 CLEV. St. L. REV. 161, 164-167 (1999).

^{14.} Throughout the history of abortion in the United States there has not been a correlation between incidence of abortion and the restrictiveness or liberalness of abortion laws. When abortion restrictions were enacted from 1820 to 1840, abortion rates began to increase and continued to do so through illegalization, lead by the AMA, at which point abortions merely became less visible and less safe. See James C. Mohr, Abortion in America (1978). At the turn of the twentieth century, abortion rates were one in seven and rose to one in three in 1936 despite abortion restrictions remaining unchanged. See Brief for 250 American Historians, Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833 app. A at 453-75 (1992).

^{15.} SOLEDAD VARELA, CTR. FOR REPROD. LAW & POLICY, PERSECUTED: POLITICAL PROCESS AND ABORTION LEGISLATION IN EL SALVADOR: A HUMAN RIGHTS ANALYSIS 27, 96 n.130 (2001), available at

putting it in the company of only two other places in the world at that time—Chile and Vatican City. ¹⁶ Moreover, because it is a poor country, surrounded by countries with abortion laws that are only slightly less restrictive, women cannot readily avoid the law by traveling. ¹⁷ Thus, unlike middle-class women in Chile, who can travel to receive relatively safe, if illegal, abortions, ¹⁸ or the relatively few women in Vatican City, who could readily obtain abortions in Rome, ¹⁹ Salvadoran women live in a world in which safe abortion is truly inaccessible.

 $http://reproductive rights.org/sites/default/files/documents/persecuted 1.pdf \\ http://reproductive rights.org/sites/default/files/documents/persecuted 2.pdf.$

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- 16. In Chile, the Church's dominance over social issues was especially prominent during the final years of Augusto Pinochet's military regime, leading to a complete ban on abortion in 1989. Tania Jiyoung Cho, The Double Moral: Compliance of International Legal Obligations of Reproductive Rights vs. Allegiance to the Catholic Church, 5 Sw. J. L. & TRADE Am. 421, 449 (1998); Sarah R. Hamilton, The Status of Women in Chile: Violations of Human Rights and Recourse Under International Law, 25 WOMEN'S RTS. L. REP. 111, 112-13 (2004). In El Salvador, the Church supported social justice and human rights through the overthrow of the military dictatorship in the 1980s. VARELA, supra note 15, at 17. It then switched course, aligning with the new conservative government in the 1990s to remove all exceptions to abortion in a 1998 constitutional amendment. Id. In Nicaragua, presidential candidate Daniel Ortega joined in the outrage of the Catholic Church over an abortion performed on a nine-year-old girl who was victim of rape. Sarah Helena Lord, The Nicaraguan Abortion Ban: Killing in Defense of Life, 87 N.C. L. REV. 537, 548 (2009). He chose former archbishop of Managua, Miguel Obando y Bravo, as his running mate and made eliminating the exceptions for abortion a major part of his platform to leverage the Church's influence and win the 2006 presidential election. Id. at 549. The influence of the Catholic Church over social issues and elections may also have played a major role in the Dominican Republic's ban on abortion under all circumstances, which went into effect in 2009. Rocio Diaz, Dominican Republic: Constitution Bans Abortion in All Cases, GLOBAL VOICES (Oct. 1, 2009), http://globalvoicesonline.org/2009/10/01/dominican-republicconstitution-bans-abortion-in-all-cases.
- 17. Guatemala has an explicit life exception, which permits abortion to save the woman's life. Honduras has no explicit life exception, but the law is normally interpreted to allow for a defense of necessity. *The World's Abortion Laws 2012*, CTR. FOR REPROD. RIGHTS, http://worldabortionlaws.com/map (last visited Nov. 6, 2012).
- 18. Access to illegal abortion is Chile is an open secret. An abortion hot-line offers women advice about how to safely terminate an unwanted pregnancy. Aaron Nelsen, *Taking Calls on Abortion, and Risks, in Chile,* N.Y. TIMES (Jan. 3, 2013), http://www.nytimes.com/2013/01/04/world/americas/in-chile-abortion-hot-line-is-in-legal-gray-area.html?pagewanted=all. An article concluding that Chile's ban on abortion did not lead to a rise in maternal mortality concedes that it is difficult to track the number of illegal abortions and that the drop in maternal mortality may be due in part to low-risk nature of clandestine abortions taking place in Chile. Elard Koch et al., *Women's Education Level, Maternal Health Facilities, Abortion Legislation and Maternal Deaths: A Natural Experiment in Chile from 1957 to 2007*, 7 PLoS ONE 5 (2012), *available at* http://www.plosone.org/article/info%3Adoi%2F10.1371%2Fjournal.pone.0036613.
- 19. Termination of Pregnancy and Abortion in Italy, Anglo Info, http://rome.angloinfo.com/information/healthcare/pregnancy-birth/termination-abortion (last visited Jan. 25, 2013).

In addition, El Salvador endeavors to enforce its abortion laws.²⁰ Although it is hard to obtain data from recent years, government data from 2000-2003 indicates that between 50 and 100 women are prosecuted for abortion annually.²¹ All of these factors—the relative poverty and geographic isolation of Salvadoran women from "abortion-friendly" regimes, and the aggressive prosecution of the crime, provide an optimal location for examining the extent to which an abortion ban actually affects the practice of abortion within a given country.

El Salvador is a poor Central American country, and it goes without saying that there are many ways in which life there is distinct from life in the United States—and some of those differences limit the lessons we might draw from its experience.²² Nonetheless, even if societal distinctions portend different answers, much of what I learned in El Salvador points the way to questions that must be raised and answered, particularly by those in the majority of U.S. society who favor banning abortion under most circumstances.

Lessons from El Salvador are particularly relevant for those engaged in the U.S. debate over abortion laws because they reveal how little the law actually matters. El Salvador's experiences with its endeavor to ban abortion teaches us not only that the law fails to stop abortion, but also much about the price of such an endeavor.

My story begins with a consideration of abortion as it currently exists in El Salvador, including a discussion of why the ban fails to stop abortions and why the law catches so few who terminate their pregnancies illegally. In the second part, I deepen my exploration of how abortion laws operate by providing a detailed account of the prosecution, conviction, and resolution of Cristina Quintanilla for an abortion-related homicide. Finally, I identify and consider the extent to which the problems observed in El Salvador's experience with

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^{20.} In an article deemed controversial on unrelated grounds, reporter Jack Hitt's *New York Times Magazine* cover story, *Pro-Life Nation*, described El Salvador's enforcement mechanism as follows: "There are other countries in the world that, like El Salvador, completely ban abortion, including Malta, Chile and Colombia. El Salvador, however, has not only a total ban on abortion but also an active law-enforcement apparatus—the police, investigators, medical spies, forensic vagina inspectors and a special division of the prosecutor's office responsible for Crimes Against Minors and Women, a unit charged with capturing, trying and incarcerating [women who have abortions]." Jack Hitt, *Pro-Life Nation*, N.Y. TIMES MAG. (April 9, 2006), http://www.nytimes.com/2006/04/09/magazine/09abortion.html?_r=1&oref=slogin.

^{21.} See Heathe Luz McNaughton et al., Patient Privacy and Conflicting Legal and Ethical Obligations in El Salvador: Reporting of Unlawful Abortions, 96 Am. J. Pub. Health 1927, 1932 fig.1 (2006) (showing between 50 and 100 prosecutions per year).

^{22.} For example, even if *Roe* is overturned, abortion likely will remain legal in many states, providing much easier access to safe abortions, even for relatively poor women in the United States, than exists for more impoverished women in El Salvador. Moreover, to the extent that abortion remains legal in some states, the normative message sent by those states that would treat abortion as murder is undermined.

criminalized abortion have implications for U.S. endeavors to restrict legal abortion.

My central observation is perhaps as unsurprising as it is morally abhorrent: to the extent that a woman is rich, abortion laws do not matter. For women with money, abortion in El Salvador remains available and relatively safe, regardless of the law.

My additional findings are equally vital to our national conversation about how and whether to use abortion laws in order to affect abortion in practice. First, abortion does not disappear in countries that criminalize abortion; indeed, El Salvador has a higher abortion rate than does the United States²³ Second, abortion law enforcement is complicated and has consequences for a population extending well beyond pregnant women and fetuses.

Before disembarking, a word about my research and about my writing style is in order. This Article is a qualitative empirical endeavor, and I relate my findings in a style that is alternately narrative and analytical. In so doing, I aim to be true both to the voices I encountered throughout my travels and to my own. I have little use for the purportedly objective stance from which much of legal scholarship emanates, and feigned neutrality seems particularly ill-suited to the topic of abortion—a topic about which any informed American not only has an opinion, but also has a predisposition to distrust commentaries rendered by those with contrary opinions. Hy goal is not to add my voice to the cacophony that passes for abortion-related discourse in the United States Instead, I seek to provide a backdrop against which readers on all sides of the abortion spectrum might evaluate anew the extent to which they are willing to support efforts to regulate abortion via the criminal law.

I. EL SALVADOR'S ABORTION BAN IN PRACTICE

I first traveled to El Salvador in October 2009, when I was invited to attend a binational conference of Nicaraguan and Salvadoran advocates for therapeutic abortion. ²⁵ I was intrigued by the stories told by Salvadoran

^{23.} Gilda Sedgh et al., *Induced Abortion: Incidence and Trends Worldwide from 1995 to 2008*, 379 The Lancet 625, 625 (2012) (comparing the one out of three pregnancies in Central America end in abortion with one out of five in the United States).

^{24.} For reasons that will become apparent later in this article, I do not believe the criminal law should play any role in limiting access to abortion. This position does not necessarily indicate my opinion as to the morality of abortion. I look forward to a day in which Americans can discuss the morality of abortion separately from discussing its legal status—much as we do with controversial moral issues such as surrogate motherhood, pornography, or kidney sales. I crave a conversation that avoids the quick slip from substance into legal regulation. This Article does not engage the morality of abortion itself, though, except insofar as it addresses the morality of attempting to regulate abortion via criminal law.

^{25.} I presented a paper entitled La ley y la vida de la mujer: Ponencia sobre la penalización del aborto en America Latina at El Segundo Encuentro Bi-Nacional Nicaragua

doctors, lawyers, and activists I met, particularly insofar as they involved abortion law enforcement and its impact on women and doctors.

Since 2009, I have made four additional trips to El Salvador, each time interviewing a broader circle of individuals whose lives and work have been affected by El Salvador's abortion laws. My research does not purport to be an empirical study of abortion in El Salvador. Instead, I have allowed myself to gather information from a gradually broadening circle of individuals recommended to me by those with whom I have spoken. El Salvador is a very small country, and experts are readily identified. By establishing relationships of trust with a variety of individuals, I have been privileged to learn from those on all sides of the abortion debate.

As with any ethnographic endeavor, the questions I ask and the conclusions I draw are in part a reflection of my own worldview. That said, my research is based not only on interviews, but also on documents and legal case records. As such, my research provides independent validation of the impact of El Salvador's abortion legislation on the lives of Salvadoran women.

A. Abortion Rates and Abortion's Legal Status

One of the most surprising things about abortion laws is that there is little evidence that restricting access to legal abortion lowers abortion rates. In this Part, I discuss the evidence for this phenomenon, and then turn to abortion rates in El Salvador, considering the reasons why abortion restrictions fail to diminish the rate at which women terminate their pregnancies.

