



Implications of the Federal Abortion Ban for Women's Health in the United States

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Abstract: *In 2007, the US Supreme Court upheld the Partial Birth Abortion Ban Act of 2003, also known as the Federal Abortion Ban or "the Ban." The decision undermines decades of established US abortion law that had recognised the preservation of the health of women as a paramount consideration. The Ban asserts that the state's interests in how an abortion is performed and in fetal life override women's rights. It thus further erodes access to safe and legal abortion care. The new law negatively affects evidence-based clinical practice, the training of new providers and clinical innovation. It may also lead to additional legal restrictions on abortion access in the US and has implications for abortion service delivery internationally. Advocates must develop strategies that focus on women's right to control their fertility throughout the trajectory of an unwanted pregnancy.* ©2008 Reproductive Health Matters. All rights reserved.

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IN April 2007, in *Gonzales v. Carhart*,¹ the US Supreme Court upheld the Partial Birth Abortion Ban Act of 2003² as constitutional. Known as the Federal Abortion Ban (or "the Ban") by opponents, the Ban is a federal law passed by the US Congress and signed by President Bush. This paper reviews the construction of so-called "partial birth abortion;" the failure of abortion rights supporters to successfully counter this construction; the legal battles over the Ban; the effects of the Court's decision on women's health, clinical practice, and abortion care providers; and potential international ramifications. This paper argues that the Supreme Court's decision undermines decades of established abortion law that had recognised the preservation of the health of women as a paramount consideration. The language of the decision also influences the larger political debate over abortion through its incorporation of claims that women may come to

regret their abortions. Finally, the decision further erodes the status of the physicians who perform abortions by discounting their clinical expertise in determining how best to protect the health of their patients.

The provision of abortion care in the US

Methods of abortion depend on the stage in pregnancy at which the abortion is performed. Eighty-eight percent of all abortions in the US occur in the first trimester of pregnancy and are performed by either administration of medication (up to nine weeks) or uterine aspiration.³ In the second trimester of pregnancy, safe abortion requires additional dilatation of the cervix through the use of either osmotic dilators such as laminaria and/or a medication such as misoprostol. Dilatation and evacuation (D&E) is the most common procedure used for second-trimester

abortion in the US and involves a combination of instrumentation and aspiration. Two variants of D&E are recognised, although there is no bright line between them: intact D&E (sometimes also called D&X) where the fetus is removed largely intact and non-intact D&E (sometimes called disarticulation/dismemberment D&E) where the fetus is removed in pieces with forceps. A smaller number of abortions use the drugs mifepristone and misoprostol to induce contractions and the expulsion of an intact, dead fetus. With all abortion techniques, however, broad classifications do not reflect distinct categories, as multiple techniques may be used in the performance of an individual abortion. For example, medications may be used to initiate the abortion but, if it is not completed within a certain time frame, instrumentation may be used to remove unexpelled tissue. Likewise, efforts to dilate the cervix for a disarticulation D&E may result in the expulsion of an intact fetus where surgical intervention is only needed to pass the fetal skull safely through the cervix. The choice of abortion technique(s) is usually determined by a combination of clinical skill of the provider, fetal presentation, medical indications in the woman, and the woman's preference.

Tracing the political attacks on abortion since legalisation

In 1973, in *Roe v. Wade*, the US Supreme Court held that the US Constitution protects the right to abortion.⁴ Under the legal structure established in *Roe*, abortion in the first trimester was a matter solely between a woman and her physician. In the second trimester, the government could regulate abortions, but only to protect the woman's health. After the point of fetal viability, the government could prohibit abortion except in cases where it was necessary to preserve the woman's life or health.

Since 1973, there have been continual legislative attacks on the right to abortion in the US. Until 1989 most abortion restrictions were struck down because they violated the central tenets of *Roe*.^{5,6} Notable exceptions included restrictions on the rights of minors and bans on the use of public funds to pay for abortions for poor women. With the appointment of several conservative justices during the administrations of Ronald Reagan and George Bush Sr., the

Supreme Court became more accepting of the regulation of abortion. In a series of decisions, the Court shifted from upholding abortion restrictions only if they met the exacting "strict scrutiny" standard, which is used to protect fundamental rights, to upholding abortion restrictions as long as they did not impose an "undue burden" on access to abortion. The Court articulated this new, lesser standard in *Planned Parenthood v. Casey* [1992].⁷ All of the Court's decisions, however, had reaffirmed the original *Roe* ruling that abortion restrictions had to provide protections for a woman's life and health.

