Abortion Partial Birth - Medical Statements

Abortion - partial birth - med statements

May 20, 1997

The Honorable Rick Santorum
United States Senate
Senate Russell 120
Washington, DC 20510

Dear Senator Santorum:

After months of intense deliberation, the American Medical Association (AMA) is writing to support HR 1122, "The Partial-Birth Abortion Ban Act of 1997," as amended. Although our general policy is to oppose legislation criminalizing medical practice or procedure, the AMA has supported such legislation where the procedure was narrowly defined and not medically indicated. HR 1122 now meets both those tests.

Our support of this legislation is based on three specific principles. First, the bill would allow a legitimate exception where the life of the mother was endangered, thereby preserving the physician's judgment to take any medically necessary steps to save the life of the mother. Second, the bill would clearly define the prohibited procedure so that it is clear on the face of the legislation what act is to be banned. Finally, the bill would give any accused physician the right to have his or her conduct reviewed by the State Medical Board before a criminal trial commenced. In this manner, the bill would provide a formal role for valuable medical peer determination in any enforcement proceeding.

The AMA believes that with these changes, physicians will be on notice as to the exact nature of the prohibited conduct.

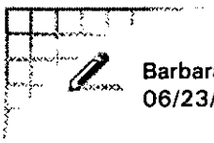
Thank you for the opportunity to work with you towards restricting a procedure we all agree is not good medicine.

Sincerely,

P. John Seward, M.D.

P. John Seward, MD

Abortion - partial birth - medical statements



Barbara D. Woolley
06/23/97 11:14:43 AM

Record Type: Record

To: See the distribution list at the bottom of this message

cc: Marjorie Tarmey/WHO/EOP
Subject: AMA/ACOG Joint Statement on HR 1122

Today, AMA and ACOG released a joint statement on HR 1122. The statement highlights where the two organizations agree and disagree to assure that interested parties get a fair understanding of the exact nature of their disagreements.

They state that although they took different positions on the legislation they agree that clarity in definition is critical to any legislation prescribing the conduct of physicians, particularly when the penalties are criminal. If the application of the statute expands beyond what AMA believes is the intent, AMA and ACOG, will oppose such applications and will fully support any physician who is prosecuted.

Message Sent To:

Maria Echaveste/WHO/EOP
Tracey E. Thornton/WHO/EOP
Janet Murguia/WHO/EOP
Jennifer L. Klein/OPD/EOP
Ann F. Lewis/WHO/EOP
Elena Kagan/OPD/EOP
Robin Leeds/WHO/EOP

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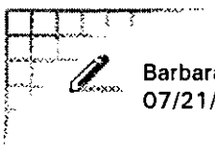

Barbara D. Woolley
07/21/97 06:47:54 PM

Record Type: Record

To: Jennifer L. Klein/OPD/EOP, Elena Kagan/OPD/EOP, Maria Echaveste/WHO/EOP

cc: Marjorie Tarmey/WHO/EOP
Subject: American College of OBGYNs - Policy on Abortion - Update

ACOGs Executive Board recently met to reaffirm position.

"continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus to survive outside the mother's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible attending physician."

Abortion - partial birth - med statements

American Medical Association

Physicians dedicated to the health of America

News Release

May 14, 1997

Statement is attributable to: Nancy Dickey, MD
Chair
American Medical Association

LATE TERM ABORTION

"The American Medical Association Board of Trustees has forwarded to its House of Delegates for its consideration at AMA's Annual Meeting in June a report regarding late term abortions as requested by the House at its last meeting (December 1996). The report does not become AMA policy until approved by the House of Delegates. The report, which is based on the advice of an expert panel convened by the AMA and consisting of representatives from American College of Obstetricians and Gynecologists, American Academy of Family Physicians, American Academy of Pediatrics and AMA Councils on Ethics, Scientific Affairs and Legislation, reaffirms existing policy that abortion is a medical procedure subject to state laws and the standards of good medical practice.

"The report finds there is no 'identified situation' where intact dilatation and extraction or intact D&X (sometimes referred to as "partial birth abortion") is the 'only appropriate procedure' to induce abortion and it recommends against the use of the procedure except in unforeseen circumstances where it may be absolutely necessary.

"In addition, the report recommends that physicians not use abortion procedures for terminating pregnancies in the third trimester, other than in extraordinary circumstances or where severe fetal anomalies inconsistent with life exist, because sacrificing the fetus and/or destruction of the fetus is rarely necessary even when ending the pregnancy to preserve the life or health of the mother. Finally, the report calls on the medical profession, community organizations and the government to initiate more aggressive education efforts in order to reduce the demand for abortions generally.

"The report does not directly address any pending legislation regarding 'partial birth abortion.' The AMA does not support any legislative proposals at this time."

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Abortion -- partial birth - medical statements

ADDENDUM TO THE REAFFIRMED 1993 ACOG POLICY ON ABORTION

The American College of Obstetricians and Gynecologists (ACOG) continues to affirm the legal right of a woman to obtain an abortion prior to fetal viability. ACOG is opposed to abortion of the healthy fetus that has attained viability in a healthy woman. Viability is the capacity of the fetus to survive outside the mother's uterus. Whether or not this capacity exists is a medical determination, may vary with each pregnancy and is a matter for the judgment of the responsible attending physician.

Approved by the Executive Board
July 1997

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

ACOG POLICY ON ABORTION

1. The abortion debate in this country is marked by serious moral pluralism. Different positions in the debate represent different but important values. The diversity of beliefs should be respected.

2. The American College of Obstetricians and Gynecologists recognizes that the issue of support of or opposition to abortion is a matter of profound moral conviction to it members. ACOG, therefore, respects the need and responsibility of its members to determine their individual positions based on personal values or beliefs.

3. Termination of pregnancy before viability is a medical matter between the patient and physician, subject to the physician's clinical judgment, the principles in their own practices and to support them at the community level.

   Society also has a responsibility to support research leading to improved methods of contraception for men and women.

5. Informed consent is an expression of respect for the patient as a person; it particularly respects a patient's moral right to bodily integrity, to self-determination regarding sexuality and reproductive capacities, and to the support of the patient's freedom within caring relationships.

   A pregnant woman should be fully informed in a balanced manner about all options, including raising

Abortion - Partial Birth - Medical Statement

May 19, 1997

The Honorable Trent Lott
Senate Majority Leader
S-230 Capitol Building
Washington, DC 20510-7010

Dear Senator Lott:

In light of the slight modifications being proposed to HR 1122, the "Partial-Birth Abortion Ban Act of 1997," we wanted to take this opportunity to reiterate our opposition to this legislation. Our statement on this issue is attached.

Sincerely,

Ralph W. Hale

Ralph W. Hale, MD
Executive Director

ACOG *Statement of Policy*

As issued by the ACOG Executive Board

STATEMENT ON INTACT DILATATION AND EXTRACTION

The debate regarding legislation to prohibit a method of abortion, such as the legislation banning "partial birth abortion," and "brain sucking abortions," has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques.

The American College of Obstetricians and Gynecologists (ACOG) believes the intent of such legislative proposals is to prohibit a procedure referred to as "Intact Dilatation and Extraction" (Intact D & X). This procedure has been described as containing all of the following four elements:

1. deliberate dilatation of the cervix, usually over a sequence of days;
2. instrumental conversion of the fetus to a footling breech;
3. breech extraction of the body excepting the head; **and**
4. partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.

Because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D & X.

Abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D & X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based upon the patient's individual circumstances.

According to the Centers for Disease Control and Prevention (CDC), only 5.3% of abortions performed in the United States in 1993, the most recent data available, were performed after the 16th week of pregnancy. A preliminary figure published by the CDC for 1994 is 5.6%. The CDC does not collect data on the specific method of abortion, so it is unknown how many of these were performed using intact D & X. Other data show that second trimester transvaginal instrumental abortion is a safe procedure.

continued. . .

STATEMENT ON INTACT DILATATION AND EXTRACTION (continued)
Page Two

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the **only** option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. **The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.**

Approved by the Executive Board
January 12, 1997

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NOT YET POLICY

ENTIRE REPORT SUBJECT TO AMA House of Delegates Review in June (1997)

REPORT OF THE BOARD OF TRUSTEES

B of T Report 26 - A-97

Subject: Late-Term Pregnancy Termination Techniques

Presented by: Nancy W. Dickey, MD, Chair

Referred to: Reference Committee B
(Mark A. Levine, MD, Chair)

Induced abortion through the first trimester was legal under common law in the United States until the middle of the 19th century.1 By 1900, it was prohibited by law unless two or more physicians agreed that the procedure was necessary to preserve the life of the pregnant woman2 During the late 1960s, state legislatures began to reconsider the legalization of abortion, and in January, 1973, abortion became legal on a national basis as a result of the U.S. Supreme Court decisions in Roe v. Wade, 410 U.S. 113 (1973) and Doe v Bolton, 410 U.S. 179 (1973).