If it were true that restrictive abortion laws led to lower rates of abortion, one would expect to see the world's lowest abortion rates in the most restrictive countries. All available data suggests no such correlation. A 2012 article in *The Lancet*, the leading British medical journal, confirms numerous earlier studies regarding the relationship between restrictive abortion laws and abortion rates. ²⁶ The article, written by researchers from the World Health Organization (WHO), employed a variety of methods for estimating abortion rates in countries around the world, particularly in those in which it is illegal under most circumstances. ²⁷

abortion. The WHO bases its estimations on numbers of women hospitalized for abortion complications (where available) and information on the safety of abortion, as well as findings from surveys of women and studies using an indirect abortion estimation methodology from country where those were available. E-mail from Dr. Gilda Segh, Guttmacher Inst., to author (July 7, 2012) (on file with author).

y El Salvador, Despenalizacion del Aborto Terapeutico, Eugenesico y Etico (San Salvador, El Salvador, October 28, 2009). (*The Law and Women's Lives: Presentation Regarding the Criminalization of Abortion in Latin America* at the Second Meeting of the Bi-National Nicaraguan and El Salvadoran Committees for the Decriminalization of Therapeutic Abortion).

^{26.} Sedgh et al., supra note 23.

^{27.} Abortion being illegal, it is hard to get accurate information about the rates of

At an aggregate level, they found no correlation between restrictive abortion laws and lower abortion rates. Indeed, the study found the opposite: "In 2008, the abortion rate was lower in subregions where larger proportions of the female population lived under liberal laws than in subregions where restrictive abortion laws prevailed."²⁸

This pattern is true in Central America, where an estimated twenty-nine percent of all pregnancies end in abortion. El Salvador isn't unusual among Central American nations, which have among the highest abortion rates in the entire world. Experts estimate that the ratio of pregnancies ending in abortion in Central America is somewhere between 1:3 and 1:4, as compared to the U.S. ratio of 1:5.30 In spite of the fact that all the countries in the region ban abortion either entirely or in all cases save those in which pregnancy poses a threat to the mother's life, there are an estimated 1.1 million abortions per year in Central America. There is no reason to believe that El Salvador's abortion rate deviates from the regional estimates.

In the following Parts, I consider how women access the means to terminate their pregnancies in spite of the fact that abortion is illegal.

^{28.} Sedgh, *supra* note 23, at 629.

^{29.} Sedgh, *supra* note 23. Data that isolates abortion rates in individual Central American countries is not readily available.

^{30.} Susheela Singh et al., *Abortion Worldwide: A Decade of Uneven Progress*, GUTTMACHER INST. (Oct. 2009), http://www.guttmacher.org/pubs/Abortion-Worldwide.pdf.

^{31.} Id. Central America's high abortion rates are something of a puzzle to contemporary demographers. Typically, high abortion rates correlate with limited access to contraception. Id. at 39-42 and accompanying text (noting that family planning services in many developing nations are not keeping up with the increasing demand driven by the increasingly prevalent desire for small families and for better control of the timing of births). But unlike most African nations, studies among married women in El Salvador demonstrate very high rates of contraception use. Contraceptive Use Among Married Women Ages 15-49, Type, POPULATION REFRENCE http://www.prb.org/DataFinder/Topic/Rankings.aspx?ind=42 (showing 73% of El Salvador's married women use a method of family planning—a rate than exceeds neighbors like Honduras, and is similar to rates in Canada and the United States). One obvious problem with this data is that it omits unmarried teens and women—many of whom are sexually active, and many of whom might be less likely to contracept for reasons distinct from those of married women. (For example, an unmarried woman's willingness to contracept might by affected by issues such as stigma, a desire to intensify a relationship, or a relative power disparity within the couple). In addition to rates of contraception, other trends may affect abortion rates. Some experts hypothesize that these might include "a rise in women's age at marriage, increased prevalence of sexual activity among unmarried women, and growing proportions of women in the labor force resulting in more prevalent and more strongly held desires to control the timing of births." Sedgh, *supra* note 23. at 12-13. For a rich discussion of the cultural trends and socio-economic factors underlying reproductive health behavior in Central America, see Lisa Remez, et al., Ensuring a Healthier Tomorrow in Central America: Protecting the Sexual and Reproductive Health of Today's Youth, GUTTMACHER INST. (2008), http://www.guttmacher.org/pubs/2008/06/16/PNG CentralAmerica en.pdf.

B. Access to Illegal Abortion in El Salvador

Abortion is a demand-driven market, and historian Leslie Reagan's work on illegal abortion in the United States might as easily apply to El Salvador today: "There would be no history of illegal abortion to tell without the continuing demand for abortion from women, regardless of law." The perennial black market for those determined to terminate their pregnancies regardless of the law long has included abortion tourism (for those able to travel to a country with more liberal laws) and illicit local practitioners of varying skill levels. Today, abortion's black market is exponentially larger and safer, owing to a combination of abortion drugs and the Internet.

In most First World countries, women can terminate an unwanted pregnancy by ingesting a drug popularly known as either RU-486 or by its current trade name, Mifeprex. The drug consists of two components used in a single formulation to induce a "medical abortion."³⁴ As formulated, the drug halts fetal development and induces uterine contractions, thereby effectively terminating well over ninety percent of early pregnancies.³⁵ Approximately one percent of all patients experience excessive bleeding, requiring a trip to the hospital and a surgical abortion.³⁶

In the United States, one can obtain Mifeprex only from a doctor's office or a clinic.³⁷ There, one learns that the drug is deemed "safe and effective" for a woman seeking to terminate a pregnancy only if it is taken during the first seven weeks of pregnancy.³⁸ After that point, one must seek a surgical abortion in order to safely terminate the pregnancy.

38. *Id*

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^{32.} LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973, at 1 (1997).

^{33.} Historian John M. Riddle has authored two rich histories of illegal abortion practices. *See* John Riddle, Eve's Herbs: A History of Contraception and Abortion in the West (1997); John Riddle, Contraception and Abortion from the Ancient World to the Renaissance (1992).

^{34.} Mifepristone blocks the hormone progesterone needed to maintain the pregnancy. Because this hormone is blocked, the uterine lining begins to shed, the cervix begins to soften and bleeding may occur. With the later addition of the second medication, misoprostol, the uterus contracts and the pregnancy is usually expelled within six to eight hours. *The Abortion Pill: Medical Abortion with Mifepristone and Misoprostol, Feminist Women's Health Ctr.*, http://www.fwhc.org/abortion/medical-ab.htm (last visited Nov. 6, 2012).

^{35.} Tekoa King & Mary Brucker, Pharmacology for Women's Health 912 (2010).

^{36.} *Mifeprex*, The RxList.com, http://www.rxlist.com/mifeprex-ru486-drug.htm (last visited Nov. 6, 2012).

^{37.} *How Do I Get Mifeprex?*, MIFEPREX: THE EARLY OPTION PILL TO END PREGNANCY, http://www.earlyoptionpill.com/section/how_do_i_get_mifeprex (last visited Nov. 6, 2012).

In Latin American countries with restrictive abortion laws, only one of the active ingredients used in Mifeprex is widely available:³⁹ Misoprostol, (also known as Cytotec), which is approved for use throughout the world for use in treating stomach ulcers.⁴⁰ It also has the effect of bringing on uterine contractions.⁴¹ Missing from the formulation of Misoprostol is the compound that halts fetal development.⁴²

In countries where abortion is illegal, the fact that Misoprostol is on the formulary for treating ulcers means that one can find a thriving black market in abortion-related sales. Evidence of this market is in plain view on the Internet. When I typed "Cytotec El Salvador" in a search engine, I got 492,000 results. "Misoprostol El Salvador" yielded 453,000 hits. The majority of links in the first few pages lead to classified ads with e-mail addresses and phone numbers. ⁴³

Medically speaking, the Misoprostol black market is troubling. Even assuming accurate dosage and appropriate timing, Misoprostol has a lower efficacy rate than does Mifeprex; pregnancy is terminated in only eighty-five percent of cases. As such, fifteen percent of those who take Misoprostol under optimal conditions experience complications ranging from the continuation of pregnancy, with uncertain effects on the fetus, to allergic reactions or bleeding and the need to seek surgical intervention to terminate their pregnancy.

There are deeper problems inherent in this particular black market, though. The Internet-procured drugs come without instructions—should the drugs be administered vaginally, as was thought to be necessary in the early years after Mifeprex's approval, or are they equally effective when taken orally? And when should they be taken? There is a specific choreography to the

^{39.} For a general description of the clinical use of misoprostol in terminating early pregnancy, see LATIN AM. FED'N OF OBSTETRICS AND GYNAECOLOGY SOCIETIES, USE OF MISOPROSTOL IN OBSTETRICS AND GYNAECOLOGY (Aníbal Faúndes ed., 2005), available at http://www.misoprostol.org/File/Other_G_FLASOG_Misoprostol_guidelines_English.pdf (last visited Jan. 24, 2013).

^{40.} Id. at 7.

^{41.} *Id*.

^{42.} See McNaughton, supra note 21.

^{43.} Cytotec El Salvador Search Results, GOOGLE, http://www.google.com (search "Cytotec El Salvador") (last visited Nov. 6, 2012); Misoprostol El Salvador Search Results, GOOGLE, http://www.google.com (search "Misoprostol El Salvador") (last visited Nov. 6, 2012). A similar search to buy misoprostol in the United States yields about 2,750,000 results. Buy Misoprostol Search Results, GOOGLE, http://www.google.com/ (search "Buy Misoprostol") (last visited Nov. 6, 2012).

^{44.} See S.W. Ngai et al., Vaginal Misoprostol Alone for Medical Abortion up to 9 Weeks of Gestation: Efficacy and Acceptability, 15 Hum. Reprod. 1159, 1159 (2000). For a comprehensive comparative review of efficacy rates at varying doses and formulations, see Daniel Grossman, Medical Methods of First Trimester Abortion: RHL Commentary, THE WHO REPRODUCTIVE HEALTH LIBRARY (Sept. 3 2004), http://apps.who.int/rhl/fertility/abortion/dgcom/en/index.html.

administration of Mifeprex—two tablets, twenty-four hours apart. 45 How do online consumers know how to use it to terminate pregnancy? Furthermore, there is no medical oversight to verify the duration of the woman's pregnancy.46

These problems intensify if a woman is taking Misoprostol, the portion of the drug available in Latin America and used to bring on uterine contractions. My online research suggests that Misoprostol can be used to terminate pregnancies as late as nine weeks, and in some cases can bring on contractions even in mid-trimester pregnancies.⁴⁷ But all of the studies of late pregnancy terminations via Misoprostol occurred under close medical supervision. Absent such supervision, there is necessarily a greater risk of severe hemorrhage or other complications.⁴⁸

Practically speaking, though, Misoprostol seems to be working in the vast majority of cases. Or at least, one might surmise that it is, given that public hospital beds in El Salvador are not filled with women dying from misoprostol-

Abortion With Self-Administered Misoprostol: A Guide For Women, GYUNITY, http://gynuity.org/resources/read/misoprostol-selfguide-eng.pdf (last visited Mar. 6, 2013).

^{45.} For abortions up to twelve weeks of pregnancy, 800 µg of Misoprostol should be administered vaginally every six, twelve, or twenty-four hours for up to three doses. Aníbal Faundes et al., Misoprostol for the Termination of Pregnancy up to 12 Completed Weeks of Pregnancy, 99 INT'L J. GYNECOLOGY & OBSTETRICS S172, S174 (2007). The dosage may also be taken in three-hour intervals orally, but this has not proven as effective. *Id.* However, pieces of the pill may remain visible if taken vaginally making it more dangerous for women in countries where abortion is prohibited. Id. at S173. Published data shows a high lack of uniformity, so it is difficult to determine what method is most effective. *Id*.

^{46.} Misoprotol use always carries the risk of excessive bleeding, cramping, and infection. All of these factors may be exacerbated, requiring medical and/or surgical intervention, in rare cases or in the event of incomplete abortion or advanced gestational stage. For a plain language description of these risks, see Abortion With Self-Administered Misoprostol: A Guide For Women, INT'L WOMEN'S HEALTH COALITION, http://www.iwhc.org/index.php?option=com_content&task=view&id=3747&Itemid=614 (last visited Mar. 6, 2013).

