



The Partial Death of Abortion Rights

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On April 18, 2007, the Supreme Court signaled a significant change in abortion jurisprudence. It held in *Gonzales v. Carhart* that a federal statute outlawing the use of “partial-birth abortion” is

constitutional, even though many members of the medical community believe that the procedure should be available when it is the safest option for terminating a pregnancy. No exception was made for protecting a woman’s health; only a threat to a woman’s life would excuse the use of the procedure. Absent that excuse, a physician who knowingly performs an intact dilation and extraction (D&X) is subject to 2 years in prison, a fine of up to \$250,000, and monetary damages for psychological injury to the husband or parents of the pregnant woman.

Ever since the 1973 decision in *Roe v. Wade*, it has been understood that states may regulate

pre-viability abortion and outlaw post-viability abortion completely, provided that the rules protect both the life and the health of the pregnant woman. And in the 1992 decision in *Planned Parenthood v. Casey*, the Court reaffirmed this principle, requiring a health exception in bans of post-viability abortion and stating that regulations regarding pre-viability abortion may not impose an “undue burden” on women. This balance reflects the view that a woman’s interest in preserving her own health should be protected more strongly than any state interest in preserving intrauterine life. The latest decision of the Supreme Court alters this balance

and holds that requiring women to submit to an unnecessarily dangerous version of an abortion procedure (in cases in which D&X is deemed by a physician to be the safest option) is neither an undue burden on them nor a dereliction of the state’s duty to guard women’s health and personal autonomy. The decision thus opens the door to revisiting any number of state and federal efforts to restrict access to abortion services.

The Supreme Court considered this very same issue 7 years ago in *Stenberg v. Carhart*, when it struck down a similar Nebraska state statute because it did not contain an exception to protect a woman’s health and because its definition of the prohibited procedure was so vague that it could reasonably have been interpreted by doctors to include not only the D&X procedure but other more

that is never medically necessary and should be prohibited.” The legislation further asserted that D&X is “never necessary to preserve the health of the woman.”

It is unclear, however, what degree of deference the Court should grant to such findings when Congress is acting as a source of scientific and medical authority. Legislation often must be passed despite the presence of scientific uncertainty, and much environmental-protection legislation, for example, could be challenged if complete scientific consensus were required before restrictions on industrial pollution could be upheld. But this case is singular in that the Court upheld congressional findings even in instances in which multiple state trial courts had found these same assertions to be based on nonexpert testimony and, in several instances, factually erroneous. The Court then argued that since medical opinion is divided about D&X, Congress has the authority to invade the doctor–patient relationship and substitute blanket legislative judgment for individualized medical judgment concerning the best care for a particular patient. Although regulation of the drugs and devices marketed for use in medical care has long been accepted, legislative restriction of doctors’ individual medical judgments is far more contentious. Where governmental involvement in medical decision making is warranted, it is best handled through dispassionate, evidence-based expert reviews. As Kassirer has written, “The data upon which many important medical decisions are based are often contradictory and still in evolution. Legislators do not have the

context nor the capacity to weigh medical evidence adequately.”² And indeed, the tradition has been to allow the medical profession to define for itself the meaning of “medically indicated.”³

The decision in *Gonzales v. Carhart* poses a threat to physicians who perform the still-legal D&E procedure and to those who determine that a D&X is indeed needed to save the life of a pregnant woman. Although the Court emphasized that a physician cannot be convicted unless he or she intentionally violated the statute, questions as to whether a woman’s life was in danger and whether the physician’s intent was to perform a D&X (as opposed to a D&E) are matters of interpretation. Even if physicians ultimately expect to be exonerated, the mere prospect of being investigated by a possibly hostile prosecutor may well have a chilling effect on their decision making. Certainly, that was the effect on many physicians after the 1975 prosecution of Dr. Kenneth Edelin, who was indicted for manslaughter for performing a second-trimester abortion 2 years after *Roe v. Wade*.⁴