In Roe v. Wade and Doe v. Bolton the U.S. Supreme Court held that states could not interfere with the physician-patient decision about abortion during the first trimester of pregnancy. After the first trimester, and prior to viability, the State could promote its interest in the health of the mother by regulating the abortion procedure in ways that are reasonably related to maternal health. Maternal health included physical, emotional, psychological well-being, familial factors, as well as the woman's age3

In Roe v. Wade, the Supreme Court noted that the timing of viability can be difficult to establish precisely. The Court defined viability as "the capacity for meaningful life outside the mother's womb, albeit with artificial aid," and not just momentary survival. The Court noted that viability usually occurred at approximately 28 weeks but could occur as early as 24 weeks.4 The Court stated that it is the professional responsibility of the physician to determine whether the fetus has the capacity for meaningful life, and not merely temporary survival.

For the stage subsequent to viability, the Court determined that the State, in promoting its interest in the potentiality of human life, could regulate and even proscribe abortion unless it was deemed by medical judgment to be necessary to preserve the life or health of the pregnant woman5 To identify the points at which the state's interest in maternal health and potential life become "compelling," the Court established the trimester framework for state regulation.6

In Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976), the Court stated that "[t]he time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician."7 The Court rejected the argument that state legislation should specify a number of weeks as the point of viability, reaffirming that the onset of viability was essentially a medical concept, not an issue for legislative determination.8

In Webster v. Reproductive Health Services, 492 U.S. 490 (1989) the Supreme Court did, however, uphold a provision in a state statute that created "what is essentially a presumption of viability at 20

weeks, which the physician must rebut with tests indicating that the fetus is not viable prior to performing an abortion."9 In Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992), the Court acknowledged that advances in neonatal care moved viability to a point somewhat earlier than when Roe v. Wade was decided. The Court went on to state that this fact had "no bearing on the validity of Roe's central holding, that viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions."10

Abortion at any stage of gestation has long been controversial in the United States, but in recent years, public debate about abortion, particularly during the second and third trimesters, has increased, as have concerns about the medical and surgical procedures used for second- and third-trimester abortion. This was most clearly demonstrated through recently proposed federal legislation, HR 1833, the "Partial Birth Abortion Act of 1995."11 The bill would modify the U.S. Criminal Code to make it a federal crime for a physician or other individual legally authorized by the State to perform an abortion that would "partially vaginally deliver a living fetus before killing the fetus and completing the delivery,"12 unless the procedure was performed to the save the life of the woman and there were no other alternative methods available. The physician would also be liable for monetary and statutory damages to the father of the fetus or the maternal grandparents of the fetus if the mother were under 18 years of age.

From a medical perspective, the language used in the proposed legislation---"partially vaginally deliver a living fetus before killing the fetus and completing the delivery"---does not refer to a specific obstetrical/surgical technique, nor does it refer to a specific stage of gestation (i.e., pre- or post-viability). In fact, the description in the proposed legislation could be interpreted to include many recognized abortion and obstetric techniques (such as those used during dilation and evacuation (D&E)), or other procedures used to induce abortion. (A definition of D&E appears on pages 7 and 8.)

Although the language in HR1833 was vague from a medical perspective, a description of "partial birth abortion" emerged during Congressional testimony in November, 1995. In the hearings, the term "partial birth abortion" was used to describe a procedure in which the fetus is converted to a footling breech position and there is a breech extraction of the body excepting the head. A partial evacuation of the intracranial contents of a living fetus is performed to effect vaginal delivery of a dead but otherwise intact fetus.13 This procedure was first described by an Ohio physician as intact dilatation and extraction (D&X), at a meeting of the National Abortion Federation in September, 1992.14 (A definition of intact D&X by the American College of Obstetricians and Gynecologists (ACOG) appears on page 8.)

Supporters of the "Partial Birth Abortion Ban Act" inside and outside of organized medicine have argued that this method of induced abortion is abhorrent and never the only or best procedure to use.15, 16, 17, 18 Opponents of the bill expressed their concern about the intrusion of legislative bodies into medical decision-making, the vagueness of the language used to describe the procedure, the lack of specific guidelines about gestational age, the absence of exceptions for cases in which the banned procedures would be necessary to preserve a woman's health, and that the life exception was too narrow.19, 20, 21, 22

HR1833 was vetoed by President Clinton in April, 1996. In March, 1997, an identical version of the "Partial Birth Abortion Ban Act," HR1122, was reintroduced into the House of Representatives and passed by a vote of 295-136.23

At the 1996 Interim Meeting, the American Medical Association (AMA) House of Delegates passed Substitute Resolution 208 (I-96), which addressed late-term pregnancy termination techniques. The resolution was adopted in lieu of Resolutions 208 (I-96) and 225 (I-96), and required: 1) that the AMA

reaffirm current policy regarding abortion, specifically policies 5.990, 5.993, and 5.995; 2), that the AMA Board of Trustees, in consultation with pertinent AMA Councils and medical specialty societies, undertake a study of which late-term pregnancy termination techniques and circumstances conform to the "standards of good medical practice" as required by policies 5.993 and 5.995; and 3) that the AMA work with pertinent medical specialty organizations to develop appropriate clinical practice guidelines for late term pregnancy termination.

AMA policy 5.990 states that "the issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures (Amended Res. 158, A-90)."

AMA policy 5.993 states that "the AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or personally held moral principles. In these circumstances good medical practice requires only that the physician or other professional withdraw from the case so long as the withdrawal is consistent with good medical practice. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities (Res. 49, I-89)."

AMA policy 5.995 states that "the AMA reaffirms that (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice. (Sub. Res. 43, A-73; Reaffirmed: I-86; Reaffirmed: Sunset Report, I-96; Reaffirmed by Substitute Resolution 208, I-96)."

In response to Substitute Resolution 208 (I-96), the AMA convened a study group comprised of one representative from each of the following groups: the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the AMA Council on Scientific Affairs, the AMA Council on Legislation, the AMA Council on Medical Education, and the AMA Council on Ethical and Judicial Affairs. A representative from the Illinois State Medical Society which introduced the original Resolution 225, and from the Pennsylvania Medical Society which introduced the original Resolution 208, also participated in the study group. Representatives were invited to comment on late term pregnancy termination techniques and circumstances that would conform to the "standards of good medical practice," and about the development of clinical practice guidelines for late-term abortion.

Substitute Resolution 208 left undefined the phrase "late-term pregnancy termination techniques" and, in particular, whether these procedures would apply only to third trimester procedures, or whether they would include all post-viability procedures (which may occur during the second-trimester). Some of the medical procedures used to induce abortion prior to viability are the same or very similar to procedures used in post-viability abortions, and therefore there is no clear distinction between some later-term pregnancy termination techniques and those which are used earlier to end the pregnancy. In this report,

viability is presumed to exist after 27 weeks of gestation (assuming an otherwise healthy fetus), and is presumed not to exist prior to 20 weeks. The time period between 20 and 27 weeks is a "gray zone" in which some fetuses may be viable while others are not. As used here, late-second-trimester abortion refers to a procedure performed between the 20th and 27th weeks of gestation, and a late-term abortion refers to a procedure performed during the third-trimester, defined at 27 weeks or more. It is also worth noting that Substitute Resolution 208 refers broadly to "pregnancy termination techniques." In this report, the techniques to be studied are those intended to induce abortion and not those intended to deliver a living fetus.

This report provides background information on late-term abortion that can be used to address Substitute Resolution 208. The report is divided into six sections. The first section describes the prevalence of induced abortion and limitations of data on later-term abortions. Procedures used to induce abortion at earlier and later stages of pregnancy are described in the second section, and a review of complications and sequelae related to abortion are described in the third section. A discussion of the legal context of medical decision-making regarding abortion appears in the fourth section, and a more detailed summary of United States Supreme Court decisions regarding abortion appears in Appendix A. The fifth section of the report describes the policies of major medical societies on late-term abortion. An overview of ethical considerations related to abortion in general and with respect to gestational age appears in Appendix B. The report concludes with a set of proposed policy statements for consideration by the AMA House of Delegates.

PREVALENCE OF AND REASONS FOR INDUCED ABORTION

The Centers for Disease Control and Prevention (CDC) defines an induced abortion as "a procedure intended to terminate a suspected or known intrauterine pregnancy and to produce a nonviable fetus at any gestational age."[24] A molar pregnancy, ectopic pregnancy, or fetal death diagnosed before any intervention are not regarded as an induced abortion.

The most scientifically reliable, national data on the incidence of abortion and characteristics of women who have abortions in the United States come from the Centers for Disease Control and Prevention and the Alan Guttmacher Institute (AGI). The Alan Guttmacher Institute is an independent, nonprofit corporation for research, policy analysis, and public education. Because the prevalence of late-term abortion procedures has been questioned in the popular press, it is worth describing the type of national abortion statistics which are collected in the United Statistics as well as methods of data collection.