^{47.} WORLD HEALTH ORG., THE SELECTION AND USE OF ESSENTIAL MEDICINES 36-38 available http://www.who.int/medicines/services/expertcommittees/essentialmedicines/TRS933Selecti onUseEM.pdf (describing the use of misoprostol for labor induction); Pak Chung Ho et al., Misoprostol for the Termination of Pregnancy with a Live Fetus at 13 to 26 Weeks, 99 INT'L J. GYNECOLOGY & OBSTETRICS S178 (2007) (finding that the dosage must be lower when terminating later term pregnancies, 400 µg vaginally every three hours up to five doses).

^{48.} One interesting self-help site on the web cautions readers as follows: Although misoprostol alone can also be used for second-trimester abortions, the chances of serious complications such as uterine rupture or hemorrhage rise as pregnancy advances. Ready access to emergency care in a medical facility is essential, and women should not attempt an abortion alone. They must also be prepared for the passing of a fetus and placenta at this stage. When bleeding and contractions begin, it is advisable to go to a hospital and report a miscarriage. The hospital may perform a surgical procedure-manual vacuum aspiration or D&C-to complete the process if it does not occur naturally. Women should wipe the vagina clean of all pill fragments (which can last for days) before going to the hospital. In countries where abortion is highly restricted by law, hospital personnel may be required to report all induced abortion attempts to legal authorities.

related infections or hemorrhages.⁴⁹ The real barrier to the use of Misoprostol in El Salvador is not medical risk or lack of availability. Instead, it is price. The going rate for the drug is around \$60 per pill, with advertised recommended dosages ranging from four pills for those whose pregnancies are six weeks or fewer, to six or eight pills for those whose pregnancies are more advanced.⁵⁰ Confusion abounds surrounding dosage for this off-label, black market drug. Indeed, one of the experts whom I interviewed reported that twenty-four pills are needed to insure pregnancy termination.⁵¹

In El Salvador, \$60, let alone \$480 (or more), is a lot of money. The average daily income per person is \$9.⁵² According to data from both the UNDP and the CIA, close to forty percent of El Salvador's population lives in poverty, and the country's wealth is concentrated in the hands of a few families.⁵³ As of 2009, approximately 17% of the population lived on less than \$2 per day.⁵⁴

49. This is not to say that women are not dying from illegal abortions. The World Health Organization reports that unsafe abortion accounts for approximately 13% of all maternal deaths worldwide, and accounts for a higher proportion of maternal deaths in Latin America (17%). In addition to hospital admissions for complications of abortion, which are notoriously hard to document in countries in which abortion is illegal (and thus patients do not acknowledge having attempted to terminate their pregnancies), the WHO notes the lasting problems associated with illegal abortions. They estimate that about 20-30% of unsafe abortions result in reproductive tract infections and that about 20-40% of these result in upper-genital-tract infection and infertility. An estimated 2% of women of reproductive age are infertile as a result of unsafe abortion, and 5% have chronic infections. David Grimes et al., *Unsafe Abortion: The Preventable Pandemic*, 368 LANCET SEXUAL & REPROD. HEALTH SERIES 1908 (2006).

50. See, e.g., SALE OF CYTOTEC IN EL SALVADOR, http://cytotecelsalvador.blogspot.es/(last visited Nov. 6, 2012) (translated from Spanish by the author).

51. Interview with Margarita Rivas, Health Educator and Dir. of Gender Studies at the Univ. of El Sal., in El Sal. (May 25, 2012).

52. At a Glance: El Salvador, UNICEF, http://www.unicef.org/infobycountry/elsalvador_statistics.html (last visited Apr. 30, 2013).

53. Central Intelligence Agency, The World Factbook, El Salvador (2009), available at https://www.cia.gov/library/publications/the-world-factbook/geos/es.html; United Nations Development Programme, Explanatory Note on 2011 HDR Composite Indices: El Salvador (2011), available at http://hdrstats.undp.org/images/explanations/SLV.pdf (explaining composite data from United Nations Development Programme, Human Development Report 2011: Sustainability and Equity: A Better Future for All (2011), available at http://hdr.undp.org/en/media/HDR_2011_EN_Complete.pdf)

54. Povertv Headcount Ratio at \$2 aDay, World http://data.worldbank.org/indicator/SI.POV.2DAY (last visited Mar. 6, 2013). The top 10% of the country earned 37% of income in 2009. Income Share Held by Highest 10%, WORLD BANK, http://data.worldbank.org/indicator/SI.DST.10TH.10 (last visited Mar. 6, 2013). The bottom 10% earned 1% of income in 2009. Income Share Held by Lowest 10%, WORLD BANK, http://data.worldbank.org/indicator/SI.DST.FRST.10 (last visited Mar. 6, 2013). About 43% of the country lived below the national poverty line in 2009. Poverty Headcount National **Poverty** Line, World http://data.worldbank.org/indicator/SI.POV.NAHC/countries (last visited Mar. 6, 2013).

As a result of its high cost, Misoprostol is out of reach for the poorest women in El Salvador. When faced with an unwanted pregnancy, those women determined to terminate their pregnancies resort to traditional methods for bringing on a miscarriage: they insert objects into their cervix, they douche with battery acid, they throw themselves down steps, they punch themselves in the stomach.⁵⁵ Not only are these methods far less effective than Misoprostol; they often leave behind incriminating evidence.

Abortion-related offenses only come to the attention of El Salvador's criminal justice system when something goes wrong and such incriminating evidence is discovered. In the case of abortion, this typically means that a woman wound up in the hospital, bleeding heavily or otherwise in grave health, and that her health care provider suspected self-induced abortion as the likely source of her illness and notified the police.⁵⁶

C. Abortion Law Enforcement in El Salvador

As in the United States, El Salvador does not maintain an official database that tracks criminal indictments, so it is difficult to get data on the frequency with which Salvadoran women are prosecuted, let alone convicted, of abortion. ⁵⁷ In El Salvador, one can gather information about prosecutions only by undertaking to visit the criminal courts where all abortion-related offenses are tried. Two Salvadoran lawyers have undertaken this time-consuming endeavor, travelling across the country and visiting every relevant criminal court. ⁵⁸ Their data, not yet published, indicates that women are indeed being caught and prosecuted for abortion. ⁵⁹ They found 120 cases of abortion

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^{55.} For an account of the various means Salvadoran woman used to terminate an unwanted pregnancy during the year following the ban on abortion, see VARELA ET AL., *su-pra* note 15.

^{56.} Family members and neighbors also are common sources for reports to police about cases of suspected abortion. Neighbors have been known to call police when a woman who looked pregnant now appears to be thinner, yet doesn't have a baby. Family members' reports, by contrast, are generated by 911 calls for emergency health care. Interview with Dra. Diaz in El Sal. (May 22, 2012) (transcription and notes on file with author); Inverview with Dra. Rosario in El Sal. (May 22, 2012) (transcription and notes on file with author).

^{57.} In the United States, one seeking prosecution data for a particular crime must gather information from localities, endeavoring to interview police officers and district attorneys offices to get a sense of their practices regarding arrests, decisions to bring charges and rates of plea bargains. Even among the 10% or so of cases that proceed to trial, the only officially reported cases found on-line are from the subset of convictions that are appealed. Absent an appellate decision or considerable newspaper coverage of a trial, there's no easy way for a member of the public to obtain information in order to gauge the rate at which a given crime is prosecuted.

^{58.} Interview with Angelica Rivas & Sara Garcia Gross in El Sal. (May 23, 2012) [hereinafter Rivas & Garcia Gross interview]; E-mail from Angelica Rivas & Sarah Garcia Gross to author (Nov. 29, 2012) (on file with author).

^{59.} Rivas & Garcia Gross interview, *supra* note 58.

prosecutions in the ten-year time frame from 2000-2010—an average of twelve abortion-prosecutions per year.⁶⁰ When I visited in May 2012, there were twenty-four women incarcerated for abortion-related offenses in the women's prison at Ilopango.⁶¹

Two things are particularly noteworthy about their findings. First, the rate of twelve prosecutions per year is at best a small fraction of the number of abortions taking place in El Salvador.⁶² And second, the majority of the cases were referred to the police from hospitals—specifically, from public hospitals. Indeed, not a single hospital report to police came from the country's private practice doctors or private hospitals.⁶³ The discrepancy between the way physicians treat cases of suspected abortion among public patients, as opposed to private, paying patients, points to a troubling discrepancy in women's expectations of medical confidentiality. Put simply, this pattern suggests that medical confidentiality is not a right, but rather, a commodity.

D. Abortion Ban's Impact on Patient Confidentiality Rights

In order to get a better sense of the intersection between abortion reporting practices in El Salvador and the criminal law, I decided to talk to some El Salvadoran health care providers about how and when women get reported to the police on suspicion of having committed an abortion. Perhaps because it is a small country, or perhaps because it is unusual for anyone from abroad to

^{60.} Id.

^{61.} *Id*.

^{62.} This conclusion is readily derived from the WHO estimates of regional abortion rates. *See* Sedgh et al., *supra* note 23 and accompanying text.

^{63.} Rivas and Garcia Gross interivew, *supra* note 58. The phenomenon of referrals by doctors working at public hospitals has been documented since the ban's enactment. *See* Heathe Luz McNaughton et al., *Patient Privacy and Conflicting Legal and Ethical Obligations in El Salvador: Reporting of Unlawful Abortions*, 96 Am. J. Pub. Health 1927, 1927 (2006). A 2006 survey of practicing obstetricians found that

[[]m]ore than half (56%) of respondents reported that they had been involved in notifying legal authorities about a suspected unlawful abortion. The odds that a respondent had been involved in reporting an unlawful abortion were higher among respondents who worked in the public sector . . . and among those who were not aware that international law protects patient—provider privacy and confidentiality.

Id. at 1929. The authors discuss three possible factors behind the public/private reporting gap:

First, public health institutions are more likely to treat indigent women and adolescents who often resort to unsafe, low-cost, and readily detectable abortion methods (e.g., insertion of foreign objects). Second, private sector providers have an explicit profit motive to protect their individual patients' privacy and avoid legal inconveniences. Finally, because public health care workers are subject to governmental oversight and are susceptible to shifting ministerial politics, they may be more fearful of reprisal if they do not comply with prevailing governmental ideology or policies.

show an interest in how things work in their corner of the world, everyone I contacted agreed to speak with me.

Before describing my interviews, it is worth considering the ethical and legal backdrop created by doctors' conflicting duties of maintaining patients' confidences, preserving life, and reporting suspected crimes. The obligation of safeguarding a patient's privacy is ancient. For over 2400 years, medical doctors have embraced the precepts articulated in the Hippocratic Oath.⁶⁴ Recited at medical school graduations across the globe, one of the Oath's central tenets is the following pledge: "Whatever I see or hear in the lives of my patients, whether in connection with my professional practice or not, which ought not to be spoken of outside, I will keep secret, as considering all such things to be private." ⁶⁵⁵

In El Salvador, as in other countries including the United States, this ethical injunction has been enacted into law, making it a crime to divulge patient information in the absence of the patient's express consent. El Salvador's Health Code section 287 states that breaching patient confidentiality may result in oral reprimand, written reprimand, a fine of up to 100,000 Colones, a five-year suspension, or the loss of one's medical license. El Breach

- a) Amonestación oral privada;
- b) Amonestación escrita;
- c) Multa de mil a cien mil colones, según la gravedad de la infracción;
- ch) Suspensión en el ejercicio profesional, desde un mes hasta cinco años;
- d) Clausura temporal desde un mes hasta el cierre definitivo del establecimiento.

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^{64.} For a detailed history of the Hippocratic Oath and its ongoing relevance, see STEVEN H. MILES, THE HIPPOCRATIC OATH AND THE ETHICS OF MEDICINE (2004).

^{65.} Raphael Hulkower, *The History of the Hippocratic Oath: Outdated, Inauthentic, and Yet Still Relevant*, 41 EINSTEIN J. OF BIOLOGY & MED. 41, 43 (2010), *available at* http://www.einstein.yu.edu/uploadedFiles/EJBM/page41 page44.pdf.