As to the substantive issue of medical necessity, Greene and Ecker have raised troubling pragmatic questions about what would count as a risk to a woman’s life, rather than merely to her health, and where the threshold of “necessity” lies: “Would a procedure that averts a 50 percent risk of death be adequate to qualify as ‘necessary to save the life of the mother?’”⁵

In an impassioned dissenting opinion delivered from the bench, Justice Ruth Bader Ginsburg recalled the statement in the 1992 *Casey* decision that “liberty finds

no refuge in a jurisprudence of doubt.” The 5-to-4 decision in *Gonzales v. Carhart*, occasioned by a change in the makeup of the Supreme Court, illustrates how fragile are the constitutional interpretations by which reproductive rights are guaranteed. The prospect of yet further revisions occasioned by future appointments to the Court adds yet another measure of uncertainty beyond the uncertainties that physicians will face when choosing how best to terminate a dangerous pregnancy. And throughout the country, in light of this decision, states will be determining whether their previously unconstitutional bans on partial-birth abortion have now been brought back into effect, many of them incorporating language and proscriptions different from and broader than those of the federal law.

But the greatest uncertainty of all concerns the continued viability of any right to abortion in all but imminently life-threatening situations. The federal statute makes no distinction between pre-viability and post-viability abortions and bans the D&X procedure in both situations, even in cases in which physicians believe that the alternatives are more dangerous to a woman’s health. The prospect that a woman’s health might be endangered by limiting access to D&X procedures is deemed insufficient to qualify as an “undue burden.” Justice Kennedy’s majority opinion in *Gonzales v. Carhart* endorses this conclusion, stating that it is “legitimate” because “a fetus is a living organism within the womb, whether or not it is viable outside the womb” and that “choosing not to prohibit [a bru-

tal and inhumane procedure] will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life.”

And thus the balance of interests shifts, with women’s health no longer paramount but rather societal morality and the state’s interest in life even before the point of viability outside the womb. For Justice Ginsburg, this vote signals an end to support

for the central premises of *Roe v. Wade*: “In candor, the Act, and the Court’s defense of it, cannot be understood as anything other than an effort to chip away at a right declared again and again by this court — and with increasing comprehension of its centrality to women’s lives.”

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The Intimidation of American Physicians — Banning Partial-Birth Abortion

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A Dutch oncologist was describing to an audience of American physicians in Amsterdam the circumstances under which euthanasia was performed in the Netherlands at a time when the practice was illegal yet widely used. Each act of euthanasia was reported, after the fact, to the local prosecutor, who investigated the case and routinely declined to prosecute any treating physician who had acted transparently and in the best interest of the terminally ill patient. The American physicians were incredulous that their Dutch colleagues were willing to place themselves at risk for criminal prosecution by providing care that might, on later review, be determined to have violated criminal law. The Americans had no confidence that their own judicial system would judge them fairly under similar circumstanc-

es, even if they had acted in good faith and in the patient’s best interest.

This lack of confidence that the U.S. judicial system would treat them fairly has cast a pall over those who practice reproductive medicine as they consider the recent decision by the Supreme Court, in *Gonzales v. Carhart*, to uphold the Partial-Birth Abortion Ban Act of 2003. The ruling creates an intimidating environment surrounding pregnancy terminations at more advanced gestational ages. The decision to pursue a second-trimester abortion is never taken lightly and usually results only after anguished discussions among the patient, her loved ones, and her health care providers. Once the decision has been made to perform a second-trimester surgical abortion, the last thing a provider needs is to have to worry that the procedure

could potentially evolve into a criminal act if a fetus in breech presentation should slip out intact through a partially dilated cervix. But this is exactly the situation created by the partial-birth abortion bill.

Defenders of the law point out that its *scienter* requirement means that physicians can be prosecuted only if it can be demonstrated that the provider “deliberately and intentionally” delivered a living fetus and performed an “overt act” to kill it. But this protection seems fragile to practitioners. In the situation just described, how would the vital status of the partially delivered fetus be determined, and by whom? The only way to complete the delivery through the incompletely dilated cervix may be to reduce the size of the after-coming head. Would any procedure to accomplish that goal be seen as facilitating the