Both the CDC and the AGI collect data on the total number of abortions in the United States. The CDC data are derived primarily from reports by state health departments, whereas the AGI collects data directly from abortion providers. For many years AGI estimates of the number of abortions performed in the United States each year have been higher and considered to be more accurate than those reported by the CDC.[25, 26] However, AGI does not collect data on gestational age. Instead, it uses CDC data on the number of abortions performed at various gestational ages and makes statistical adjustments for discrepancies between AGI and CDC data when publishing its estimates.

Although the CDC collects annual data on abortion, the data have limitations. First, all states do not provide abortion-related information to the CDC. As recently as 1992, Alaska, California, Iowa, New Hampshire and Oklahoma did not collect data on abortion. For these states the CDC conducted limited surveys of abortion providers or estimated the number of abortions.[25-27] Second, information from state health departments on abortion is often incomplete, with some states lacking information on as many as

40% to 50% of the abortions performed in the states.26, 27 Third, the categories used by the CDC to report the method of abortion differentiate between D&E, labor induction procedures, and hysterotomy/ hysterectomy, but they do not have a separate category for D&X. Fourth, states vary in their method of recording gestational age. Some use the number of weeks since the first day of the woman's last menstrual period, and others record the physician's estimate of gestational age. Finally, although the CDC is the only organization which collects national data on abortion by weeks of gestation, it does not provide a detailed breakdown of abortions performed at 21 weeks and beyond.

Despite these limitations, the CDC and AGI remain the most reliable sources of national data on abortions. As shown in Table 1, the vast majority (95%) of induced abortions are done at or before 15 weeks' gestation, in the first or very early second-trimester.27

Table 1: Induced Abortion: 1992

Gestational Age	Number	Percent of procedures
≤ 8 weeks	798,850	52%
9-10 weeks	377,570	25%
11-12 weeks	181,960	12%
13-15 weeks	94,060	6%
16-20 weeks	60,040	4%
21 weeks or more	16,450	1%
TOTAL	1,528,930	100%

A more detailed, estimated breakdown of the number of induced abortions at 21 weeks or more appears in Table 2.27 The estimate is based on data from the CDC abortion surveillance reports, data collected by the National Center for Health Statistics (NCHS) from 14 states, and AGI survey data; estimates were calculated by the AGI. However, these estimates must be viewed cautiously. First, they are based on a limited number of states which may not be representative of the nation as a whole, and reporting by these states may be incomplete. Second, assuming that the number of providers who perform late-term abortions is relatively small,27 they may have relatively large caseloads. The number of late-term abortions would be underestimated if these providers were not in the NCHS sample. Third, random errors in coding gestational age could substantially inflate the estimated number of abortions performed beyond 26 weeks, because these procedures constitute such a small proportion of abortions overall. Fourth, clinician errors in estimating gestational age could bias the data in unknown ways. Finally, natural fetal deaths beyond 20 weeks of gestation reported to the NCHS may be mistakenly counted as abortions if the fetus were removed using procedures commonly used to induce abortion.27

Table 2: Estimated Number of Late-Second- and Third-Trimester Induced Abortions

Gestational Age	Number	Percent of procedures at 21 weeks or later
21-22 weeks	10,340	63%
23-24 weeks	4,940	30%
25-26 weeks	850	5%
>26 weeks	320	2%

TOTAL	16,450	100%

According to these estimates, two-thirds of abortions beyond 20 weeks are performed between 21 and 22 weeks. After 26 weeks, the number of abortions nationwide is estimated as being between 320 and 600. While it is not possible to quantify the type of D&E procedure used in these circumstances, it is estimated that 86% of all abortions performed past 20 weeks of gestation are performed by dilation and evacuation (D&E), and most of the remainder by inducing labor.27

In 1992, teenagers were more likely than older women to have an abortion at 16 weeks of gestation or later.25 Approximately 9% of women 19 years of age and younger who had an abortion in 1992, had the procedure performed at 13 weeks of gestation or later, compared to 5% of women 20 years of age and older.25 Seven percent of women who were black or of other races who had an abortion in 1992 had the procedure performed during the second- or third-trimester, compared to 5% of white women. Differences between Hispanic and non-Hispanic women were minimal (6.5% and 6.3%, respectively)25

Little research has been done on reasons for induced abortion in the second-trimester. In 1987, AGI conducted a survey of patients in 30 abortion facilities in which at least 400 abortions were performed annually and which performed abortions at 16 or more weeks of gestation.28 The 30 providers represented each of the four regions of the country and the average patient response rate was 80 percent. Of the 1,900 women in the survey, 420 had been pregnant for 16 or more weeks and they were asked to report the most important reasons for their delay in having an abortion. Seventy-one percent reported that they did not recognize that they were pregnant or misjudged gestation. Forty-eight percent reported having difficulty making arrangements for an abortion (particularly raising enough money for the procedure), 33% were afraid to tell their parents or partner, and 24% reported having had great difficulty with the decision to have an abortion. Women having a later abortion were more likely than other women to cite personal health problems, possible fetal health problems, or rape or incest as having caused the pregnancy.

Medical reasons for second-trimester abortions can include maternal indications, such as those which threaten her health or life. For some women the condition may have existed prior to the pregnancy, for others a condition may have occurred during the pregnancy, and for others, the condition could have resulted from the pregnancy itself.

Some serious fetal abnormalities are not diagnosed until the second-trimester and the discovery of such anomalies prompt some women to decide to terminate the pregnancy by inducing abortion. Amniocentesis is usually performed between the 14th and 18th weeks of pregnancy, and the results usually are not available for another two to three weeks. Chorionic villus sampling (CVS) can be performed earlier, between the 10th and 12th weeks of pregnancy. Preliminary results are usually available within 48 hours and confirmatory, final results typically take a maximum of 7 to 10 days. However, the timing of an induced abortion prompted by the discovery of fetal anomalies through CVS or amniocentesis is almost certain to occur after the first trimester.

PROCEDURES USED TO INDUCE ABORTION

The procedure used to induce abortion depends, in part, on gestational age, commonly defined as the number of weeks since the first day of the last menstrual period, based on a 28-day menstrual cycle29 The percentage of reported legal abortions by weeks of gestation and type of procedure appears in Table 3.25 As can be seen, suction or sharp curettage and dilatation and evacuation are the most common procedures used to induce abortion in the United States (99%). However, by 16 weeks of gestation and beyond, approximately 9% of induced abortions are performed using labor induction techniques.

Hysterotomy and hysterectomy are used very rarely, regardless of gestational age.

Table 3: Percentage of Reported Legal Abortions, by Weeks of Gestation and Type of Procedure---United States, 1992

	Weeks of gestation				
Type of procedure	<8-12 weeks	13-15 weeks	16-20 weeks	≥21 weeks	Total
Curettage (suction or sharp)a	99.9%	98.2%	86.0%	86.4%	99.0%
Labor inductionb	0.0% c	1.0%	8.8%	9.1%	0.6%
Hysterotomy Hysterectomy	0.0% c	0.0%c	0.0%c	0.1%	0.0%c
Otherd	0.09%	0.8%	5.1%	4.4%	0.4%
Totale	100%	100%	100%	100%	100%

aIncludes dilatation and evacuation
bIncludes intrauterine saline instillation and intrauterine prostaglandin instillation
c<0.05%
dIncludes instillation procedures not reported as a specific category
eReported by 35 states and New York City

First Trimester Procedures to Induce Abortion

Since the 1970s, vacuum aspiration, also referred to as suction curettage, has been the most common procedure used to induce abortion in the first trimester (i.e., from the 6th through 12th week of gestation).24-26 Prior to the procedure a pelvic examination is done to determine the size and position of the uterus. A speculum is used to visualize the cervix, a local anesthetic such as a paracervical block is administered, and the cervix is then dilated using rigid dilators (e.g., the Pratt dilator)30 Osmotic dilators may be used prior to the procedure. Once the cervix is sufficiently dilated, a suction tube is inserted and rotated inside the uterus to loosen and remove the contents. The suction tube may be attached to a suction machine or syringe. A curette may be used to scrape the endometrium, thereby ensuring the removal of any remaining tissue.30, 31 These procedures are typically performed on an outpatient basis.

Menstrual regulation, also known as menstrual extraction, is a type of early suction curettage. After inserting the cannula, the clinician attaches the syringe, releases the pinch valve, and suctions blood and tissue into the syringe. The procedure can be performed no later than 42 to 50 days from the last menstrual period.32 Neither anesthesia nor dilation are usually necessary.