^{66.} See United States v. Wilk, 572 F.3d 1229, 1236 (11th Cir. 2009) (holding that defendant's confidential medical records were admissible at a murder trial where records were obtained either by grand jury subpoena or enforcing order after arrest); Lee v. Superior Court, 99 Cal. Rptr. 3d 712, 734 (4th Dist. Ct. App. 2009) (holding that HIPAA did not protect against the disclosure of private health information to the district attorney as required under the Sexually Violent Predator Act); 45 C.F.R. § 164 (2012); see also HIPAA Privacy Rule, 45 C.F.R. §§ 160-164 (2000) (articulating the privacy rules promulgated by HHS pursuant to HIPAA). HIPAA permits disclosure under certain circumstances including when the covered entity is obligated by law to disclose information or where the information is requested as part of a judicial proceeding. See generally Health Insurance Portability and Accountability Act of 1996 (HIPAA), 29 U.S.C.A. §§ 1181-6039F (1996) (requiring health care providers and health plan to have policies and procedures concerning use and disclosure of protected health information).

^{67.} Codigo de Salud, DECRETO Nº 955 LA ASAMBLEA LEGISLATIVA DE LA REPUBLICA DE EL SAL, Art. 284.—Constituyen infracciones graves contra la salud . . . 2) La revelación del secreto profesional establecido en los Arts. 37 y 38 del presente Código; Art. 287.—Las sanciones disciplinarias que se impondrán a los que cometan las infracciones señaladas en los artículos anteriores son las siguientes:

⁽Health Code, Act No. 955 The Legislature of the republic of El Salvador, Sect. 284—Establish serious violations against health . . . 2) The breach of professional confidentiality

of confidentiality is also a crime. Penal Code section 187 provides that revealing such information is punishable by a sentence of six months to two years in prison and a one- to two-year suspension of the doctor's medical license. 68

These laws exist in tension with both ethical and legal injunctions. The same Hippocratic Oath that demands patient confidentiality also includes provisions such as the following: "I will give no deadly medicine to anyone if asked, nor suggest any such advice; likewise, I will not give a pessary to a woman to induce abortion." As in the case of patient confidentiality, the prohibition on performing an abortion has been enacted into law. Penal Code Section 135 states that any physician who induces or performs an abortion faces six to twelve years in prison.

The problem facing doctors in El Salvador is not simply the injunction against procuring an abortion, but also the broader obligation to report cases of suspected abortion. ⁷¹ Criminal Procedure Code Article 312 resolves the tension

specified in the sections 37 and 38 of this code; Sect. 287.—The disciplinary sanctions to be imposed against those who commit the offenses mentioned in the previous articles are:

- a) Private Oral Reprimand
- b) Written Reprimand
- c) Fine of 1,000 to 100,000 colones depending on the seriousness of the offense
- ch) Suspension from practice, for one month to five years
- d) Temporary closure of one month to permanent closure of the establishment.) (translated by author).
- 100,000 colones converts to roughly \$11,431.83. Currencies Center, YAHOO! FINANCE, http://finance.yahoo.com/currency-converter/#from=USD;to=EUR;amt=1 (last visited Nov. 7, 2012).
- 68. REVELACIÓN DE SECRETO PROFESIONAL Art. 187.- El que revelare un secreto del que se ha impuesto en razón de su profesión u oficio, será sancionado con prisión de seis meses a dos años e inhabilitación especial de profesión u oficio de uno a dos años, available at http://www.oas.org/dil/esp/Codigo_Penal_El_Salvador.pdf. (Breach of Professional Confidentiality section 187. Revealing private information that has been obtained because of profession or trade, shall be punished with imprisonment for six months to two years and the disqualification of profession or occupation for one to two years).
- 69. There is some debate as to the meaning of the prohibition on using a "pessary" (vaginal suppository) to bring about an abortion. Although some see this clause as a blanket injunction against abortions, others argue that this particular method was considered more dangerous to women than other methods of terminating pregnancy. Joyce Arthur, *Hypocrisy and the Hipporatic Oath*, Humanist in Canada (July 2009), http://mypage.direct.ca/w/writer/hippo.html.
- 70. Republica de El Salvador, CÓDIGOS PENAL. EDITORIAL JURÍDICA SALVADOREÑA; 2001. CÓDIGO PENAL, Art. 135 (2001) ("Any doctor, pharmacist or person who carries out activities related to said professions, who performs an abortion, shall be sentenced to six to twelve years in prison. They shall also be suspended from practicing their profession for the same period.") (translated by author).
- 71. Salvadoran law does not explicitly state that providers must report suspected abortion, however, health care workers are obliged to report injuries that result from criminal acts perpetrated against their patients. Because abortion is a "criminal act," this requirement could be construed to mean that providers are obliged to report unlawful abortion. *See* Republica de El Salvador, Códigos Penal y Procesal: Ley Penitenciaria y su

between these competing obligations by freeing doctors of the duty to report crimes when knowledge thereof is acquired by way of patient confidentiality.⁷²

At the end of the day, a doctor must choose between two conflicting precepts. There are legal risks on both sides. The doctor who fails to report a patient suspected of having intentionally terminated her pregnancy risks prosecution and civil sanctions, even though Penal Code Section 232 provides a legal defense for inaction. Likewise, the doctor who reports a patient may face civil and criminal sanctions for revealing confidential patient information. The would be interesting to see how the legal system might respond to these competing sanctions, but for now the question remains hypothetical. Few in El Salvador have heard of any cases brought against doctors for either keeping or breaching abortion-related patient confidences. Instead, a real-world pragmatism seems to inform whether and when doctors report patients to the police.

REGLAMENTO. EDITORIAL JURÍDICA SALVADOREÑA; 2001. CÓDIGO PENAL, Art, 312 (2001) ("El funcionario o empleado público, agente de autoridad pública que en el ejercicio de sus funciones o con ocasión de ellas, tuviere conocimiento de haberse perpetrado un hecho punible y omitiendo dar aviso dentro del plazo de 24 horas al funcionario competente, será sancionado con 50 a 100 días multa. Igual sanción se impondrá al jefe o persona encargada de un centro hospitalario, clínica u otro establecimiento semejante, público o privado, que no informare al funcionario competente del ingreso de una persona lesionada dentro de las 8 horas siguientes al mismo, en casos que racionalmente deberán considerarse como provenientes de un delito." (A functionary or public employee, agent of public authority who becomes aware of an unlawful act during the exercise of his or her responsibilities and does not report it within 24 hours will be levied a fine of between 50 and 100 days' pay. The same punishment will be applied to the supervisor or manager of a hospital, health center or other public or private establishment that does not report admitting a patient who was injured in what could reasonably be considered a criminal act within 8 hours of seeking care)) (translated by author).

72. See Republica de El Salvador, Código de Salud (con reformas incorporadas). Republica de El Salvador. Códigos Penal y Procesal: Ley penitenciaria y su reglamento. Editorial Jurídica Salvadoreña; 2001. Código Penal, Art. 232 (2001) ("Tendrán la obligación de denunciar los delitos de acción pública: . . . 2) Los médicos, farmacéuticos, enfermeros o demás personas que ejerzan profesiones relacionadas con la salud, que conozcan esos hechos al prestar los auxilios de su profesión, SALVO que el conocimiento adquirido por ellos este bajo el amparo del secreto profesional" (Doctors, pharmacists, nurses and other health professionals must report unlawful criminal acts that they become aware of in the context of their professional relationship, unless the information they acquire is protected under the terms of professional secrecy)) (emphasis added) (translated by author).

73. For a thorough discussion of these conflicting laws, see Heathe Luz McNaughton et al., Patient Privacy and Conflicting Legal and Ethical Obligations in El Salvador: Reporting of Unlawful Abortions, 96 Am. J. Pub. Health 1927, 1932 (2006).

74. My search of El Salvador's legal databases did not reveal a single case, nor did any of the abortion rights advocates, doctors or defense lawyers I interviewed know of a prosecution or sanction on either grounds. One of the doctors I met mentioned hearing of an incident in which a law student reported her doctor to the police for breach of confidentiality. Apparently, an emergency room doctor notified the police because she suspected the young woman had terminated her pregnancy. No one seems to know whether the incident actually happened, let alone how it was resolved.

E. Doctors Role in Abortion Law Enforcement

Even if abortion laws fail to lower a country's rate of abortions, one of the most significant things they do alter is the relationship between women and their doctors. If one views the fetus as a person, then the obstetrician has two patients—the pregnant woman and her fetus.⁷⁵ Recognizing the fetus as a second patient alters the fiduciary relationship between doctor and patient, obligating the doctor to attend to the fetus's wellbeing, even if doing so requires the doctor to protect fetuses from their mothers. This limit on patient confidentiality is not unfamiliar; pediatricians scan their patients for signs of parental child abuse or neglect. But parents hire pediatricians to care for their children, whereas women seek out obstetricians for their own care.

I wondered how doctors in El Salvador decided when their duty to safeguard confidentiality should give way to their duty to protect a fetus or to their obligations to report a suspected crime. I decided to speak to two doctors, as I wanted to get at least two different perspectives on the doctor's role in abortion law enforcement. The first is Dra. Rosario, a seasoned obstetrician and an outspoken advocate of abortion law reform in El Salvador. The second is Dr. Diaz, a comparatively unknown obstetrician. He came to my attention only because his name appeared as the attending physician in the transcripts of a controversial abortion-related prosecution.

1. Interview with Dra. Rosario

I met Dra. Rosario through my encounters with the small but resilient group of abortion-reform advocates in El Salvador (La Agrupación Ciudana).⁷⁷ Born into a medical family and raised in San Salvador, Dra. Rosario is

^{75.} Indeed, U.S. hospitals have embraced the name "maternal-fetal health centers," ignoring the manner in which it compromises doctors fiduciary duty to their pregnant patient by incorporating a duty to the fetus, a second patient. Unsurprisingly, doctors and their pregnant patients occasionally disagree about a given course of treatment. These conflicts have been termed "maternal-fetal" conflicts, eclipsing the fact that the conflict is between the doctor and his or her pregnant patient. See Michelle Oberman, Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts, 94 Nw. U. L. REV. 451, 469-77 (2000).

^{76.} I've chosen to refer to both doctors by pseudonyms.

^{77.} La Agrupación Ciudana was formed in 2009, an outgrowth of the second binational meeting on abortion rights, organized by Morena Herera of El Salvador, and several Nicaraguan advocates. The Agrupacion is marked by its determination to forge a popular constituency for legalized "ethical, eugenic and therapeutic abortion," rather than electing to force the hand of the government as a signatory to various human rights treaties now interpreted as mandating an exception in the case of threat to maternal life. AGRUPACION CIUDADANA, http://agrupacionciudadana.org (last visited Nov. 6, 2012). For a description of the variety of international and domestic laws that have been invoked to secure this exception, see Nancy Northup, Symposium Volume: New Scholarship On Reproductive Rights: Introduction, 18 COLUM. J. GENDER & L. 391, 395-402 (2009).

powerful woman who has served in the Ministry of Health, as well as on the faculty of a prominent medical school. Her office is in one of the many tall office buildings in the Colonia Médica neighborhood, where the country's most important private medical practices are arrayed around a small circular patch of grass, marked by a statue of an enormous golden hand cradling a tiny baby in its palm.

"Can you tell me about doctor-patient confidentiality rights in El Salvador?" I asked, having decided to start with a generic medical ethics question. 78

I needn't have worried about putting her on the defensive. Dra. Rosario looked me straight in the eye and answered. "Here, the right to confidentiality comes with a price tag. Patients at the private hospitals buy their privacy—no one ever reveals their secrets. You could lose your medical license and spend three to six years in prison for breaching patient confidentiality. And besides, they're your patients—you know them, or their families, or their friends. Your reputation and your livelihood depend on them."

"What percentage of Salvadorans go to private doctors and hospitals?"

"Three percent. Maybe five percent." She smiled and shook her head when she saw the look on my face.