The construction of "partial-birth abortion"

In 1992, at a meeting of the National Abortion Federation, physician Martin Haskell made a presentation on a variation of D&E that he used to perform abortions after 20 weeks of pregnancy. He called this procedure dilation and extraction, or D&X. His technique involved dilating the woman's cervix over several days, extracting the fetus until the skull lodged in the cervix, and then puncturing the skull and removing the contents to allow for removal without damage to the woman's cervix.⁸ An infiltrating anti-abortion activist at the meeting understood the political opportunities of introducing this clinical information into the public debate over abortion. Abortion opponents developed a series of cartoon-like drawings to accompany a graphic and misleading description of Dr. Haskell's technique.⁹ After using a series of alternative names, abortion opponents finally settled on "partial-birth abortion," a political term with no medical meaning.¹⁰

The use of visual images by anti-abortion activists to move people in the abortion debate is not new. The most famous was in the movie *The Silent Scream*, which aired on US national television in 1984 and is still widely shown by abortion opponents.¹¹ Posters displaying large pictures of aborted fetuses are a common sight at protests outside abortion care facilities.^{12,13} Additionally, the widespread availability of ultrasonography has brought images of fetal development into the public eye, "personifying" the fetus, which is being used to generate conversations about when it should be too late to have an abortion.¹⁴ The cartoon images of "partial-birth abortion" provided new props for

anti-abortion activists in their efforts to outlaw all abortions. For example, in April 1993, the Freedom of Choice Act (FOCA) was introduced in the US Congress to codify the principles of *Roe* in federal statutory law. The National Right to Life Committee distributed four million brochures and ran advertisements with the five cartoons, accompanied by the claim that passage of FOCA “would lead to an increase in the use of this grisly procedure.”¹⁰ These images became part of the larger campaign that led to the defeat of FOCA.

These images also created a sense of urgency for action to protect “the innocent in the process of being born,”¹⁵ insinuating that these abortions were being performed on viable fetuses. The name “partial-birth abortion” invokes images of wanted (and viable) babies rather than unwanted (and non-viable) fetuses and plays on public discomfort with later abortions. In reality, however, the procedures being targeted for regulation occurred in the second trimester of pregnancy before the point of fetal viability.

Response of pro-choice organisations

Unprepared for the “partial birth” campaign, pro-choice organisations vacillated in how to respond and did not immediately understand their opponents’ strategy of using “partial-birth abortion” as a means to limit access to abortion more generally. Some organisations claimed that the D&X procedure depicted in the cartoons was rare, while others said it was never done. Many pro-choice spokespersons focused on disproving the validity of the pictures themselves. Still other advocates focused on the vulnerability of the women needing the procedure, who they claimed were poor or young. Finally, the movement seemed to settle on bringing attention to those women needing the procedure whose wanted pregnancies had “gone terribly wrong”.¹⁰ None of these shifting strategies was successful in altering the growing opposition to “partial-birth abortion”, and polls showed increasing public support for a ban, despite the lack of clarity about what would actually be banned. By 2003, when the Federal Abortion Ban was passed, 70% of the public supported the passage of such bans.¹⁶

Underlying some of the vacillation among abortion rights supporters was an ongoing discomfort with second-trimester abortion and a

genuine concern that political focus on second-trimester abortions would jeopardise all abortions. Polls in the US show consistent support for legal abortion, but these same polls reveal deep ambivalence about abortions after the first trimester. While a strong majority of Americans support abortion in the first trimester, only 25% support the legality of second-trimester abortion, and 68% of those surveyed in 2007 favoured making second-trimester abortion illegal.¹⁶ At the same time, there is support for abortion access for maternal health and fetal conditions, many of which, paradoxically, can only be diagnosed in the second trimester. Similarly, there is broad support for abortions prior to viability although fetal viability is not reached until after the end of the second trimester. Thus, there is little public understanding about the relationship between abortion procedures, fetal development and women’s reasons for abortion. The campaign to ban “partial-birth abortion” successfully leveraged this lack of understanding.