In the last several years, pharmaceutical agents have also been used to induce abortion in the first trimester. These include mifepristone (RU-486), a synthetic hormone, which can be used within 9 weeks of the last menstrual period.31 Mifepristone causes the lining of the uterus to shed by blocking progesterone, thereby terminating the pregnancy. To induce abortion, the woman takes one oral dose of mifepristone followed a few days later by misoprostol, to stimulate uterine contractions and expel the

embryo.31 Methotrexate used in conjunction with misoprostol represents a second pharmaceutical approach.33

Early-Second-trimester Procedures to Induce Abortion

During the second-trimester the most common procedure used to induce abortion is dilation and evacuation (also referred to dilatation and evacuation or D&E), which refers generically to transcervical procedures performed at 13 weeks gestation or later34-36 Labor induction techniques can also be used during the second-trimester though they are more common in the late-second and third-trimesters. These procedures are described below.

Dilation and evacuation procedures are usually performed early in the second-trimester, that is, in the 13th through 15th week of gestation.25, 36 Ultrasonography is used prior to the procedure to confirm gestational age, because the underestimation of gestational age can have serious consequences during a D&E procedure.32, 37-39 D&E is similar to vacuum aspiration except that the cervix must be dilated more widely because surgical instruments are used to remove larger pieces of tissue. Osmotic dilators are usually used. Intravenous fluids and an analgesic or sedative may be administered. A local anesthetic such as a paracervical block may be administered, dilating agents, if used, are removed, and instruments are inserted through the cervix into the uterus to remove fetal and placental tissue. Because fetal tissue is friable and easily broken, the fetus may not be removed intact. The walls of the uterus are scraped with a curette to ensure that no tissue remains. In pregnancies beyond 14 weeks, oxytocin is given intravenously to stimulate the uterus to contract and shrink30- 32

Mid-Second-Trimester and Third-Trimester Procedures to Induce Abortion

By the 16th to 24th week of gestation there are several alternative procedures that can be used to induce abortion, though some are more common than others. These include dilation and evacuation (which may or may not be preceded by induced fetal demise), dilation and extraction (D&X), labor induction, hysterotomy and hysterectomy.

By the 16th week of gestation, ultrasonography should be used to verify gestational age. Dilation and evacuation procedures performed in the mid- to late-second-trimester involve the preoperative use of laminaria or osmotic dilators (rather than surgical dilators) which are inserted in the endocervical canal in order to dilate the cervix. The procedure is usually performed under local anesthesia, using sedation and paracervical block. Intracervical vasopression is often used to minimize bleeding, and high dose oxytocin is administered intravenously prior to the procedure. Fetal tissue is extracted through the use of surgical instruments, followed by extraction of placental tissue and subsequent curettage32, 36 Because the fetus is larger at this stage of gestation (particularly the head), and because bones are more rigid, dismemberment or other destructive procedures are more likely to be required than at earlier gestational ages to remove fetal and placental tissue. Some physicians use intrafetal potassium chloride or digoxin to induce fetal demise prior to a late D&E (after 20 weeks), to facilitate evacuation30

To minimize uterine or cervical perforation either from instruments used during the D&E, or through piercing by fetal parts, some physicians use a form of D&E that has been referred to in the popular press as intact dilation and extraction (D&X). According to the American College of Obstetricians and Gynecologists, intact D&X is comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus.19 This procedure may minimize trauma to the woman's uterus, cervix, and other vital organs. Intact D&X may be preferred by some

physicians, particularly when the fetus has been diagnosed with hydrocephaly or other anomalies incompatible with life outside the womb.
As gestational age increases, particularly during the 16th to 24th week, labor induction techniques are more commonly used to induce abortion.25 Labor induction techniques can be subdivided by the type of abortifacient used (hypertonic solutions such as urea or saline), and prostaglandin inductions (e.g., prostaglandin E2 suppositories).32, 39 The use of hypertonic solutions typically produce fetal death from osmotic insult, and labor then usually follows. In a saline abortion, a needle is inserted through the abdomen and the amniotic sac is injected with a concentrated salt solution. This results in fetal demise and induces contractions of the uterus. Over several hours, the contractions cause the cervix to dilate and the contents of the uterus to be expelled. Alternatively, urea, a nitrogen-based solution that causes fetal demise when injected into the amniotic sac, typically is used in conjunction with subsequent administration of prostaglandins, to induce contractions of the uterus and to expel its contents31 Unlike saline instillation, the use of urea does not cause maceration of the fetal tissues and thereby interfere with the histologic diagnosis of some types of fetal abnormalities.40

Hysterotomy and hysterectomy have been used to terminate pregnancy but are not used routinely as a form of abortion because maternal mortality and morbidity associated with these procedures are significantly greater than those associated with other procedures used to induce abortion26, 34, 41, 42 Hysterotomy involves the surgical delivery of the fetus through an incision in the uterine wall and the abdomen. Anesthesia is administered through an epidural, a spinal, or through general anesthesia. After removing the fetus the umbilical cord is cut and placenta removed. Hysterotomy involves major surgery and must be done in a hospital setting. It typically lengthens a woman's hospital stay and recovery31 Hysterectomy is appropriate in cases in which there is a preexisting pathology, such as large leiomyomas or carcinoma in situ of the cervix.32

ABORTION-RELATED COMPLICATIONS AND SEQUELAE

Maternal Mortality

Maternal mortality is the most serious complication resulting from induced abortion, and the risk of maternal death increases with gestational age. In 1991, the overall rate of maternal mortality was one per 167,000 abortions.43 The risk of maternal death from induced abortion at 8 weeks gestation or less was one in 600,000 procedures, but by 16-20 weeks increased to one in 17,000 procedures. At 21 weeks or more it increased to one in 6,000 procedures, and exceeded the risk of maternal death from childbirth, which was one in 13,000 deliveries, though the difference was not statistically significant43

Maternal mortality rates comparing dilation and evacuation, labor induction, and hysterectomy/ hysterotomy at 13 weeks gestation or later are shown in Table 4.44 For all types of procedures maternal mortality rates increase with gestational age, but they are significantly greater for hysterectomy and hysterotomy, regardless of gestational age. Maternal mortality rates, overall, are higher for labor induction than D&E (7.1 and 3.7, respectively), but mortality rates resulting from labor induction and D&E are comparable for induced abortions performed at 21 weeks or more (11.9 and 10.3).

Table 4: Maternal Mortality Rates* for Induced Abortion Procedures at 13 Weeks' Gestation or Later, United States, 1974-1987

Type of procedure	Weeks of gestation			
	13-15 weeks	16-20 weeks	≥21 weeks	Total
Dilation and evacuation	2.0	6.5	11.9	3.7
Labor induction	3.8	7.9	10.3	7.1
Hysterectomy/ hysterotomy	28.1	103.4	274.3	51.6

*Per 100,000 abortions

Maternal Morbidity

It is difficult to estimate abortion-related morbidity because definitions of what constitutes a complication vary widely, and because in the United States national data on abortion-related morbidity have not been collected on a systematic, ongoing basis. The best available national data on complications was collected during the 1970s by the Joint Program for the Study of Abortion (JPSA), sponsored by the Population Council (New York, NY) and the CDC.45 JPSA consisted of three prospective studies of abortion between 1971 and 1978, and involved a sample of hospitals and clinics throughout the United States. Between 73,000 and 84,000 women were involved in each phase of the research program.

The most commonly used indicator of abortion-related morbidity is admission to a hospital. This excludes minor physical sequelae but captures fairly accurately the more serious maternal aftereffects of induced abortion. The CDC defines major complications from induced abortion as those that result in major unintended surgery, a hemorrhage requiring a blood transfusion, a hospitalization of 11 days or more, or a temperature of at least 38.0oC (100.4oF) that lasts for 3 or more days.46

Between 1970 and 1990 the overall risk of major complications from abortion-related procedures declined dramatically. From 1970 to 1971 there were eight major complications per 1000 abortion patients who did not have a preexisting medical condition or undergo sterilization in those years.47 Between 1975 and 1978 the rate dropped to five major complications per 1000 abortions,46 and by 1990, the National Abortion Federation (Washington, DC) estimated that there was one complication per 1000 abortions.48 The overall decline in complication rates can probably be attributed to an increased proportion of procedures being performed earlier in the pregnancy, improvements in medical technology, and improvements in medical training.

