The federal abortion ban: a clinical and moral dilemma, and international policy setback

At 3 am on a Saturday morning you are called to your hospital ER to admit a transfer patient, a 28-year-old woman at 20 weeks of pregnancy. The pregnancy—her first—had been proceeding normally until she began experiencing abdominal pain and heavy vaginal bleeding Friday afternoon. The treating doctor at the transferring hospital determined that the patient was miscarrying, that it was not possible to save the pregnancy, and that completing the spontaneous abortion (miscarriage) would be the most appropriate treatment. The patient is being transferred to your hospital because no one on staff at the outside hospital provides abortions at 20 weeks gestation.

When you see her, the patient is pale and appears to be in pain. She is tachycardic, with a heart rate of 120 beats per minute, but normotensive at 110/68. The vagina contains blood and clots, the cervix is dilated, with brisk bleeding now, and the fetus is partially presenting through the cervix.

At this point, you, as the clinician, face a difficult decision. From a clinical point of view, a procedure to complete the abortion and empty the uterus is clearly the appropriate choice. Delaying treatment to see if the miscarriage will complete on its own would be inappropriate, since the patient is in pain and bleeding heavily. If she continues to bleed, she may require blood transfusion and possibly a hysterectomy, subjecting her to surgical risk and making her unable to bear children in the future. Her life, however, is fortunately not at immediate risk—and therein lies your dilemma as a clinician.

The new abortion law signed by President Bush in November 2003 could potentially send you to jail if your clinical management steps could be construed as involving “vaginally deliver[ing] a living, unborn child’s body” and then committing an “overt act that the person knows will kill the partially delivered infant” [1]. Although the law includes an exemption for cases in which the woman’s life is in danger, in this case, it is the woman’s health—not her life—that is at risk, a scenario for which there is no exemption.

What would you do?

With the passage of the Federal Abortion Ban (named the “Partial Birth Abortion Ban” by the law’s sponsors) in the United States, clinicians caring for women of reproductive age now face both a difficult clinical management situation and an ethical and moral quandary, in treating patients needing abortion care.

While the ban’s passage is not surprising, given the rapid erosion of reproductive rights in the U.S., the ban is at odds with the gradual international trend towards more progressive abortion-related policies. This international trend is also fragile, and there have been several notable setbacks, such as when Romania and Poland re-imposed restrictive laws, with severe and tragic consequences. As the lone superpower, the U.S. plays an important global leadership role. If successful in the U.S., the new ban could accelerate extremist conservatism in other countries, even in countries that have far more restrictive abortion laws, and far more deadly consequences for women.

A recent commentary in the New England Journal of Medicine asked, “Is this bill, as it states, simply an act intended to ban ‘a gruesome and inhumane procedure that is never medically necessary’? Or is it a carefully calculated first step in a plan to ultimately eliminate virtually all legal abortions, either by outright ban or by intimidation of abortion services providers?” [2]. The ban is a confusing and—some believe—intentionally deceptive restriction, written in a way that draws an artificial distinction around a fictitious procedure. The result is a procedure ban that erodes the principles on which the right of choice is based.

The ban’s supporters describe it as confronting “a form of violence... directed against children who are inches from birth” [3]. But the ban’s language does not specify any gestational age, so even a fetus much earlier in pregnancy with no likelihood of surviving outside the womb could potentially be considered “inches from birth” for the purposes of this law. Equating the fetus to a child (and thus abortion to infanticide), supporters of the bill remove the pregnant woman from the scenario altogether and address only the “cruelty” of abortion to the fetus. Describing so-called “partial birth” abortion as “gruesome” and deservingly illegal draws an illogical distinction between “partial birth” and all other abortion,
given that abortion procedures are designed to end a pregnancy.