State-level bans on “partial-birth abortion”

Between 1995 and 2000, more than half of the states in the US passed laws to ban “partial-birth abortions”. Although there is no such medical procedure, these bans used sweeping language that made it a crime for a physician to take further steps to remove a fetus from a woman’s body if the physician has drawn a “substantial portion” of the fetus into the vagina prior to fetal demise. Despite claims that they were preventing abortion right before birth, these state laws rarely stipulated the gestational age to which they applied. Instead, by virtue of their definition of the banned manoeuvres, these laws applied to second-trimester abortions, and in some states, first-trimester abortions as well. Many of the state laws were challenged and struck down by the lower federal courts.¹⁷ In 1996 and 1997 two national bans on “partial-birth abortion” passed the US Congress but were vetoed by President Bill Clinton.

In 2000, the US Supreme Court ruled in *Stenberg v. Carhart* that the Nebraska law banning “partial-birth abortion” was unconstitutional because there was no exception to protect the health of the pregnant woman and because it included not just intact D&E, but D&E more broadly.¹⁸ Having joined with four other Justices

in the majority opinion, Justice Sandra Day O'Connor also wrote a concurring opinion in which she outlined her view that a ban could be constitutional if it both provided an exception for a woman's health and clearly defined the prohibited technique.

Ignoring the Court ruling and Justice O'Connor's advice, the Federal Partial Birth Abortion Ban Act of 2003 was passed by both houses of Congress and signed into law by George W Bush. It contained no exception for women's health, no recognised medical terms, no gestational limits, and no particular technique was named. Instead, Congress issued a series of "findings" that claimed that "partial-birth abortion" was never necessary to protect a woman's health.

The Ban defined the outlawed procedure as one in which a physician:

*"deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother, for the purpose of performing an overt act that the person knows will kill the partially delivered living fetus; and performs the overt act, other than completion of delivery, that kills the partially delivered living fetus."*²

Given its similarity to the Nebraska law struck down in *Stenberg v. Carhart* [2000], abortion rights supporters immediately challenged the Ban. Trials in three federal courts focused on the vagueness and breadth of the language of the ban, the medical necessity for use of intact D&E procedures in certain clinical situations and the need for an exception for women's health. Experts testified that intact D&E may be the safest procedure for women with certain medical conditions such as uterine scars, bleeding disorders, heart disease or compromised immune systems; women with particular health conditions that arise during pregnancy such as placenta praevia; and women carrying fetuses with certain medical conditions or abnormalities such as severe hydrocephaly.¹⁹⁻²¹ In these cases, induction abortion may not be possible and an intact D&E may have less risk of uterine perforation than non-intact D&E, as there are fewer insertions of instruments into the uterus. None of these circumstances are allowable under the Ban.

Judges in all three courts found the Ban unconstitutional, as it had no exception to protect women's health. The government appealed these decisions to three appellate ("Circuit") courts, all of which affirmed that the Ban was unconstitutional. The government then appealed two of these decisions to the US Supreme Court, which heard in the cases in November 2006. In *Gonzales v. Carhart* [2007], the Court reversed the lower courts' decisions and upheld the Federal Abortion Ban.

Gonzales v. Carhart [2007]

Like *Stenberg v. Carhart* [2000], *Gonzales v. Carhart* [2007] was a split 5-4 decision, but with a different outcome. The difference in the decision was the replacement of Justice O'Connor with Justice Alito, an abortion rights opponent. While Justice O'Connor voted to strike down the Nebraska ban, Justice Alito voted to uphold the Federal Abortion Ban. (Justice Rehnquist was also replaced during this time, but his vote to support the bans was replicated by his successor, Justice Roberts.)

The new decision disregards science and legal precedent in a number of ways. First, it equates "partial-birth abortion" with intact D&E. In the ruling, Justice Kennedy states: "The Act excludes most D&Es in which the fetus is removed in pieces, not intact."¹ But "most" is undefined and the distinction between intact D&E and what Kennedy calls "standard" D&E is not found in the law itself, but only in the Court's decision.

Previous Court decisions regarding abortion recognised protection of the woman's health as paramount. The language of the 2007 decision makes clear that the State need not necessarily defer to medical judgment about which procedures may be safer for certain women:

"[I]f some procedures have different risks than others, it does not follow that the State is altogether barred from imposing reasonable regulations."