The risk of complications is related to the abortion method used. Between 1975 and 1978, the last years of the Joint Program for the Study of Abortion, the complication rate associated with vacuum aspiration was two per 1000 procedures, while dilation and evacuation had a complication rate of seven per 1000 procedures. Procedures that induced labor (saline or prostaglandin instillation) had a higher rate (21 and 25 per 1000 procedures, respectively), and those involving major surgery had the highest rate of complications.47

The risk of complications and complication rates from induced abortion are also related to gestational age. From 1975 to 1978 there were between 1 and 4 major complications per 1000 procedures performed through the 12th week of gestation.32 There were 6 major complications per 1000 procedures performed in weeks 13 to 14, 13 per 1000 in weeks 15 to 16, and 19 per 1000 in weeks 17 through 2032

More recent, international data have also shown that complication rates increase with gestational age. Direct comparisons on abortion-related complication rates between countries must be made with caution because of differences in the definition and measurement of complications. Nonetheless data from 1988 for Denmark, West Germany, and New York State, and from 1987 for Canada, England and Wales, showed complication rates ranging from 0.4% to 3.4% for first-trimester abortions, and from 1.1% to 8.7% for second-trimester abortions. 49 However, more research on major complication rates associated with various procedures and by gestational age is needed before any firm conclusions about the relative safety of procedures can be made.

Cervical incompetence and compromised subsequent pregnancies are important but unresolved concerns related to abortions performed in the second- or third-trimester. Unfortunately, there is little research on whether these complications are more likely to result from D&E (or intact D&X), or from labor induction techniques. Some physicians prefer D&E over labor induction methods for second-trimester abortions because, they argue, it has a lower mortality rate, it takes less time, it is less expensive, it can be done on an outpatient basis, and it takes less of a psychological toll on some women because it does not imitate labor.33, 50, 51 Other physicians prefer to induce labor because they find it a less distasteful procedure.50 Still others prefer it because they feel that it is less likely to interfere with the diagnosis of cytogenetic, anatomical, or DNA abnormalities in the fetus, particularly if saline instillation is avoided52 However, one research study involving 60 patients who underwent D&E at 14-22 weeks of gestation after fetal abnormalities were detected, found that D&E successfully and consistently confirmed abnormal prenatal diagnoses.40

In summary, maternal mortality during second-trimester abortions is lower for dilation and evacuation procedures than for labor induction methods. However, for procedures performed at 20 weeks' gestation and beyond, the rates are similar. More systematic research is needed on complications and complication rates associated with various types of abortion procedures at 13 weeks of gestation and beyond.

THE LEGAL CONTEXT OF MEDICAL DECISION-MAKING REGARDING ABORTION

In light of changes in the composition of the United States Supreme Court, it is impossible to predict with certainty the Court's actions with respect to any law regulating abortions and abortion procedures. Since its 1973 decision in Roe v. Wade, 410 U.S. 113 (1973), the Supreme Court has consistently affirmed that prior to viability (which the Supreme Court defined as the capacity for meaningful life outside the womb), a woman has a constitutionally protected right to choose to have an abortion, and that after viability is achieved, the State may restrict abortions, if the law contains exceptions for pregnancies which endanger a woman's life or health. The Supreme Court has acknowledged that the time when viability is achieved may vary with each pregnancy and has recognized that the determination of whether a particular fetus is viable is a matter for the judgment of the responsible attending physician (Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976)). However, in Webster v. Reproductive Health Services, 492 U.S. 490 (1989), the Supreme Court upheld a Missouri statute which created a rebuttable presumption of viability at 20 weeks.

In Roe v. Wade, the Court established guidelines for state regulation of abortion based on gestational stage and viability. For the stage prior to approximately the end of the first trimester, the Court held that the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician. For the stage subsequent to approximately the end of the first trimester, the Court held that the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health. For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life, may, if it chooses, regulate and even proscribe abortion, except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

Subsequent to Roe v. Wade, the Supreme Court has rendered a number of decisions on the constitutionality of state abortion regulations, including several which impact the medical decision-making process. For example, the Supreme Court has invalidated provisions of state statutes that require a woman to secure the approval of three physicians and a hospital committee before obtaining an abortion (Doe v. Bolton, 410 U.S. 179 (1973)); require a physician to preserve the life and health of the fetus at every stage of pregnancy (Planned Parenthood of Central Missouri v. Danforth); prohibit the use of saline amniocentesis as a method of abortion (Id.); and require physicians to give their patients information regarding the abortion procedure, the attendant health risks and those of childbirth and the probable gestational age of the fetus (City of Akron v. Akron Center for Reproductive Health, Inc., 462 U.S. 416 (1983) and Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986)).

In Colautti v. Franklin, 439 U.S. 379 (1979), the Supreme Court struck down a Pennsylvania statutory provision that subjected a physician who performed an abortion to potential criminal liability if he or she failed to exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus, when the fetus was viable or when there was sufficient reason to believe that the fetus might be viable. The Court expressed uncertainty as to whether the Pennsylvania statute permitted physicians to consider their duty to the patient to be paramount over their duty to the fetus, or whether it required physicians to make a "trade-off" between the woman's health and additional percentage points of fetal survival. (Id. at 400). The Court held that where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions. (Id.).

In Colautti, the Supreme Court also reaffirmed previous decisions that the determination of whether a fetus is viable must be a matter for the judgment of the responsible attending physician. State regulation that impinges on this determination, if it is to be constitutional, must allow the attending physician "the room he needs to make his best medical judgment." (Id. at 396, citing Doe v. Bolton, 410 U.S. at 192.)

The Court also addressed the issue of balancing maternal and fetal interests in Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747 (1986). Specifically, the Supreme Court considered a provision of a Pennsylvania statute that set forth two requirements for a post-viability abortion: 1) every person who performs an abortion post viability exercise that degree of care which would be required in order to preserve the life and health of any unborn child intended to be born and not aborted, and 2) that the abortion technique employed be that which would provide the best opportunity for the unborn child to be aborted alive unless, in the good faith judgment of the physician, that method or technique would present a significantly greater medical risk to the life or health of the pregnant woman than would another available method or technique. The Supreme Court found the statute to be unconstitutional, reasoning that the language of the statute could be construed to require the mother to bear an increased medical risk in order to save her viable fetus.

In Planned Parenthood Association of Kansas City, Missouri v. Ashcroft, 462 U.S. 476 (1983), the Supreme Court upheld a provision in a Missouri statute that required the attendance of a second physician at the abortion of a viable fetus. The statute also required the second physician to take all reasonable steps in keeping with good medical practice to preserve the life and health of the viable fetus, provided that such steps did not pose an increased risk to the life or health of the woman. The Court found that the second-physician requirement reasonably furthered the State's compelling interest in protecting the lives of viable fetuses. However, in Thornburgh, the Court struck down a similar provision in a statute that required the presence of a second physician during an abortion performed when viability was possible. In holding the provision unconstitutional, the Court was persuaded that the statute provided no exception for an emergency situation when the mother's health would be endangered by the delayed arrival of the second physician.

The Supreme Court, in Webster v. Reproductive Health Services, upheld a provision in a state statute that required a physician, before performing an abortion on a woman he or she has reason to believe is carrying a fetus of 20 or more weeks gestational age, to first determine if the fetus is viable by using the degree of care, skill, and proficiency commonly exercised by a prudent physician in similar practice under similar conditions. In making this determination of viability, the statute provided that the physician perform or cause to be performed medical examinations and tests necessary to determine the gestational age, weight, and lung maturity of the fetus. In its ruling, the Supreme Court construed the provision to require a physician to perform only those tests that are useful to making subsidiary findings as to viability. Id. at 513. The Court recognized that the tests in question regulate the discretion of the physician in determining the viability of the fetus, but they found that the requirement of the tests permissibly furthered the State's interest in protecting potential human life. Id. at 519.

In Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992), the Supreme Court, in a plurality opinion, rejected the trimester framework, which it did not view to be part of the essential holding of Roe v. Wade. The Court determined that only when state regulation imposes an undue burden on a woman's ability to have an abortion, does the power of the State infringe on the woman's constitutionally protected liberty interest.

Applying the undue burden standard, the Court reversed the position it had taken in several previous cases and upheld provisions of a Pennsylvania statute that required physicians to provide patients with information about the nature of the abortion procedure, the health risks of the abortion and of childbirth, and the probable gestational age of the fetus. The Court also upheld the requirement that the physician or qualified nonphysician inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father and a list of agencies which provide adoption and other services as alternatives to abortion.

POLICIES OF MAJOR MEDICAL SOCIETIES ON LATE-TERM ABORTION

At this time, medical societies have responded in a variety of ways to the recent controversy over late-term abortion and procedures used to perform late-term abortions. In October, 1995, for example, the Board of Trustees of the American Medical Association voted to remain neutral with regard to the "Partial Birth Abortion Ban Act of 1995." In December, 1996, the AMA House of Delegates adopted Substitute Resolution 208 which, as described earlier, reaffirmed existing AMA policy on abortion, resolved to undertake a study of late-term pregnancy termination techniques and circumstances to ensure that they conform to the standards of good medical practice, and resolved that the AMA would work with

pertinent medical specialty organizations to develop clinical practice guidelines appropriate for late term pregnancy termination.

As of April, 1997, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have not issued formal policies on late-term abortion. Both organizations, however, sent representatives to the study group convened by the American Medical Association in April, 1997.