The only logical extension, based on the valuation of the fetus as a child, is that other kinds of abortion will also face bans or restrictions on the basis that they too are “inhumane” to the “unborn child.” Anti-abortion legislators are already pursuing this logic: a recently proposed Virginia law requires that fetuses receive pain medication (through the pregnant woman) before abortions after the first trimester [4]. This proposed law builds on the use of a “cruelty to fetuses” argument that legitimates subjecting pregnant women to interventions that have nothing to do with protecting their health. The ultimate result of this logic can be found in South Dakota’s recent proposed law that bans all abortions unless a mother’s life is in danger. There is no exception for rape victims or women who could suffer permanent serious health problems from delivery. The chief sponsor of the proposed legislation, Republican Rep. Matt McCaulley, explained, “When we’re considering an innocent life, the health of the mother is not a substantial enough justification to take the innocent life” [5].

In addition to furthering a fetus-centered framework for abortion (which lays the groundwork to ban all abortion), the Federal Abortion Ban is the first federal law to criminalize abortion since the U.S. Supreme Court decision in Roe v. Wade legalized abortion in the United States in 1973. Physicians convicted of performing the procedure face up to 2 years in jail. Incarceration is a serious threat, and one that undoubtedly intimidates potential providers. In addition, the “chilling effect” of criminalization may deter clinicians from a wider range of patient care, education, and research activities than is explicitly banned. Physicians challenging the ban in court have had their patients’ medical records subpoenaed by the U.S. Department of Justice. The Justice Department argues that the records are needed to counter the plaintiffs’ claim that procedures outlawed by the Federal Abortion Ban are at times necessary to preserve a woman’s health. Opponents of the subpoena worry that the Justice Department is violating patients’ privacy and intimidating and harassing abortion patients and providers. In some cases, judges have rejected the subpoena, agreeing that turning over the records would violate patients’ privacy protections.

The chilling effect has international implications as well, by discouraging reform of restrictive abortion laws. The Mexico City Policy, or “global gag rule”, currently bans foreign non-governmental organizations from receiving U.S. family planning aid if they provide any abortion-related counseling or advocate liberalizing abortion, with their own funds. Like the global gag rule, the Federal Abortion Ban is likely to create confusion about what is and is not banned, and thus has the potential to “chill” a much broader range of clinical and educational activities.

Finally, Federal Abortion Ban supporters are exploiting and fomenting discomfort over late term abortions, even though the law is written in a way that applies to abortions over much a broader range of gestational ages. Some abortion-rights advocates might understandably believe that restricting or banning later term abortion would be a reasonable compromise to shore up public support for abortion rights, given that the vast majority of abortions in the United States occur in the first trimester [6]. But ceding this issue in the hopes of establishing a truce or compromise is simply misguided. The Federal Abortion Ban specifies no gestational limits, and the ban itself is predicated on principles antithetical to allowing women to make decisions about their pregnancies: namely, that fetal “interests” can overcome the health considerations of the pregnant woman, and can justify the criminalization of medically appropriate care.

The Federal Abortion Ban can be a difficult subject to discuss: the terminology of the legislation and issue is misleading and inflammatory. However, the principles underpinning opposition to the ban should be clarified, including the following three principles:

- All medical care, including abortion care, should be based on clinical standards with the goal of meeting patients’ needs and minimizing risk to patients.
- Physicians should not risk criminal prosecution or imprisonment for providing clinically appropriate care for their patients.
- The decision about whether to continue or terminate a pregnancy is a highly personal one. The rights and means to make this decision are fundamental to women’s full participation in society and to women’s equality.

Compromising on core principles like these is unlikely to be helpful, and in the long run, will undermine efforts to retain the shrinking reproductive rights and freedoms that remain in the U.S. In addition, U.S. leadership toward conservative policies may stall—or even reverse—the progress made by other countries in reproductive health. In these countries, the consequences for women—who may lack access to safe abortion and basic health care—are likely to be far more severe than in the U.S.

Whether or not we provide abortion care, as clinicians, researchers and advocates for sound reproductive health policies (whether in the U.S. or internationally), we can help by supporting our colleagues who are standing up for principles such as patient confidentiality and women’s health and well-being. We can also clarify confusing or misleading elements of the new law and media reports of the issue, and help focus discussion on the underlying principles at stake. The passage of the Federal Abortion Ban need not be the beginning of the end of legal abortion, but the beginning of
an honest and meaningful discussion about the importance of safeguarding reproductive rights.

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References