Even assuming that the Ban only targeted intact D&E, the Court decision ignored all of the examples given during the three trials describing when an intact D&E might be the safest method for a particular woman. The extent to which the Court's decision was inconsistent with prevailing scientific evidence was reflected in the quick

denunciation of the decision by the American College of Obstetricians and Gynecologists:

*"This decision discounts and disregards the medical consensus that intact D&E is safest and offers significant benefits for women suffering from certain conditions that make the potential complications of non-intact D&E especially dangerous. Moreover, it diminishes the doctor-patient relationship by preventing physicians from using their clinical experience and judgment."*²²

The Court's concern that women may come to regret their abortion decisions also ignored prevailing scientific evidence:

"Respect for human life finds an ultimate expression in the bond of love the mother has for her child... While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained... It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form."

There is, however, substantial scientific evidence demonstrating that women do not experience long-term psychological harm from abortion.^{23,24} Rather than regret, the most common emotion experienced by women following an abortion is relief. The implications of the Court's findings were outlined by Justice Ginsburg in her dissent from the majority opinion:

"The solution the Court approves, then, is not to require doctors to inform women, accurately and adequately, of the different procedures and their attendant risks... Instead, the Court deprives women of the right to make an autonomous choice, even at the expense of their safety."

In addition to its scientific inaccuracies, the 2007 decision discounts the clinical expertise of physicians who provide abortions, referring to them as "abortion doctors" rather than obstetrician-gynaecologists, surgeons or by their academic titles.

"The law need not give abortion doctors unfettered choice in the course of their medical practice, nor

should it elevate their status above other physicians in the medical community."

The Court further claims that upholding the ban on "partial-birth abortion" is done to protect the profession of medicine.

"There can be no doubt the government has an interest in protecting the integrity and ethics of the medical profession."

Consequences of the ban for clinical practice

Because the law does not provide guidance on how to avoid violating the Ban, physicians who provide second-trimester abortions have to make a range of decisions that are driven both by the need to avoid criminal prosecution and to ensure they can continue to practise in accordance with their best clinical judgment.²⁵ Two changes they have been making with implications for women's health include decreasing cervical dilatation before the procedure and/or ensuring fetal demise before initiating the procedure.

Adequate dilatation, however, is a critical factor in the safety of any D&E.²⁶⁻²⁹ Inadequate cervical dilatation can enhance discomfort and increase risk to the woman, because of potential injury to the cervix, which can also affect future fertility. During the course of the oral argument, justices questioned whether the amount of dilatation the provider was seeking could be seen as "intent" to perform an intact procedure.³⁰ This may lead some providers not to dilate adequately for fear of appearing to induce an intact D&E, in spite of documentation of their intent to avoid an intact D&E. Dr Eleanor Drey, a clinical expert on second trimester abortions, said in the aftermath of the decision:

*"This is where it becomes frightening for physicians. To do a safe D&E, you like to have more dilators. Now we are being told that more dilation means you have intent to do a criminal procedure."*³¹

As regards ensuring fetal demise before initiating a second trimester abortion, within weeks of the Court's decision, the National Abortion Federation (a professional organisation for abortion providers) and Planned Parenthood Federation of America released new clinical guidelines on digoxin administration, which can be injected

through the abdomen into the amniotic fluid or fetus for the purpose of inducing fetal demise. Other medications such as potassium chloride (KCL) can also be used.

Some physicians do articulate clinical justifications for the use of agents to induce fetal demise prior to the initiation of any abortion in the later second trimester. These include ease of procedure and the desire not to risk delivering a live but non-viable fetus.^{32,33} Regarding ease of procedure, only one blinded, randomised controlled trial has explored the issue, and that study (n=126) found no differences in blood loss, pain scores, procedure difficulty or complications between procedures preceded by digoxin and those preceded by a placebo.³³ However, it is unacceptable to induce fetal demise only due to fear of prosecution rather than scientific evidence, physician experience or patient preference.³⁴

“This Ban not only forces me to provide a treatment [digoxin] that is unnecessary. . . but it talks about me as if I and my colleagues are heartless, cruel people. It is so insulting to me, as a physician who cares deeply about my patients, and to me as a woman.” (Personal communication, Dr Sacheen Carr-Ellis, June 2007)