The American College of Obstetricians and Gynecologists was the first medical specialty society to oppose the "Partial Birth Abortion Act of 1995" and to develop formal policy on intact dilatation and extraction. In November, 1995, ACOG released a statement in which it expressed its disappointment that the Congress "has attempted to regulate medical decision-making today by passing a bill on so-called "partial-birth" abortion."53 The statement noted that "the College finds it very disturbing that any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community---demonstrating why Congressional opinion should never be substituted for professional medical judgment."53

In January, 1997, ACOG released a Statement of Policy on Intact Dilatation and Extraction. According to the College, intact dilatation and extraction (intact D&X) contains four elements: "Deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus."19 The policy notes that "because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D&X."19 The policy further states that "abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D&X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based on the patient's individual circumstances. . . Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D&X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the **only** option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision-making is inappropriate, ill-advised, and dangerous."19

RECOMMENDATIONS

The Board of Trustees recommends the adoption of the following statements of policy and that the remainder of this report be filed:

1. The American Medical Association reaffirms current policy regarding abortion, specifically policies 5.990, 5.993, and 5.995 (see page 3). In summary:

the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate

facilities;
abortion is a medical procedure and should be performed by a physician in conformance with standards of good medical practice;
support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures;
neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles.

2. The term 'partial birth abortion' is not a medical term. The American Medical Association will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

3. According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

4. The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

5. In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

6. The AMA will work with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop clinical guidelines for induced abortion after the 22nd week of gestation. The guidelines will address indications and contra-indications for such procedures, identify techniques which conform to standards of good medical practice and, whenever possible, should be evidence-based and patient-focused.

7. The American Medical Association urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing data surveillance systems of induced abortion. This would include but not be limited to: a more detailed breakdown of the prevalence of abortion by gestational age as well as the type of procedure used to induce abortion at each gestational age, and maternal and fetal indications for the procedure. Abortion-related maternal morbidity and mortality statistics should include reports on the type and severity of both short- and long-term complications, type of procedure, gestational age, maternal age, and type of facility. Data collection procedures should ensure the anonymity of the physician, the facility, and the patient.

8. The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions. The demand for abortions, with the exception of those indicated by serious fetal anomalies or conditions which threaten the life or health of the pregnant woman, represent failures in the social environment and education. Such measures should help women who elect to terminate a pregnancy through induced abortion to receive those services at the earliest possible stage of gestation.

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APPENDIX A

UNITED STATES SUPREME COURT DECISIONS REGARDING ABORTION

The following is an analysis of Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705 (1973), and other Supreme Court decisions concerning abortions.

Roe v. Wade

A pregnant single woman (Roe) brought a class action suit challenging the constitutionality of a Texas criminal abortion law, which proscribed procuring or attempting an abortion except on medical advice for the purpose of saving the mother's life. A licensed physician (Hallford), who had two state abortion prosecutions pending against him, was permitted to intervene in the suit. A childless married couple (the Does) separately brought an action, basing alleged injury on the future possibilities of contraceptive failure, pregnancy, unpreparedness for parenthood and impairment of the wife's health.

A three-judge District Court consolidated the actions, and held that Roe and Hallford, and members of their classes, had standing to sue. The court ruled that declaratory (i.e., specific ruling by the court), though not injunctive (i.e., prohibitions on future conduct), relief was warranted, and declared the abortion statute void as vague and overly broad in infringing the plaintiff's Ninth and Fourteenth Amendment rights. The court ruled the Does' complaint not justiciable. Appellants (Roe and Hallford) appealed to the U.S. Supreme Court on the injunctive rulings, and appellee (Wade, District Attorney of Dallas County) cross-appealed from the District Court's grant of declaratory relief to Roe and Hallford.

The U.S. Supreme Court held that state criminal abortion laws that except from criminality only a life-saving procedure on the mother's behalf without regard to the stage of her pregnancy and other interests involved, violate the Due Process Clause of the Fourteenth Amendment, which protects the right to privacy, including a woman's qualified right to terminate her pregnancy, from infringement by state action. Roe v. Wade, 410 U.S. 113, 93 S. Ct. 705 (1973). In reaching its decision, the Court concluded that the word "person" as used in the Fourteenth Amendment does not include the unborn.

The Court declined to "resolve the difficult question of when life begins." Id. at 159. However, the Court established guidelines for state regulation of abortion based on gestational stage and viability that determine the level of regulations that states can impose: 1) for the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician, 2) for the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health, and 3) for the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion, except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. The Court also held that the State may define the term "physician" to mean only a physician currently licensed by the State, and may proscribe any abortion by a person who is not a physician as so defined.

In reaching its holding, the Court reasoned that the State does have an important and legitimate interest in preserving and protecting the health of the pregnant woman and in protecting the potentiality of human life. These two interests are separate and distinct, with each growing in substantiality as the woman approaches full term and, at a point during pregnancy, each becomes a "compelling" interest that may warrant increasing levels of regulation.

The Court asserted that with respect to the state's interest in the health of the mother, the compelling point, in light of medical knowledge at the time, is at approximately the end of the first trimester. The Court reached this conclusion because of the medical fact that until the end of the first trimester, the mortality rate from abortion may be less than the morality rate from normal childbirth. From this, the Court held that from and after the end of the first trimester, a state may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. The Court cited examples of permissible state regulation including requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the abortion is to be performed (i.e., whether it must be a hospital or may be a clinic or some other place of less-than-hospital like status); as to the licensing of the facility and the like. Id. at 163.

Prior to this compelling point, the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that in his medical judgment, the patient's pregnancy should be terminated. If that decision is reached, the judgment may be effectuated by an abortion free of interference by the State.

With respect to the State's interest in potential life, the Court found that the compelling point is at viability, because the fetus then presumably has the capability of meaningful life outside the mother's womb. The Court held that if the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother. The Court did not define when viability occurs. In dicta, the Court stated: "Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." Id. at 160.

Doe v. Bolton

The case of Doe v. Bolton, 410 U.S. 179, 93 S. Ct. 739 (1973), was decided with Roe v. Wade. The case involved a Georgia law which proscribed an abortion except as performed by a duly licensed Georgia physician when necessary in his best clinical judgment because continued pregnancy would endanger a pregnant woman's life or injure her health; the fetus would likely be born with a serious defect; or the pregnancy resulted from rape. The law also imposed certain requirements including that the woman be a resident of Georgia, and posed three procedural conditions: 1) that the abortion be performed in a hospital accredited by the JCAH; 2) that the procedure be approved by the hospital staff abortion committee; and 3) that the performing physician's judgment be confirmed by independent examinations of the patient by two other licensed physicians.

The District Court gave declaratory, but not injunctive, relief, invalidating as an infringement of privacy and personal liberty the limitation to the three situations and certain other provisions, but holding that the State's interest in health protection and the existence of a potential of independent human existence justified regulation of the manner of performance as well as the quality of the final decision to abort.

The appellant (Doe) appealed to the U.S. Supreme Court, which invalidated the provisions of the Georgia law that required that: a) any abortion be performed in a hospital; b) a woman secure the approval of three physicians and a hospital committee before obtaining an abortion; and c) a woman seeking to obtain an abortion be a resident of the state.

The Court also found that the requirement that a physician's decision to perform an abortion must rest upon his or her best clinical judgment of its necessity was not unconstitutionally vague. The Court

reasoned that whether "an abortion is necessary" is a professional judgment that the Georgia physician will be called upon to make routinely. Id. at 192. The Court went on to state: "that the medical judgment may be exercised in the light of all factors--physical, emotional, psychological, familial, and the woman's age--relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage of, the pregnant woman." Id. at 192.

Planned Parenthood of Central Missouri v. Danforth

Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 96 S. Ct. 2831 (1976), involved two Missouri-licensed physicians, one of whom performed abortions at hospitals and the other of whom supervised abortions at Planned Parenthood. These physicians had brought suit for injunctive and declaratory relief challenging the constitutionality of a Missouri abortion statute. Specifically, the provisions of the statute that they challenged were: 1) a provision defining viability as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems;" 2) a provision requiring that before submitting to an abortion during the first 12 weeks of pregnancy a woman must consent in writing to the procedure and certify that her consent is informed and freely given and is not the result of coercion; 3) a provision requiring, for the same period, the written consent of the spouse of a woman seeking an abortion unless a licensed physician certifies that the abortion is necessary to preserve the mother's life; 4) a provision requiring, for the same period, and with the same proviso, the written consent of a parent or person in loco parentis to the abortion of an unmarried woman under age 18; 5) a provision requiring the physician to exercise professional care to preserve the fetus' life and health, failing which he is deemed guilty of manslaughter and is liable in an action for damages; 6) a provision declaring an infant who survives an attempted abortion not performed to save the mother's life or health an abandoned ward of the State, and depriving the mother and a consenting father of parental rights; 7) a provision prohibiting after the first 12 weeks of pregnancy the abortion procedure of saline amniocentesis as "deleterious to maternal health;" and 8) provisions prescribing reporting and recordkeeping requirements for health facilities and physicians performing abortions.