All the elevator buildings in the Colonia Medica, plus several hospitals including one devoted entirely to maternity care, serve approximately 300,000 of the country's six million residents.⁷⁹

Dra. Rosario continued, "Eighty percent of Salvadorans get their care from public hospitals, located throughout the country. The rest go to social security hospitals and doctors, and they get something in between."

It wasn't so foreign, really. Almost twenty percent of Americans lack health insurance, and get their care where they can, when they can. ⁸⁰ Add to that Americans receiving health care via Medicaid and the Veteran's Administration, and the picture becomes still more familiar. Generally speaking, we, too, live in a tiered health care system.

Nonetheless, in the States no one thinks patients paid for by public funds should have fewer rights to confidentiality than private-paying patients.⁸¹

^{78.} Interview with Dra. Rosario in El Sal. (May 22, 2012) (transcription and notes on file with author).

^{79.} *Id*.

^{80.} Emily Carrier, et al., The Uninsured and Their Health Care Needs, Kaiser Family Foundation (Oct. 2011), available at http://www.kff.org/uninsured/upload/8246.pdf; Sonya Streeter, et al., The Uninsured, Kaiser Family Found. (Oct. 2012), available at http://www.kff.org/uninsured/upload/7451-08.pdf; Five Facts About the Uninsured Population, Kaiser Family Foundation (Sept. 2012), available at http://www.kff.org/uninsured/upload/7806-05.pdf.

^{81.} The fact that the most blatant violations of confidentiality in recent years occurred in public hospitals is not unique to El Salvador. *See, e.g.*, Ferguson v. City of Charleston, 532 U.S. 67 (2001) (holding that a urine test conducted by the hospital in conjunction with

"Why aren't the doctors in public hospitals worried about the consequences of breaching patient confidentiality when they report women for abortion?" I asked.

"Well, a lot of doctors think they're obligated to report women they suspect of having done something to terminate their pregnancies; they do it because they think the law says they must. And then there are those who report because they really believe it's a terrible crime to terminate a pregnancy and they want to see the law enforced. And of course, doctors in public hospitals typically are young, hoping to build a reputation and then to start a private practice. They'll do what they need to do to avoid conflict with their nurses or their superiors."

"Do women know the public hospital doctors might report them?"

"It depends," said Dra. Rosario. "Some of them are savvy enough to know exactly what sort of things separate the public from the private hospitals. But my guess is that most women don't know. No one talks much about abortion or the law, and even if they knew, poor women seek care at public hospitals simply because they're bleeding to death and they have no other option."

Dra. Rosario had done little to conceal her bias in favor of patient confidentiality. I wondered if the confidentiality principles posed more of a concern to those health care providers who believed abortion should be illegal.

2. Dr. Diaz's Interview

I knew it would be difficult to find a doctor willing to speak openly about breaching patient confidentiality. Moreover, because abortion indictments and prosecutions are unpublished, I lacked easy access to the names of doctors who served as witnesses in these cases. 82 In my case, I caught a break, although I didn't know why until later.

Several years ago, a controversial abortion prosecution appeared in the international press. With some help, I managed to follow up on the case and to

law enforcement absent the patient's consent was a violation of the Fourth Amendment right to be free from unreasonable searches).

The use of criminal sanctions in the public hospital setting disproportionately affects poor, minority women. *See generally* Michele Goodwin, *Prosecuting the Womb*, 76 GEO. WASH. L. REV. 1657, 1661 (2008) (describing how fetal drug laws are inconsistent, ineffective, and exempt reproductive practices by affluent groups that are equally risky to the unborn fetus); Dorothy E. Roberts, *Punishing Drug Addicts Who Have Babies: Women of Color, Equality, and the Right of Privacy*, 104 HARV. L. REV. 1419 (1991) (arguing that given the historical context of devaluing black mothers, prosecuting these women violates their equal protection and privacy rights regarding reproductive choices).

82. See Rivas & Garcia Gross interview, *supra* note 58 and accompanying text for a description of the labor-intensive empirical work undertaken by Angelica Rivas and Sarah Gross, who sought simply to identify cases in which abortion was prosecuted. Identifying medical witnesses would be more challenging still, as it would require the production of transcripts—a cost-prohibitive and tediously time-consuming endeavor.

track down the attending physician mentioned in the transcript. At the time, he'd been a young attending physician at one of three public hospitals that serve San Salvador's poor. He became involved in the prosecution when a mother brought her twenty-five-year-old daughter to the hospital, hemorrhaging and passing blood clots. ⁸³ Upon examination, Dr. Diaz found evidence of both uterine enlargement and placental tissue in her vaginal cavity. According to the daughter, Dr. Diaz called police after examining her. ⁸⁴ All that's known for certain is that, within hours of her admission, police arrived at her mother's apartment and that her mother permitted them to search her home, where they found a dead baby. ⁸⁵

Ten years later, I found Dr. Diaz's contact information online, and he agreed to meet with me. I didn't understand the source of my good fortune in securing the interview until I got to his office and saw a Jewish candelabra on his desk. "What's this?" I asked, surprised to see the menorah given that current estimates suggest no more than 200 Jews live in the entire country. Br. Diaz responded that he was a Converso—part of a long line of Jews who sought refuge from the 1492 Spanish Inquisition by hiding their religious identity and practices. He said he'd guessed I was Jewish from my name (he had guessed correctly, although I'd never considered my surname, created at Ellis Island two generations ago, to be particularly Jewish). "That's why I agreed to meet you," he told me. We chatted a little in broken Hebrew, and, oddly moved, I turned to the conversation at hand.

Dr. Diaz remembered the sequence of events around the reporting differently than did the defendant:

"It was her mother who found out about the baby when she noticed blood underneath the bed, and it was the mother who pressed charges. In any case, all we did was come and perform some tests to figure out if the woman had been

^{83.} In order to protect his identity, I have not used the names of those involved in this prosecution.

^{84.} This chronology of events is according to the Defendant. Interview with Defendant (June 2, 2011). The trial record is less clear about the sequence of events, noting only that a police officer responded to a 911 call and found a dead baby under her bed. 2002 Spanish-Language Ruling in El Salavdoran Infanticide Case re: Carmen Climaco, LIFESITENEWS.COM (Nov. 28, 2006), http://www.lifesitenews.com/news/archive/ldn/2006/nov/061128a. It is clear that Karina's mother permitted the officer to enter her home; what's unclear is whether she summoned the officer, or whether Dr. Diaz notified the police.

^{85.} *Id*

^{86.} *Jewish Diaspora: Country Trends*, HISTORICAL BOY'S CLOTHING, (May 20, 2009, 3:20 AM), http://histclo.com/act/rel/faith/jew/dis/jdcs.html.

^{87.} For a detailed history of Conversos in the Iberian Peninsula, see Jose Faur, IN THE SHADOW OF HISTORY: JEWS AND CONVERSOS AT THE DAWN OF MODERNITY (1992) (analyzing the effect of Conversos on Judaism and Christianity); see also Norman Rith, CONVERSOS, INQUISITION, AND THE EXPULSION OF THE JEWS FROM SPAIN (2002).

pregnant. It didn't mean we were going to call the police, but somehow the police got there at that moment."88

"Would you have reported her, though?"

"Now," he answered, "we are supposed to protect what our patients tell us and we do."

"Even though the law says that you have to report it?" I asked. "It's contradictory."

"Yes," he answered, "And I have to be sincere with what I am about to say, but in El Salvador the law is not applied to everyone, but rather only to certain individuals. For example, in private hospitals things are done where no one really knows what happened except for the doctor and the patient."

Dr. Diaz is now in private practice; his office is in the same neighborhood as Dra. Rosario's. Unlike Dra. Rosario, Dr. Diaz has strong feelings against abortion. I probed in search of his responses to the conventional "hard cases" of rape and incest. In response, he described a patient whom he had attended during his residency.

"After giving birth she would cry all the time, just crying and crying. And I asked her one day why she was crying and she said, 'I was not supposed to have this child. I was raped and this child is the product of that."

"And how did you respond?" I asked.

"In all honesty if you ask me, I cannot agree with abortion. But I do believe this: first, that girls like her should have the opportunity to rely on the law to seek justice against those who raped her. Second, that there should be a system in place that would allow for these unwanted babies. For both of them."

Of course, El Salvador prosecutes rape and supports legalized adoption. The reality, there and here, is that the success of these legal mechanisms depends upon social and cultural perceptions of those who participate in them. Rape laws are antiquated and under-enforced. Adoption laws within the country are undergoing modernization in areas such as permitting access to information for adoptees, yet in contrast to other countries in the region,

^{88.} Interview with Dr. Marco Diaz in El Sal. (May 23, 2012). In asserting that the Defendant's mother pressed charges against her daughter, Dr. Diaz made the common mistake of confusing civil and criminal charges. Even if her mother had found the baby and called the police, as opposed to simply permitting them to enter and search her apartment, in criminal actions it is the state that presses criminal charges.

^{89.} For a detailed analysis of the origins of rape law in the region, focusing specifically on Nicaragua, see Martha I. Morgan, *The Bitter And The Sweet: Feminist Efforts To Reform Nicaraguan Rape And Sodomy Laws*, 26 U. MIAMI INTER-AM. L. REV. 439, 449-50 (1994-95). For a broad description of Latin America's culture of machismo and the extent to which it informs law enforcement of crimes against women, see Patricia M. Hernandez *The Myth Of Machismo: An Everyday Reality For Latin American Women*, 15 St. Thomas L. Rev. 859 (2003).

relatively few Salvadoran children are relinquished for international adoptions. $^{90}\,$

Rather than explore those issues, I wanted to probe Dr. Diaz's comfort level with the outright ban on abortion.

"How does it feel as a doctor to see a ten-year-old girl, pregnant as the result of incest?" I asked.

"The law here is very strict," he replied. "It says that you can never terminate a pregnancy. There is never an extenuating circumstance. . . . In my medical view, I'd say it was worth it to allow her to have that baby. I've seen people who during the pregnancy it was bad because of situations like those, but when the baby is born, the woman's life is completely transformed. I've seen women who now come, well yes they do need support, and that's what they don't have here. You can have a difficult situation, but as long as you're supported you will continue to go forward. You'll be able to overcome any obstacle."

My conversation with Dr. Diaz shook me at many levels. It was oddly refreshing to meet someone who supported the abortion law. He was troubled not by the law's failure to make exceptions in hard cases like incest, which quite honestly have nothing to do with the fetus's moral status. Instead, he was bothered by the hypocrisy that marks the law's enforcement. And yet, Dr. Diaz was unwilling to acknowledge that he'd ever divulged patient confidences, whether in the past or today, in his private practice.

For purposes of understanding how the crime of abortion gets prosecuted in El Salvador, I could not help but be stunned by Dr. Diaz's agreement with Dra. Rosario that a doctor's choice between reporting and maintaining confidentiality depends not so much upon the doctor's beliefs regarding abortion, but rather, upon whether the patient is a paying patient in a private clinic or hospital, or is a poor woman forced to seek care at a public facility.

In order to understand how abortion prosecutions actually work their way from the emergency room through the legal system, I would need to find an actual case. In this endeavor, as in all others, the warmth and interconnectedness of the Salvadorans I met made my task easy.

^{90.} El Salvador: ARTICLE 19 Applauds Adoption of Acces to Public Information Law, INFORMATION POLICY (Dec. 9, 2010), http://www.i-policy.org/2010/12/el-salvador-article-19-applauds-adoption-of-access-to-public-information-law.html (regarding law reform permitting access to information for adoptees). Compare the number of children adopted from Guatemala in 2007 (4728) with the number adopted from El Salvador in the same year (16). Compare Guatemala Adoption, Adoptive Families (2008),

http://www.adoptivefamilies.com/guatemala_adoption.php (last visited Apr. 30, 2013), with El Salvador, Intercountry Adoption: Bureau of Consular Affairs—U.S. Department of State, http://adoption.state.gov/country_information/country_specific_info.php?country-select=el_salvador (last visited Apr. 30, 2013).