Ultimately, the fear of prosecution may cause some physicians to stop performing second-trimester abortions entirely, further reducing the small number who offer this service in the US. According to a survey of abortion providers conducted by the Guttmacher Institute, in 2005 approximately 67% of abortion-providing facilities offer abortions after 14 weeks but only 20% offer abortions after 20 weeks.³⁵ The federal law upheld in 2007 states that physicians can be prosecuted only if they “deliberately and intentionally” deliver a live fetus to a certain point and then perform an “overt act” to kill it. However, if for example, the cervix fails to dilate completely during the course of an abortion, they may be forced to choose between risking the woman’s health and handling the fetus in a way that could be misinterpreted as violating the ban. Thus, physicians may be unwilling to risk liability:

*“Lacking confidence in the judicial system, physicians may choose to avoid performing second-trimester surgical abortions, thus restricting access to them, perhaps even if the mother’s life is in jeopardy.”*³⁶

While many physicians will carefully document their intent to do a “standard” D&E rather than a banned procedure, misinterpretation or questions about what they are doing could lead to a criminal indictment and prosecution. As a result, some facilities began limiting medical students, nursing students or residents’ access to observation of second-trimester abortions.³⁷ This may also have a significant chilling effect on the training of new providers and further enhance the notion that these abortions are somehow “different” from other abortions.³⁸

Clinical research related to second-trimester surgical abortion has been short-circuited by the Supreme Court decision. The intense scrutiny of the intact D&E technique during the court cases led many expert providers to examine the appropriate use of the technique. The available data, collected through retrospective case review, demonstrate a trend toward increased safety with intact D&E over standard D&E when gestational age is taken into account.³⁹ This cannot now be studied further in the US.

Implications for abortion law and policy

The legal future of D&E is also in jeopardy. In the wake of the Supreme Court decision in 2007, individual states may introduce new restrictions on abortion by medical induction and “standard” D&E. Intact D&E was found to be “gruesome” by the Supreme Court. Will “standard” D&E or induction be deemed undesirable as well? Whatever new tactics the anti-abortion movement come up with, however, the language used is likely to be politically loaded with non-medical terms and phrases.⁴⁰ Worse, it is unclear how such proposals would be viewed by a Court that looks at how a procedure demonstrates respect for the life of the unborn (see Court decision section IV.A) rather than at women’s health as the basis for determining constitutionality.

The 2007 Supreme Court decision expresses concern that women may come to regret their abortion, though it cites no evidence for this. Many states already have biased counseling mandates and ultrasound viewing requirements, and the number of states introducing such legislation “to protect women” may increase in response to the language in the Supreme Court decision.

Internationally, the Ban will have political and clinical ramifications. Anti-choice forces are

increasingly sharing strategies across countries. In Britain, the Netherlands, Spain and Italy, for example, such groups are currently motivating local police to investigate women who have had second-trimester abortions and clinics providing them, in order to create a climate of concern whose aim is to reduce the legal time limit for abortion (Personal communication, Marge Berer, February 2008). The deprecating language towards physicians who provide abortions and the implication that women need protection and guidance from them may equally find advocates among members of the pro-choice community who do not understand why women have abortions after the first trimester.

Protection of women's health has been a primary organising message for advocates throughout the world who are seeking to liberalise restrictive abortion laws. The US has now joined other countries in which the state's interest in the fetus is elevated above protecting women's health.

Perhaps most importantly, the US is a leader in training clinicians in D&E procedures, and has sent experts to Vietnam, Nepal, India, South Africa and Eastern Europe to train clinicians so that women needing abortions after the first trimester have the option of surgical abortion. If the Ban decreases training opportunities for clinicians in the US to become skilled in D&E, the international community may lose an invaluable resource as well.

Mobilising a response

The response by abortion rights supporters to the 2007 Supreme Court decision and other efforts to restrict abortion must begin with building public understanding of and support for the need for second-trimester abortions. While efforts should be made to ease barriers so that women can access abortion services earlier in their pregnancies, some women will always need abortions after the first trimester, whether because of difficulty accessing services, not recognising that they are pregnant, or are wrestling with the decision of what to do, or because the need for abortion does not arise until later in pregnancy. Advocates must begin to frame the discussion of second-trimester abortion in the context of all abortion – the issue is women's right to participate fully in society, and the ability to determine if and when to have children. A broad agenda must recognise that women's rights do not end when they become pregnant, and that they are entitled to make choices during pregnancy about their own health care and the trajectory of their pregnancy.