The District Court upheld the above provisions, with the exception of the professional-skill requirement, which was held to be unconstitutionally overbroad because it failed to exclude the pregnancy stage prior to viability.

The U.S. Supreme Court held that the definition of viability did not conflict with the definition in Roe v. Wade. The Court found that the provision maintained the flexibility of the term "viability" recognized in Roe. The Court reasoned that it was not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The Court stated that: "The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician." Id. at 64.

Also of interest is the Court's ruling regarding the provision in the Missouri statute prohibiting the use of saline amniocentesis after the first 12 weeks of pregnancy. The statute imposed the prohibition on the ground that the technique was deleterious to maternal health. The Court held that the outright legislative proscription of saline failed as a reasonable regulation for the protection of maternal health. The Court stated that the provision was an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks; thus, the provision could not

withstand constitutional challenge.

In reaching this holding, the Court was persuaded by the following factors: 1) the prevalence of the use of saline amniocentesis as an accepted medical procedure (employed in a substantial majority of all post-first-trimester abortions), 2) the severe limitations on the availability of the prostaglandin technique suggested as an alternative to saline amniocentesis by appellees, and 3) the fact that alternative methods of hysterotomy and hysterectomy are significantly more dangerous for the woman than the saline technique, yet were not proscribed by the statute.

With respect to the other provisions challenged by appellants, the Court found that the consent provision was not unconstitutional, the spousal consent provision was unconstitutional, the blanket parental consent provision was unconstitutional, the reporting and recordkeeping requirements were constitutional if administered in a way that was not unduly burdensome, and the requirement that a physician preserve the fetus' life and health was impermissible.

Webster v. Reproductive Health Services

State-employed health professionals and private nonprofit corporations providing abortion services brought suit for declaratory and injunctive relief challenging the constitutionality of a Missouri statue regulating the performance of abortions. Among other things, the statute: 1) set forth findings in it preamble that the life of each human being begins at conception and that unborn children have protectable interests in life, health, and well-being and required that all state laws be interpreted to provide unborn children with the same rights enjoyed by other persons, subject to the Federal Constitution and the Supreme Court's precedents; 2) specified that a physician, prior to performing an abortion on any woman whom he or she had reason to believe was 20 or more weeks pregnant, must ascertain whether the fetus is "viable" by performing such medical examinations and tests as are necessary to make a finding of the fetus' gestational age, weight, and lung maturity; 3) prohibited the use of public employees and facilities to perform or assist abortions not necessary to save the mother's life; and 4) made it unlawful to use public funds, employees or facilities for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life.

The District Court struck down each of the above provisions, among others, and enjoined their enforcement. The Court of Appeals affirmed, ruling that the provisions violated Roe v. Wade. In Webster v. Reproductive Health Services, 492 U.S. 490, 109 S. Ct. 3040 (1989), the Supreme Court did not determine the constitutionality of the Act's preamble, but reasoned that the preamble did not by its terms regulate abortion or any other aspect of appellees' medical practice. Rather, the Court asserted that the preamble could be read to express a value judgment favoring childbirth over abortion.

The Supreme Court upheld the Missouri Act's restrictions on the use of public employees and facilities for the performance or assistance of abortions not necessary to save the life of the mother. The Court's view was that Missouri's refusal to allow public employees to perform abortions in public hospitals left a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals at all. The challenged provision only restricted a woman's ability to obtain an abortion to the extent that she chose to use a physician affiliated with a public hospital.

On the issue of the use of public funds, employees or facilities for the purpose of encouraging or counseling a woman to have an abortion not necessary to save her life, appellees contended that they were not adversely affected under the state's interpretation of the provision. The Court concluded that

there was no longer a case or controversy on the issue.

On the viability-testing provision, the Court construed the provisions as not requiring a physician to perform tests irrelevant to the expressed statutory purpose of determining viability. The Court reasoned that to interpret the provision to require a physician to perform those tests needed to make the three specified findings in all circumstances (i.e., gestational age, weight and lung maturity), including when the physician's reasonable professional judgment indicates that the tests would be irrelevant to determining viability or even dangerous to the mother and the fetus, would make that portion of the provision conflict with the other requirement that a physician apply his reasonable professional skill and judgment.

The Court asserted that the viability-testing provision was concerned with promoting the state's interest in potential human life, rather than in maternal health, and created what is essentially a presumption of viability at 20 weeks which the physician must rebut with tests indicating the fetus is not viable prior to performing an abortion.

Although the Court acknowledged that the tests called for in the Missouri statute increase the expense of abortion, and regulate the discretion of the physician in determining the viability of the fetus, the Court was satisfied that the requirement of these tests permissibly furthered the State's interest in protecting potential human life. The Court held the provision to be constitutional.

Of particular note, the Court stated in dicta that the Roe trimester framework falls into the category of prior constructions of the Constitution that have proved unsound in principle and unworkable in practice. The Court declared that: [t]he key elements of the Roe framework--trimesters and viability--are not found in the text of the Constitution or in any place else one would expect to find a constitutional principle." Id. at 518. Significantly, the Court questioned why the State's interest in protecting potential human life should come into existence only at the point of viability.

The appellants and the United States as amicus curiae urged the Court to overrule its decision in Roe v. Wade; however, the Court determined that the facts of Webster differed from those at issue in Roe and thus the case afforded the Court no occasion to revisit the holding in Roe. The Court did state that to the extent indicated in the opinion, the Court would modify and narrow Roe and succeeding cases.

Planned Parenthood of Southeastern Pennsylvania v. Casey

In Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833, 112 S. Ct. 2791 (1992), Justices O'Connor, Kennedy and Souter delivered the opinion of the Court, with Justices Stevens, Blackmun, Rehnquist and Scalia concurring in parts and dissenting in parts. At issue in the case were five provisions of the Pennsylvania Abortion Control Act of 1992 which required that a woman seeking an abortion give her informed consent prior to the procedure and specified that she be provided with certain information 24 hours before the abortion is performed. The law also mandated the informed consent of one parent for a minor to obtain an abortion (with a judicial bypass provision) and required that a married woman, with certain exceptions, sign a statement indicating that she had notified her husband. Under the law, certain reporting requirements were also imposed on facilities providing abortion services.

The District Court issued a permanent injunction against enforcement of the regulations which they found to be unconstitutional. The Court of Appeals for the Third Circuit affirmed in part and reversed in part,

upholding all the regulations except the spousal notification provision.

The Supreme Court reaffirmed the "central holding" of Roe v. Wade. The Court defined that central holding to be: 1) a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State, 2) a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger a woman's life or health, and 3) the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child. Id. at 846.

Of particular note, the Court rejected the trimester framework, which it did not view to be part of the essential holding of Roe. The Court reasoned that the trimester framework suffers from certain basic flaws: "in its formulation it misconceives the nature of the pregnant woman's interest; and in practice it undervalues the State's interest in potential life, as recognized in Roe." Id. at 873. The Court determined that only when state regulation imposes an "undue burden" on a woman's ability to have an abortion, does the power of the State infringe on the woman's constitutionally protected liberty interest.

In discussing the "undue burden" standard, the Court concluded that a finding of an undue burden signifies a conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.

The Court stated that as with any medical procedure, the State may enact regulations to further the health or safety of a woman seeking an abortion. Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.

With respect to the specific provisions of the Pennsylvania statute, the Court upheld the informed consent requirement which mandated that at least 24 hours before performing an abortion a physician inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the probable gestational age of the unborn child. The statute also required that the physician or a qualified nonphysician inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion.

In upholding the informed consent requirement, the Court overruled the Akron I and Thornburgh cases to the extent that they found a constitutional violation when the government required the giving of "truthful, nonmisleading information" about the nature of the procedure, the attendant health risks and those of childbirth and the probable gestational age of the fetus. The Court also declared that the conclusion in Akron I that a 24-hour waiting period did not further the State's legitimate interest that the woman's decision be informed was wrong. Although the Court acknowledged that the 24-hour waiting period might increase the cost and risk delay of abortions, the Court did not find that the waiting period constituted an undue burden.

The Court found that the spousal notification requirement did place an undue burden, and, therefore, held it to be invalid. The Court upheld the parental consent provision, noting that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided that there is an adequate judicial bypass procedure. The Court also upheld the recordkeeping and reporting requirements of the Pennsylvania statute, except for the provision requiring a married woman to report her reason for failure to provide notice to her spouse.