II. FROM THE HOSPITAL TO THE COURT ROOM TO PRISON: A CASE STUDY

I wanted to know how it happened—the way in which a woman could present to an emergency room for care and find herself under arrest for suspected abortion. Early on in my research I met Dennis Muñoz, a seemingly fearless young defense lawyer who had handled several abortion-related cases in his career. He took me to meet Cristina, his former client.

A. Cristina's World

We sat, her lawyer Dennis and I, in plastic lawn chairs at the dining room table in her grandmother's *sala*. Cristina beamed as her 10 year-old son served us the small fish she'd fried over the single gas burner in the corner kitchen. Her grandmother, the woman who'd raised her, stood outside scrubbing clothes under the faucet in the concrete trough. Cristina's nineteen-month-old daughter slept in a striped hammock.

The rice and tortillas on our plates and our glasses filled with Coke, Cristina sat in the second hammock, facing us. My cotton shirt clung to me and I angled my chair in search of the fan's promise of a current. Her son had moved to the far end of the room where an American movie was playing on the television.

Cristina began her story at the point where she was eighteen and expecting her second child. Several months into her pregnancy, she'd moved to San Salvador with her son, living in the second bedroom of her mother and step-father's apartment so that she'd be close to the public hospital when her baby came. Her boyfriend, Carlos Reyes, was in his mid-thirties. He had returned to the United States in order to maintain his work permit, but he called often and he sent money—sometimes as much as \$100—every month. Cristina had begun using his surname, and they both were excited about their baby. Because she was underage, Cristina's small salary from her occasional work as a maid and Carlos's money orders were written to the accounts of third parties who would then give Cristina the cash. By Salvadoran standards, Cristina did not consider herself poor.

It was Saturday, October 23, 2004. Earlier that week, Cristina and her mother had shopped for new linens and baby clothes, having decided to invest the money they'd otherwise have spent on a baby shower. As her mother prepared to leave for work, Cristina mentioned that she'd had diarrhea earlier that morning. Neither she nor her mother was alarmed, though. Cristina had had stomach problems regularly since her appendix burst, about a year before, and her baby wasn't due for another month or so.

After dinner, when her mother returned from her shift at the tortilla factory, Cristina mentioned that her stomach was upset. She lay down on the bed she shared with her four-year old son. She felt sick, but it didn't feel like she was

having contractions; she knew because she remembered how they'd felt four years before.

Several hours later, she got out of bed and told her mother she couldn't sleep. Her mother had her drink tea with sugar.

In the middle of the night Cristina awakened with the sense that she had to go to the bathroom. She sat up in bed and felt a sudden, tremendous pain. The apartment was so small that she managed to make her way to the bathroom by dragging herself, one hand on each wall. She felt she was drowning. She felt she was suffocating. The last thing she remembers is struggling to push open the metal bathroom door.

She woke up in a hospital bed where a woman stood over her demanding, "Y el bebé?" Her bed was moved to another room, or perhaps just to the back corner of the open birth ward. Cristina doesn't remember. Three new faces appeared at her bedside, asking, "What's your name? Where do you live? How many months pregnant were you?" She kept falling asleep, and they kept shaking her awake, saying, "You have to answer us." It took her some time to realize they were not nurses but police investigators, and that she was under arrest.

She stayed two or three days at the hospital and then was transferred, handcuffed and still bleeding, to the Ilopango police station.

Between interrogations and while awaiting her preliminary hearing, she lay on the dirt floor of a fifteen by fifteen foot cell, trying to understand how she'd come to be charged with killing her newborn. There were no mattresses on the cell floor; her eight cellmates told her there was supposed to be a cushion for each woman. Still, she realized she was lucky. The other cells had ten women in them.

At her preliminary hearing, presided over by a justice of the peace, she learned that the state had charged her with homicide because her fetus's gestational age was beyond seven months. According to the state's theory of the case, once a woman experiences labor pains, she cannot mistake them for any other sort of pain. Cristina, they claimed, killed her child by not telling someone she was in labor, as she must have known, having given birth once before.

The justice of the peace told the prosecutor to respect Cristina's loss. He dismissed the case for lack of proof. The prosecution did not meet the elements of the charged crime and had presented illogical, incoherent theories.

Fifteen days later, her case was re-opened and Cristina was placed under state supervision pending her trial. She met her new public defender on the day of her preliminary hearing. Cristina didn't know what happened to her former lawyer, but the new one had not read her file, didn't know the charges against her, nor had she even bothered to learn Cristina's name. The state had charged her with *homicidio culposo*—our version of manslaughter—which carried a potential penalty of two to eight years.

At trial, her lawyer failed to object when the judges decided to convict Cristina of a far more serious crime than the one with which she had been charged: *homicidio aggravado*, or aggravated homicide. The judges claimed her crime merited this charge, given the innocence of the victim, the fact that dilation takes twelve hours, that, as an experienced mother, Cristina must have known she was in labor, and most importantly, that Cristina's failure to take precautionary actions led to the baby's death. Unlike *homicidio culposo*, this crime carried a thirty to fifty year sentence. Cristina received a thirty year sentence. Her lawyer declined to appeal.

Inside Ilopango, Cristina met other women who'd been convicted of similar crimes. There were perhaps eight such women out of the hundreds in prison with her. Among those eight, Cristina didn't distinguish between those who'd miscarried and those who'd purposely terminated their pregnancies. Nor did she distinguish between those who were convicted of abortion, and sentenced to a maximum of four years, and those whose fetuses were seven months or older at the time of their demise, and who were convicted of homicide. They stuck together, or at least Cristina tried to help them out.

The drug traffickers and mass murderers were treated the best, she told me. The other inmates applauded them. The worst treatment, by contrast, was reserved for those who had killed their children. "*Te comiste a tus hijos*," ("You ate your children"), they called out in passing to her and to the others incarcerated for abortion-related offenses.

^{91.} A brief search of the medical literature regarding precipitous labor and delivery offers textbook cases of preterm deliveries like Cristina's. See REBECCA G. STEPHENSON & LINDA J. O'CONNOR, OBSTETRIC AND GYNECOLOGIC CARE IN PHYSICAL THERAPY (2d ed. 2000) 248 ("Precipitous labor occurs in 10% of all deliveries. This indicates completion of the first and second stages of labor in less than 1 hour. It occurs more in multiparas than in primigravidas. The infant is sometimes injured during this rapid, uncontrolled labor because of the force on the presenting part. . . . There is no known etiology for precipitous labor."). I spoke with Dr. Anne Drapkin Lyerly about Cristina's case. Dr. Drapkin Lyerly, a professor of Social Medicine and Obstretrics and Gynecology at the University of North Carolina, offered several explanations for what might have happened to cause Cristina's miscarriage. "My first guess," she said, "involves infection. The fact that she had ongoing gastrointestinal problems is a common sign of infection. In pregnant women, such infections can spread to the amniotic sac, leading to precipitous delivery and/or miscarriage." She added that a quick pathology investigation of the placenta would have revealed the presence or absence of infection. In Cristina's case, no such examination was performed. Dr. Drapkin Lyerly was particularly troubled by the court's logic in blaming Cristina for not recognizing stomach pains as labor pains. "There's no logic to the court's position," she said. "There no reason why she should have known it was labor, and a lot of reasons why she shouldn't have—her history of gastro-intestinal trouble actually means she was unlikely to know it was different; women deliver precipitously all the time, vaginal birth changes the musculature such that later deliveries tend to be much faster than first-time births. And given that she was a month away from her due date, she was more likely to think she was not in labor." Telephone interview with Dr. Anne Drapkin Lyerly, Assoc. Professor of Social Med. and Obstretrics and Gynecology, Univ. of N.C. (Aug. 2, 2012).

She met my friend Dennis, the lawyer who secured her release, after she'd served almost two years of her sentence. She showed him her certificates of good behavior and her new high school diploma, which she'd managed to earn in spite of having entered prison with only a ninth-grade education. To hear her tell it, his arrival did not surprise her. She knew she was innocent and although she does not describe herself as a religious person, she had never lost faith that she'd be free again.

B. What Cristina's Case Has to Do with Abortion

On the rutted Jeep ride back to San Salvador, I asked Dennis what Cristina's case had to do with abortion prosecutions. As I saw it, he'd won a reversal of a wrongful conviction—expensive and challenging work, to be sure—but the underlying case could have involved any crime. I didn't want to detract from the victory he'd secured, but I'd been coming to El Salvador for several years in order to study the enforcement and impact of abortion laws. I couldn't quite figure out what he wanted to me to learn about abortion law from Cristina's case. She hadn't had an abortion, after all.

At first, Dennis didn't understand my question. In Spanish, there is no difference between the word for miscarriage and the word for abortion. Any interruption of pregnancy is termed an *aborto*. If one wants to get technical about it, one can say *aborto provocado* to denote an intentional abortion, but in casual conversation, no one bothers to distinguish the two concepts.

"These are all abortion cases," he explained to me. "A woman whose fetus was under seven months gestation is charged with abortion, and if the fetus is over seven months, it's called homicide because the fetus was viable."

"But aren't there thousands more cases involving women who commit abortion—you know, like a woman who didn't want to have a child, so she took drugs or found a doctor or someone to give her an abortion when she was three months pregnant?"

Dennis answered me in the pragmatic way of lawyers. "Yes, there are many abortions in El Salvador for sure. But how do you prosecute them without evidence? There's a rule here called *corpus delecti*," he said, and he reminded me of the old criminal law principle requiring the state to prove that a crime has taken place. ⁹²

"It's much easier to prove the crime if you have a body," he remarked. "To catch an early abortion, you need evidence that it's provoked. Undissolved pills in the vagina or a perforated uterus. There has to be some evidence. I've heard of cases like that—I even have one now. My client put pills in her vagina and then regretted her decision and went to a public hospital, where they reported

^{92.} As applied in homicide cases, the term *corpus delecti* has at least two component elements: the fact of death, and the criminal act or agency of another person as the cause thereof. 40 Am. Jur. 2d *Homicide* § 4 (2013).

her to the police for attempted abortion. She's facing two to eight years, but I think we'll make a plea bargain and hopefully she'll just get probation. Honestly, though, her case is the exception. Most abortion prosecutions involve pregnancies that are much farther along."

C. Medical Emergencies, Abortion Laws and Probable Cause

What connects Cristina's prosecution to abortion law in the larger sense is not her wrongful conviction, but the way in which she was treated when she arrived at the hospital hemorrhaging. Because abortion is always a criminal act, any woman who presents to a hospital bleeding from her vagina is suspected of having committed an abortion. The practical impact of criminalizing abortion is to shift the burden of proof to the woman, who must persuade her doctor that she did not provoke the bleeding. There are many causes for vaginal bleeding, though, and it is difficult to diagnose its source, ⁹³ particularly when one is sick enough to require emergency care and poor enough to have sought such care at a public hospital. It's no wonder that there are cases like Cristina's, in which a woman who suffered a miscarriage is prosecuted.

As is reflected in the study of El Salvadoran abortion prosecutions and in the comments of the doctors I interviewed, the hospital, or at least the public hospital, has compromised its status as a refuge for the sick. At least for women experiencing vaginal bleeding, it is also a locus for crime detection. ⁹⁴

^{93.} Vaginal bleeding affects 20% to 30% of all pregnancies in the first trimester. Dvne. MD. Bleeding During Pregnancy, E-MEDICINE http://www.emedicinehealth.com/pregnancy bleeding/article em.htm. In small amounts this may be something normal and harmless including implantation bleeding (spotting associated with implantation of the embryo into the uterine wall) and post-coital bleeding (bleeding after intercourse) or threatened miscarriage that poses a risk of losing the baby. Id. Miscarriages occur in up to 50% of those who bleed and may take the form of a completed miscarriage, incomplete miscarriage, blighted ovum (the embryo has failed to develop properly in the proper location), intrauterine fetal demise (the developing babies dies in the uterus), ectopic pregnancy (the fertilized egg implants outside the uterus, usually in the Fallopian tube), or a molar pregnancy (abnormal tissue inside uterus rather than a developing fetus). Id. Bleeding in the second and third trimesters is much more dangerous and may be a symptom of placenta previa (the placenta partially or completely covers the cervical opening), placenta abruption (placenta separates from the uterus prematurely), uterine rupture (abnormal splitting open of the uterus causing the baby to be partially or completely expelled into the abdomen), or fetal vessel rupture (the baby's blood vessels from the umbilical cord attach to the membranes instead of the placenta and pass over the entry to the birth canal). Id. In all cases diagnosis involves thorough physical exam and review of medical history and often laboratory and ultrasound tests. Id.