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References

- Gonzales v. Carhart 127 S.Ct. 1610; 2007.
- Partial-Birth Abortion Ban Act. 18 USC §1531; 2003.
- Strauss LT, Gamble SB, Parker WY, et al. Abortion surveillance: United States, 2003. *Morbidity & Mortality Weekly Report Surveillance Summary* 2006; 55(11):1–32.
- Roe v. Wade. 410 U.S. 113; 1973.
- Tribe LH. *Abortion: The Clash of Absolutes*. New York: Norton, 1992.
- Hull NEH, Hoffer W, Hoffer PC. *The Abortion Rights Controversy in America: A Legal Reader*. Chapel Hill: University of North Carolina Press, 2004.
- Planned Parenthood of Southeastern Pennsylvania v. Casey. 505 U.S. 833; 1992.
- Haskell M. Dilation and extraction for late second trimester abortion. second trimester abortion: from every angle. National Abortion Federation Risk Management Seminar. Dallas, 13–14 September 1992. p.27–34.
- Gorney C. Gambling with abortion: why both sides think they have everything to lose. *Harpers* 2004;309(1854): 33–46.
- Esacove AW. Dialogic framing: the framing/counterframing of “partial-birth” abortion. *Sociological Inquiry* 2004;74(1): 70–101.
- Several Sources Shelters. *The Silent Scream*. April 2007. At: <www.silentscream.org>.
- Baird-Windle P, Bader EJ. *Targets of Hatred: Anti-Abortion Terrorism*. New York: Palgrave for St. Martin's Press, 2001.
- Gorney C. *Articles of Faith: A Frontline History of the Abortion Wars*. New York: Simon & Schuster, 1998.
- Petchesky RP. Fetal images: the power of visual culture. In: *The Politics of Reproduction*. *Feminist Studies* 1987;13(2): 263–92.

15. Mason C. Cracked babies and the partial birth of a nation: millennialism and fetal citizenship. *Cultural Studies* 2000;14(1):35–60.
16. Gallup Poll News Service. Gallup's Pulse of Democracy: Abortion. Accessed 1 April 2007. At: <www.galluppoll.com/content/default.aspx?ci=1576&pg=1&VERSION=p>.
17. Center for Reproductive Rights. So-Called 'Partial-Birth Abortion' Ban Legislation: By State. 2004. Accessed 17 August 2007. At: <www.reproductiverights.org/pdf/pub_bp_pba_bystate.pdf>.
18. *Stenberg v. Carhart*. 530 U.S. 914; 2000.
19. *National Parenthood Federation of America et al v. John Ashcroft; City and Country of San Francisco v. John Ashcroft*. 320 F Supp 2d 957: US District Court for the Northern District of California; 2004.
20. *National Abortion Federation et al v. John Ashcroft*. 330 F Supp 2d 436: US District Court for the Southern District of New York; 2004.
21. *Leroy Carhart et al v. John Ashcroft*. 331 F Supp 2d 805: US District Court for the District of Nebraska; 2004.
22. American College of Obstetricians and Gynecologists. ACOG Statement on the US Supreme Court Decision Upholding the Partial-Birth Abortion Ban Act of 2003. Press release. 18 April 2007.
23. Adler NE, David HP, Major BN, et al. Psychological responses after abortion. *Science* 1990; 248(4951):41–44.
24. Adler NE, David HP, Major BN, et al. Psychological factors in abortion: a review. *American Psychologist* 1992;47(10): 1194–204.
25. Gostin LO. Abortion politics: clinical freedom, trust in the judiciary, and the autonomy of women. *JAMA* 2007;298(13): 1562–64.
26. Autry AM, Hayes EC, Jacobson GF, et al. A comparison of medical induction and dilation and evacuation for second-trimester abortion. *American Journal of Obstetrics and Gynecology* 2002;187(2):393–97.
27. Darney PD, Atkinson E, Hirabayashi K. Uterine perforation during second-trimester abortion by cervical dilation and instrumental extraction: a review of 15 cases. *Obstetrics and Gynecology* 1990;75(3 Pt 1):441–44.
28. Hogue CJ. Impact of abortion on subsequent fecundity. *Clinical Obstetrics and Gynaecology* 1986;13(1):95–103.
29. Halperin R, Zimmerman A, Langer R, et al. Laminaria dilatation and evacuation for pregnancies with mid-trimester premature rupture of membranes: a retrospective cohort study. *European Journal of Obstetrics & Gynecology and Reproductive Biology* 2002;100(2):181–84.
30. Alberto R. Gonzales, Attorney General, Petitioner v. Leroy Carhart, et al.: Oral Argument. Supreme Court 2007 November 8 [cited No. 05-380 July 12]; At: <www.supremecourtus.gov/oral_arguments/argument_transcripts/05-380.pdf>
31. Vesely R. Courts force new abortion methods: Legal second-trimester procedures could be harmful to women. 2007 June 4 [cited 2007 June 6]. At: <www.insidebayarea.com/search/ci_6056631>.
32. Blumenthal PD, Castleman LD, Jain JK. Abortion by labor induction. In: Paul M, Lichtenberg ES, Borgatta L, et al, editors. *A Clinician's Guide to Medical and Surgical Abortion*. New York: Churchill Livingstone, 1999.
33. Jackson RA, Teplin VL, Drey EA, et al. Digoxin to facilitate late second-trimester abortion: a randomized, masked, placebo-controlled trial. *Obstetrics and Gynecology* 2001;97(3):471–76.
34. Darney PD, Rosenfield A. The Supreme Court joins the multispecialty group practice of the Congress and the President. *Obstetrics and Gynecology* 2007;110(2 Pt 1):226–27.
35. Jones RK, Zolna MRS, Henshaw SK, et al. Abortion in the United States: incidence and access to services, 2005. *Perspectives on Sexual and Reproductive Health* 2008;40(1):6–16.
36. Greene MF. The intimidation of American physicians: banning partial-birth abortion. *New England Journal of Medicine* 2007;356(21):2128–29.
37. Survey conducted by the Fellowship in Family Planning, May 2007, unpublished.
38. Joffe C. The abortion procedure ban: Bush's gift to his base. *Dissent* 2007(Fall):57–61.
39. Chasen ST, Kalish RB, Gupta M, et al. Dilation and evacuation at >or=20 weeks: comparison of operative techniques. *American Journal of Obstetrics and Gynecology* 2004;190(5): 1180–83.
40. Richardson CT, Nash E. Misinformed consent: the medical accuracy of state-developed abortion counseling materials. *Guttmacher Policy Review* 2006:6–11.