^{94.} See McNaughton et al., supra, note 63 (documenting public hospitals as a source of police reports).

III. EL SALVADOR'S EXPERIENCE AND IMPLICATIONS FOR U.S. ADVOCATES OF ABORTION RESTRICTION

In this Part, I turn to the question of what the United States might learn from El Salvador's experience with criminalizing abortion. In so doing, I wish to address those who are in the majority in the United States—those who favor making abortion illegal under some, most, or all circumstances. I recognize that nothing I learned in El Salvador will alter the stance of those whose support for an outright ban stems from their belief that terminating fetal development should be illegal under all circumstances, regardless of whether the life in question is non-viable. Adherents to this absolute position are relatively rare in the United States, though. Instead, the overwhelming majority of Americans would permit some exceptions to a ban on abortion—such as cases in which pregnancy threatens the mother's life or cases in which the fetus is non-viable.

I also recognize that the United States might try other routes to criminalize abortion, rather than adopting El Salvador's comprehensive approach wherein both women who terminate their pregnancies and those who assist them are punished for the crime of abortion. Even if the United States were to focus its abortion crime on doctors though, the ostensible purposes of such a law would be to reduce access to and incidence of abortion. As such, for purposes of this Article, it is a distinction without a difference. The questions I ask in this Part involve what, if anything, we can glean from El Salvador's experience with banning abortion?

A. Federalism and Access to Abortion

Federalism is perhaps the most obvious factor to bear in mind when considering what El Salvador's experience with abortion laws portends for the United States. If *Roe v. Wade* is reversed, the result will not be a national ban on abortion, but rather, a system wherein each state might determine when and whether abortion should be legal. As such, matters of class and geography will determine whether a woman has access to safe and legal abortion.

It already is the case that poor women, particularly if they are located in states with few or no abortion providers, face greater obstacles in pursuing an

^{95.} Only 13% of those surveyed in a June 2011 Gallup Poll endorsed banning abortion even when the pregnancy endangered the woman's life. *Abortion*, GALLUP, http://www.gallup.com/poll/1576/abortion.aspx#2 (last visited May 1, 2013). Although I have yet to find a poll that asks those who would ban abortion even if a woman's life was in danger whether they would permit the termination of a *non-viable pregnancy* that threatened a woman's life, one would have to assume that the number would be less than 13%.

^{96.} Saad, supra note 2.

abortion than do their wealthier U.S. sisters. ⁹⁷ Harris v. McRae, ⁹⁸ the U.S. Supreme Court decision permitting states to deny Medicaid funding for abortions, established a de facto class-based limitation on access to abortion. ⁹⁹ Limited insurance coverage, coupled with political opposition to abortion, have raised the costs of obtaining an abortion for women living in states in which the majority oppose unqualified access to legalized abortion. ¹⁰⁰

Should abortion become illegal in a given state, we likely would see an amplification of existing disparities in access. As we have seen throughout history, abortion is a demand-driven commodity, and women will continue to find ways to terminate unwanted pregnancies. Wealthier women would engage in abortion-related tourism when seeking to terminate their pregnancies.

99. Recent data indicate the economic toll taken on poor women who seek abortion is a real one. See, e.g., Rachel K. Jones & Megan L. Kavanaugh, Changes in Abortion Rates Between 2000 and 2008 and Lifetime Incidence of Abortion, 117 Obstetrics & Gynecology 1358 (June 2011), http://journals.lww.com/greenjournal/Fulltext/2011/06000/Changes_in_Abortion_Rates_Bet ween_2000_and_2008.14.aspx; Heather D. Boonstra, The Heart of the Matter: Public Funding of Abortion for Poor Women in the United States, Guttmacher Pol'y Rev., (Winter 2007), http://www.guttmacher.org/pubs/gpr/10/1/gpr100112.html. For a discussion regarding the controversy stirred by the Affordable Care Act's provisions about insurance and abortion and contraceptive coverage, see, for example, Wayne Greene, Hobby Lobby Founders Sue over Affordable Care Act's Birth Control Mandate, Tulsa World (Sep. 12, 2012),

http://www.tulsaworld.com/news/article.aspx?subjectid=336&articleid=20120912_336_0_O KLAHO188633. A study among at-risk teens underscored the connection between abortion rates and the cost of contraception. By providing access to free contraception, researchers in St. Louis reduced the abortion rates by over 60%, from 7.5 to 4.4 per thousand women, as compared to the national rate of 19.6 per thousand women. *Abortion Rates Plummet with Free Birth Control*, E! SCIENCE NEWS (Oct. 4, 2012), http://esciencenews.com/articles/2012/10/04/abortion.rates.plummet.with.free.birth.control.

100. Eight states have laws restricting insurance coverage of abortion in all private insurance plans; twenty restrict abortion coverage in plans that will be offered in the insurance exchanges set up by the Affordable Care Act, and eighteen restrict abortion coverage for public employees. State Policies in Brief: Restricting Insurance Coverage of Abortion, 2012 GUTTMACHER INST. (Nov. 2012), current version available at http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf. See also Janessa L. Bernstein, The Underground Railroad to Reproductive Freedom: Restrictive Abortion Laws and the Resulting Backlash, 73 BROOK. L. REV. 1463, 1470 (2008) (examining the implications of state legislation in the post-Roe/Casey era that impede access and increase the costs of abortion).

101. LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973 (1997); *see also* Mark A. Graber, *The Ghost of Abortion Past: Pre-Roe Abortion Law in Action*, 1 VA. J. Soc. Pol'y & L. 309, 311 (1994) (reviewing the history of abortion law in America and how illegality affects safety as opposed to incidence, especially for low-income women of color).

^{97.} Disparities in access to abortion are shown in vivid relief on an interactive map available through the Kaiser Family Foundation. *Abortion Access, by State, 2008*, KAISER FAMILY FOUND., http://www.statehealthfacts.org/comparemapreport.jsp?rep=8&cat=15, (last visited Apr. 30, 2013).

^{98. 448} U.S. 297 (1980).

There would likely be a black market for mifepristone, which would join the existing online market in drugs ranging from Viagra to Vicodin. Nor is it reasonable to believe the criminal justice system could control access to mifepristone, given its epic failure to stem the availability of Vicodin, the abuse of which is now epidemic in many of the nation's poorest rural communities. And because poor women in the United States are not nearly as poor as are poor women in El Salvador, they will be better able to afford to buy illegal mifepristone. In short, access to abortion will continue, regardless of whether it is legal.

A lingering uncertainty, in view of the interest of pro-life advocates in reducing the incidence of abortion, is whether re-criminalizing abortion in the United States might reduce its incidence. The WHO data suggesting that the world's lowest abortion rates occur in countries with the most liberal abortion laws lead me to think that tightening access to legal abortion will not reduce the rate at which women terminate their pregnancies. ¹⁰⁴ At the same time, it seems counter-intuitive to imagine that a change in the law would not cause at least some women to carry to term pregnancies they might otherwise have terminated. The data we have is aggregated over entire populations. What we do not know is whether women in the United States would continue to terminate their unwanted pregnancies at the same rate as they do today, were the United States to make abortion a crime. ¹⁰⁵

B. Detection of Illegal Abortion

One of the most direct consequences of banning abortion in El Salvador has been to conscript doctors into service in defense of the law. The United States already has experience with the endeavor to use doctors as arms of the state. Faced with perceived economic and public health challenges such as

^{102.} Erik Eckholm, *Abuses Are Found in Online Sales of Medication*, N.Y. TIMES (July 9, 2008), http://www.nytimes.com/2008/07/09/health/09drugs.html (repoting that hundreds of websites sell controlled drugs, including Vicodin and OxyContin, without prescriptions and that the Drug Enforcement Agency has had little success in prosecuting those involved).

^{103.} The U.S. 2012 poverty line for a single-person household was \$11,170. 2012 HHS Poverty Guidelines, U.S. Department of Health & Human Services, (Feb. 9, 2012), http://aspe.hhs.gov/poverty/12poverty.shtml. Although 46.2 million people live below the poverty line, Karen Weise, Record U.S. Poverty Rate Holds As Inequality Grows, Bloomberg Businessweek Global Economics (Sep. 12, 2012), http://www.businessweek.com/articles/2012-09-12/record-u-dot-s-dot-poverty-rate-holds-asinequality-grows, few live on so little that they would be unable to afford to buy illegal abortion drugs, assuming the prices are similar to those now seen in Latin America. See Cytotec, supra note 50.

^{104.} Sedgh et al., supra note 23.

^{105.} I have avoided discussing adoption in this Article, but clearly, policies facilitating adoption could play an important role in encouraging women to carry to term their unwanted pregnancies, rather than opting for illegal abortion, in the event that the United States were to criminalize abortion.

illegal immigration and pregnant addicts, state legislatures have endeavored to force doctors to report their patients to the state. In each case, these laws have been met with resistance.

Even if U.S. doctors, whether as a profession or as individuals, have sought to protect their patients' confidences, child abuse reporting laws stand as an example of an instance in which the law has successfully enlisted doctors' assistance in policing criminal activity. There are two problems extrapolating from this example to the likely assistance of physicians in enforcing abortion bans.

First, the widespread norm condemning child abuse is far weaker when the subject is abortion. The medical profession is as morally divided on the question of abortion as is the remainder of the U.S. population. ¹⁰⁸ Add to the

106. Consider, e.g., California Proposition 187, a 1994 ballot initiative that required, among other things, doctors to report undocumented patients to the Immigration and Naturalization Services. Courts. *Proposition 187: Text of Proposed Law*, Am. Patrol, Report, http://www.americanpatrol.com/Reference/prop187text.html (last visited Apr. 30, 2013). The law was ultimately found unconstitutional. *See* League of United Latin Am. Citizens v. Wilson, 908 F. Supp. 755, 786-87 (C.D. Cal. 1995); *see also* Ferguson v. City of Charleston, 532 U.S. 67, 84-86 (2001) (describing and finding unconstitutional a program at the Medical University of South Carolina wherein doctors performed non-consensual drugs tests on pregnant patients, and in certain cases, reported those who used illegal drugs to the police).

107. The American Medical Association adopts the position that "[t]ransplacental drug transfer should not be subject to criminal sanctions or civil liability." Am. MED. ASS'N, WOMEN PHYSICIANS CONGRESS: POLICY COMPENDIUM 18 (Jan. 2012) [hereinafter AMA POLICY], available at http://www.ama-assn.org/resources/doc/wpc/wpc-policy-compendium-2012-final.pdf. The AMA encourages the federal government to increase funding for drug treatment, prevention, and education particularly for drug-addicted pregnant women. Id. The AMA has advocated against state laws that attempt to criminalize drug addition in pregnant women. See, e.g., Pregnant Women's Rights, Am. MED. ASS'N, http://www.amaassn.org/ama/pub/physician-resources/legal-topics/litigation-center/case-summariestopic/pregnant-womens-rights.page (last visited Nov. 9, 2012) (discussing Ankrom v. State, CR-09-1148, 2011 WL 3781258 (Ala. Crim. App. Aug. 26, 2011), and Ex Parte Ankrom, No. 1110176, 2013 WL153748 (Ala. Jan. 11, 2013), and advocating against construing "child" in an Alabama criminal child endangerment statute to include fetuses). When California passed Proposition 187, which required verification of legal immigration status to receive public assistance, public education, and non-emergency health care services, the California Medical Association and California Association of Hospitals and Health Systems stood vehemently opposed. Nancy H. Martis, #187 Illegal Aliens. Ineligibility for public services. Verification and Reporting., CALIF. http://www.calvoter.org/archive/94general/props/187.html.