Résumé

En 2007, la Cour suprême des États-Unis d'Amérique a validé la loi de 2003 interdisant l'avortement par naissance partielle. La décision affaiblit la législation sur l'avortement établie depuis des décennies qui reconnaissait que la protection de la santé de la femme était une considération dominante. La loi de 2003 affirme que les intérêts de l'État quant à la manière dont l'avortement est pratiqué et à la vie fœtale priment sur les droits des femmes. Elle sape un peu plus l'accès à un avortement légal et sans risque. La nouvelle loi influence négativement la pratique clinique à base factuelle, la formation de nouveaux prestataires de services et l'innovation clinique. Elle risque aussi d'amener des restrictions juridiques supplémentaires sur l'accès à l'avortement aux États-Unis et d'influencer la prestation de services d'avortement au plan international. Les défenseurs de l'avortement doivent préparer des stratégies centrées sur le droit de la femme à maîtriser sa fécondité tout au long d'une grossesse non désirée.

Resumen

En el año 2007, la Suprema Corte de EE.UU. confirmó la ley de Prohibición del aborto por nacimiento parcial, promulgada en 2003, también conocida como la Prohibición federal del aborto o "la Prohibición". La decisión anula la antigua ley de aborto de EE.UU., establecida hace décadas, donde se reconocía la conservación de la salud de las mujeres como un factor fundamental. La Prohibición afirma que los intereses del Estado respecto a la forma en que se realiza el aborto y la vida del feto invalidan los derechos de las mujeres. Por tanto, reduce aun más el acceso a los servicios de aborto seguro y legal. La nueva ley afecta negativamente la práctica clínica basada en evidencia, la capacitación de nuevos prestadores de servicios y la innovación clínica. Además, podría significar más restricciones jurídicas sobre el acceso al aborto en EE.UU. y afecta la prestación de servicios de aborto mundialmente. Los defensores deben formular estrategias que se centren en el derecho de las mujeres a controlar su fertilidad a lo largo de la trayectoria de un embarazo no deseado.