108. One study found that 97% of ob-gyns questioned encountered patients seeking abortions, whereas only 14% performed them. Debra B. Stulberg et al., *Abortion Provision Among Practicing Obstetrician—Gynecologists*, 118 J. OBSTETRICS & GYNECOLOGY 609, 611 (Sept. 2011). The study showed a correlation between ob-gyns who perform abortion and gender (more female than male), age (more younger than older), location (more in the Northeast and West), and religious affiliation (more Jews than Catholics, Evangelicals and Protestants). *Id.* Additionally, the AMA refrains from taking an association-wide stance on abortion stating that "[t]he issue of support of or opposition to abortion is a matter for

moral ambivalence physicians' ethical injunction to protect patient confidentiality and one can see a prescription for random compliance, at best, with laws requiring doctors to report patients suspected of having had abortions.

The second problem with requiring doctors to report patients they think may have terminated their pregnancies is practical: in the United States, as in El Salvador, it remains virtually impossible to distinguish abortion from miscarriage. Absent evidence of deliberate self-harm or other trauma, doctors either will opt to protect confidentiality, or will follow their gut feelings about a particular patient's circumstances and symptoms—feelings that may be drawn from bias rather than empirical evidence—in deciding whether report her to the police. This determination will be more complicated, not less, in the event that the law permits abortion under some circumstances, such as rape. Such exceptions will invite doctors to evaluate the veracity of a patient's version of a given sexual encounter—an evaluation that doctors are not trained to make.

It may be easier in the United States than it is in El Salvador to discern whether a woman provoked a late-term abortion or simply suffered a miscarriage. We have far superior access to medical technology. Pathology laboratories could quickly test fetal tissue for evidence of abnormalities that might have led to pregnancy loss. ¹¹⁰ The availability of medical technology, combined with a presumption of innocence, should limit cases like Cristina's and minimize the risk of wrongful convictions. What cannot be avoided, though, is the problem of false accusations, in which a woman (and her family) will have to suffer not only the loss of a wanted pregnancy, but also the traumatic allegation that she provoked the fetus's demise.

The challenge of distinguishing abortion from natural miscarriage acquires emotional intensity as a pregnancy advances. Generally, a woman who loses a viable pregnancy is assumed to have miscarried, and is treated with sympathy. This sympathy derives from a societal assumption that a woman who loses a late pregnancy must have wanted to have a baby because if not, she would have had a legal abortion. It is the absence of access to legal abortion early in

members of the AMA to decide individually, based on personal values or beliefs." AMA POLICY, *supra* note 107, at 2.

^{109.} Drapkin Lyerly, supra note 91

^{110.} *Id*.

abortion for reasons of geography and economics. Add to this the fact that a woman may delay abortion because she is morally ambivalent about abortion, and it becomes clear how even an advanced pregnancy might not necessarily be a wanted one. There are, for example, a small set of cases involving denied or concealed pregnancy, unattended births, and sometime deaths of newborns. Of course, the legal status of abortion makes no difference in these cases, which are prosecuted under current homicide laws. See CHERYL L. MEYER & MICHELLE OBERMAN, MOTHERS WHO KILL THEIR CHILDREN (2001); Michelle Oberman, Mothers Who Kill: Coming to Terms with Modern American Infanticide, 8 DEPAUL J.

pregnancy, the presumption of a wanted pregnancy may no longer hold, and the woman who presents with a pre-term delivery of a dead fetus becomes a crime suspect.

C. Fear of Hospitals

It bears noting that criminalizing abortion will create a disincentive to seek care on the part of women who are experiencing vaginal bleeding or other medical symptoms that might indicate abortion. Some of these women may have elected to terminate their pregnancies; some may simply fear being accused of having done so. In either case, it is worth considering the public health implications of placing this tax on seeking medical care.

Public health advocates raised similar concerns when hospitals sought to use drug testing to detect substance abuse by pregnant women. In that case, they argued that these women and their babies would be better served by obtaining treatment than by punishment.¹¹²

The case of abortion is distinct. Assuming she has illegally terminated her pregnancy, the bleeding or sick woman is a criminal. If she chooses to avoid the hospital in order to evade prosecution, she is no different than others patients injured in the course of criminal activity, and therefore afraid to seek treatment. What remains uncertain is how society will respond to a possible increase in deaths among girls and women who did not seek treatment for their abortion-related illnesses. It was stories about and pictures of such women that helped pave the road to *Roe v. Wade* in the 1960s and 1970s. ¹¹³

D.Catching the "Wrong" Women

Perhaps the most important challenge for those who favor using the criminal law to restrict access to legal abortion is not moral, but practical. If the law in a given jurisdiction permits abortion only in cases in which a woman's

HEALTH CARE L. 3, 27-36 (2004) (discussing neonaticide, the characteristics and stories of women and girls involved in recent neonaticide cases, the range of responses from the criminal justice system and the shocking ambivalence of society).

112. Not only does prosecution of pregnant addicts violate their constitutional rights, but it also decreases pregnant women's use of pre-natal care putting themselves and their fetus at risk, making treatment and prevention sounder policy options. Tiffany Lyttle, *Stop the Injustice: A Protest Against the Unconstitutional Punishment of Pregnant Drug-Addicted Women*, 9 N.Y.U. J. LEGIS. & PUB. POL'Y 781, 782 (2006); Shawn N. Randolph, *Pregnancy and the Criminalization of Perinatal Substance Abuse: Unethical, Unconstitutional and Poor Public Policy*, 2 S. CAL. REV. L. & WOMEN'S STUD. 375, 392 (1992); Deanna Rae Reitman, *The Collision Between the Rights of Women, the Rights of the Fetus and the Rights of the State: A Critical Analysis of the Criminal Prosecution of Drug Addicted Pregnant Women*, 16 St. John's J. Legal Comment. 267, 302 (2002).

113. Linda Greenhouse, *Misconceptions*, N.Y. TIMES (Jan. 23, 2013), http://opinionator.blogs.nytimes.com/category/linda-greenhouse.

life is in danger, it must rest on unambiguous medical standards defining qualifying circumstances, and likewise must have a legal protocol in place so that access to a qualifying abortion will be swift and risk-free.

Numerous cases from around the world testify to the difficulty of meeting these pre-conditions. For example, consider the Irish case of Savita Halappanavar, a pregnant woman who sought care when she began hemorrhaging. Hospital officials told her she was fully dilated and would miscarry the fetus, but that because she was seventeen weeks pregnant and the fetus had a heartbeat, they could not induce labor or perform an abortion. Three days later, she miscarried, but not before she developed a fatal blood infection from which she ultimately died. It is 12010, the European Court of Human Rights cited Ireland for failing to articulate standards protecting existing rights to lawful abortion where a mother's life was at risk. In January 2012, the Irish government established a fourteen-member expert group to make recommendations, but the recommendations have not yet been issued.

Alongside the problem of articulating medical and legal protocols for accessing permissible abortions is the reality of a robust black market. In an era of Internet pharmacies and in a country where abortion remains legal in some states, the law simply cannot stop a woman from terminating a pregnancy under the circumstances typically invoked as morally reprehensible by proponents of criminalization of abortion—cases in which the pregnant woman has had multiple abortions, or is opting for an abortion because of the fetus's sex. Even the endeavor to limit legalized abortion to cases such as rape likely will increase the number of women who resort to the black market for care, rather than opting to recount and defend her sexual victimization as "real rape." 119

Of course, the fact that a law inevitably will be broken is not a justification for legalization. If that were the case, we would have no criminal laws at all.

^{114.} Sorcha Pollack, *Ireland Abortion Scandal: Death of a Pregnant Woman Prompts Soul-Searching*, TIME (Nov. 14, 2012), http://world.time.com/2012/11/14/ireland-abortion-scandal-death-of-a-pregnant-woman-prompts-soul-searching.

^{115.} *Id*.

^{116.} Woman Dies After Abortion Request 'Refused' at Galway Hospital, BBC News (Nov. 14, 2012), http://www.bbc.co.uk/news/uk-northern-ireland-20321741.

¹¹⁷ *Id*

^{118.} Alongside contemporary norms regarding prenatal disclosure of sex, there are many medical reasons justifying the endeavor to discern a fetus's sex. Even if one banned ultrasound technicians and doctors from disclosing a fetus's sex when they feared the information would be put to ill use, a determined woman or couple would simply not disclose their reasons for wanting to know their fetus's sex.

^{119.} Whereas some countries permit women to terminate their pregnancies merely based upon their allegation that they were raped, others require women asserting rape-related justifications for abortion to have reported their crime to police. Given the pace of the criminal justice system, the risk of delay and humiliation in the event that the defendant is found not guilty likely will lead the woman to endeavor to terminate the pregnancy illegally.

The particular problem with criminalizing abortion is that, to the extent El Salvador and our own history are predictive, criminalizing abortion will not necessarily diminish its incidence, and to the extent that it does so, the law will disproportionately affect poor women who lack access to the black market.

IV. CONCLUSION

My recounting of life under an absolute abortion ban prompts a central question for those who would overturn *Roe* in order to permit states to enact laws that reflect the majority's moral preference regarding access to abortion: Why overturn *Roe* and more generally, why ban legal abortion?

My research points to a number of troublesome outcomes of El Salvador's abortion ban: women with money are immune, women without money have reason to fear seeking healthcare, and the black market plus the wealth-gap insures that the criminal law will fall randomly on poor women, rather than catching a subset of women whom the majority might consider deserving of punishment.

One might nonetheless argue that, at the very least, outlawing abortion will save the lives of some fetuses. Perhaps the WHO data demonstrating the lack of correlation between restrictive abortion laws and lower abortion rates is too aggregated to take into account the lives of individual fetuses whose mothers opt to carry them to term rather than risk violating the law. Although it seems plausible, indeed likely, that some women will opt to have a child they might have aborted, were it legal, at the aggregate level, there is no reason to believe the criminal law will bring about a net effect of lowering the rate of abortions. Instead, the only known way to lower the rate of abortions is to facilitate access to contraception. 121

For forty years we have been consumed as a society with pushing the line in the legal sands of abortion while, during the same timeframe, little has happened to improve the circumstances facing women as mothers—circumstances that surely drive the determinants of abortion rates far more than its legal status. Those who would limit access to legal abortion are not necessarily hard-hearted. Given infinite resources, they might well support the expansion of financial assistance and services intended to support poor women and their children. They might endeavor to ease the path to relinquishing a

^{120.} See Sedgh, supra note 23 and accompanying text.

^{121.} An example comes from a recent study showing that free contraception reduces abortion rates. See, e.g., Lauran Neergaard, Study: Free Birth Control Leads to Fewer Abortions, SAN JOSE MERCURY NEWS (Oct. 5, 2012), http://www.mercurynews.com/family-relationships/ci_21703123/study-free-birth-control-leads-fewer-abortions (regarding the St. Louis study that reduced abortion rates by over 60% by providing at-risk teens with free contraception); Abortion Rates Plummet with Free Birth Control, E! SCIENCE NEWS (Oct. 4, 2012),

http://esciencenews.com/articles/2012/10/04/abortion.rates.plummet.with.free.birth.control.

child for adoption. But in a world of limited resources, the first step they would take is driven by their moral conviction that the law should not countenance what they view as immoral behavior.

Those who seek to employ the criminal law in support of their moral opposition to abortion must contend not only with this challenge, but also with the troubling question that arises once one accepts that criminalizing abortion will neither lower its incidence nor necessarily catch those women "most deserving" of punishment. What are we willing to do to poor women in the name of moral opposition to abortion?