Chief Justice Rehnquist, Justice Scalia, Justice White and Justice Thomas, concluded that the Court was mistaken in Roe when it classified a woman's decision to terminate her pregnancy as a "fundamental right" that could be abridged only in a manner which withstood strict scrutiny. These Justices concluded that a woman's decision to abort her unborn child is not a constitutionally protected "liberty" because: 1) the Constitution says nothing about it and 2) the long-standing traditions of American society have permitted it to be legally prohibited. Under the rational basis test, these four Justices stated that the Pennsylvania statute should be upheld in its entirety.

Justice Blackmun concluded that application of the strict scrutiny standard of review required by the Court's previous abortion decisions required the invalidation of all the challenged provisions of the Pennsylvania statute.

Justice Stevens, concurring in part and dissenting in part, agreed with the Court's reaffirmation of Roe v. Wade, but disagreed with its rejection of the trimester framework. He did not view it as a contradiction to recognize that the State may have a legitimate interest in potential human life and to conclude that that interest does not justify the regulation of abortion before viability. Instead, he asserted that it was appropriate to consider the nature of the interests at stake in order to determine when, if ever, the State's interest outweighs the pregnant woman's interest in personal liberty.

appendix B

MEDICAL ETHICS REGARDING ABORTION

Major Ethics Principles Applied to Abortion in General

There are many methods of ethics reasoning, none of which has produced conclusive arguments on all the issues of abortion. The most common current form of reasoning in medical ethics involves the application of four basic ethics principles, with balancing of conflicting principled positions and of practical considerations according to the specific circumstances. While there are good reasons to use additional methods, for the sake of brevity, this common form of reasoning is used here.

Autonomy: There are four main arguments that apply the principle of autonomy. The first supports abortion as a matter of the woman's choice. The second supports abortion in defined circumstances. The third is applicable in different ways depending on the circumstance. The fourth opposes abortion.

The first argument has features in common with an ownership argument, and states that as long as the fetus is in the woman's body and is unwanted, the woman has the right to end the fetus' life, the fetus being afforded significantly weaker rights than the woman. This will be referred to as the 'autonomy/ownership' argument.

The argument by Judith Jarvis Thomson asserts that a fetus' claim to continued existence while dependent on the pregnant woman's body depends on that woman's welcome. The argument states that a woman who does not consent to pregnancy is not obligated to lend her body to support the fetus. This argument applies even if the fetus is attributed full standing as a person. It does not apply after viability since delivery can remove the fetus from being dependent.

The third argument attributes some measure of person status to the fetus and asserts that the fetus' rights challenge the woman's after acquisition of sufficient developmental status. Positions vary on when that status is achieved, and on whether there is a single threshold or a continuum of developing status and rights. This will be referred as the 'conditional fetal rights' argument.

The last argument in this list attributes full person status to the conceptus and all subsequent stages, and debars abortion except for threat to the life of the woman. This will be referred to as the 'full fetal rights' argument.

Nonmaleficence: Nonmaleficence argues for non-destructive procedures for the fetus. It also would debar sacrificing the life of the woman for the fetus, and would seek to minimize damage to the woman of either a physical or an emotional nature. While arguments can be slanted to emphasize one form of harm over another, the principle of nonmaleficence is not determinative by itself of a general position on abortion.

Beneficence: Beneficence for one individual is also limited by the needs of beneficence to others. Beneficence to the fetus would preempt all abortion. Beneficence to the woman would permit abortion in circumstance when childbearing would be detrimental to the woman.

Justice: Justice is about balancing the deserts of different individuals. Fairness for women to compete in society can be used as an argument in favor of abortion. On the other hand, if the fetus is ascribed full

viability is in question, a gray zone exists. In such cases, precise interpretations of what constitutes personhood and viability become weighty.

When fetal abnormalities are such that exit through the birth canal is mechanically impossible, and if abortion has been justified, a second question arises, namely: is there an ethical preference between types of abortion procedure. For instance, might one of the following have more justifiability than the other: delivery by cesarean section with expected fetal demise; hysterotomy; D&X with in utero destruction; or D&X with destruction when partly outside of the woman's body. This question requires a revisitation of the above mentioned relevant factors: attributed personhood; fetal viability; the relevance or not of the fetus' bodily boundaries; and fetal suffering if there is reason to believe it is sensate. In such cases, well defined meanings for personhood and viability are necessary, and as much knowledge as possible about sensation is desirable.

It is worth noting that D&X procedures are not generally applicable in early second and first trimesters. The AMA is not currently revisiting its position on abortion at these stages of gestation.

Relevant Features of Procedures Used to Induce Abortion

One feature that distinguishes the D&X procedure from other destructive procedures is that the fetus may be partly outside the woman's body. A second relevant feature is whether the procedure occurs electively, with intent to abort, or during spontaneous labor with severe medical complications. In the latter case it may be closer to an emergency delivery and still-birth and should be distinguished from an intended abortion. Nonetheless, the technical steps of the procedures may have similarity. Since the ethical features differ, but the technical steps may be similar any position on the matter should take both circumstances and procedure into account.

Third, D&E and D&X abortions share the feature of going beyond the bodily boundaries of the fetus for the purpose of its destruction. This feature is not significant to the autonomy/ownership argument, or to the conditional fetal rights argument if the fetus is not attributed personhood or viability. It is relevant to Thomson's argument since her argument justifies fetal removal and does not speak to fetal destruction, and the applicability of the argument, especially after viability, would therefore be in question. If the fetus is attributed personhood and is viable this feature would emphasize the applicability of the conditional fetal rights, now arguing against abortion. The full fetal rights argument would find the feature relevant and reason against abortion.

Fourth, suffering of the fetus may be relevant, but does not lead to conclusively different positions about types of procedure under any of the four arguments. Close-to-full-gestation normal fetuses presumably have similar sensation to a newborn infant, but there are no good data to guide estimates of suffering as a result of one course of action over another, either for close-to-full-gestation or any other fetal stage. Once sensate, autonomy indicates a fetal interest in comfort. Some procedures include a lethal procedure prior to the destructive process, which some accounts suggest would reduce fetal suffering. Under the autonomy/ownership argument fetal suffering is arguably irrelevant, but compassion might indicate minimization of suffering. Under Thomson's argument, the same reasoning applies. Under the conditional fetal rights argument, the sensate fetus' suffering is relevant, and how well prior ending of the fetus' life to avoid suffering is justified varies. For instance, it may be easier to justify the act if there is no fetal viability outside the uterus and harder to justify it if there is viability. Under the full fetal rights argument, fetal suffering is relevant, but opposition to suffering may be trumped by the interest in life if survival entails suffering.

Ethical Implications of Various Policy Positions

The ethics of policy positions are distinct from the ethics of particular acts. For instance, it is possible that acts are not ethically defensible, but their debarment is even less defensible; the correct policy in such cases permit wrong acts as a matter of choosing the lesser wrong. Conversely, it is possible that acts are ethically defensible in themselves, but the consequences of policy permitting them would be indefensible; the correct policy in such cases debar defensible acts as a matter of choosing the lesser wrong. So, although the above reasoning may lead a person to a reasoned position regarding particular instance of abortion, it would not lead by simple extrapolation to an obvious policy position. The ethics of medical policy positions is also distinct from legal policy positions.

The question for the medical profession of whether or not to endorse these abortion procedures is three fold: 1) Are the procedures necessary parts of the medical sphere for some well defined circumstances? 2) If so, are the procedures also optional procedures in a wider range of circumstances? If so, their use should be a matter for decision-making between the woman and the physician, based on personal morals and medical judgment. 3) Are the procedures medically unnecessary and therefore open for legislation?

Corresponding to these three question there are three general options.

Option 1: Restriction of the procedure: This option could involve a range of types of restriction, some stringent, some less so. The restriction of the procedures to emergency circumstances would permit only the version of the reduction procedure that may not even be classifiable as an elective abortion. Elective D&E and D&X would not be allowed. Restriction of the procedures to circumstances involving a morbidly abnormal fetus would permit both D&E and elective D&X but would still prevent destructive procedures for a viable fetus.

Option 2: Keep decisions exclusively in the medical realm. This option would allow the woman, in consultation with her physician, to determine the propriety of using the procedure. It would leave informed consent as the ethical safeguard to misuse of the procedure. Although some have noted the difficulty of this standard for such extenuating and complex circumstances and have recommended additional safeguards such as involvement of an ethics committee, others object that such procedures would be either intrusive or evidence of an *a priori* position.

Option 3: Abandonment of the procedures. It could be possible to abandon elective D&X without preventing women from having a termination by another procedure. The ethical distinction between the procedures, as noted above, is that with D&X the fetus is partly emerged from the birth canal prior to the destructive procedure. However, logical distinction in the policy arena may be difficult due to the similarities between elective D&X and D&E, and the similarities between D&X for intended abortion and D&X for emergency circumstances that started with intent to deliver a baby but was precluded by major medical complications.

Some physicians believe that all situations permit a cesarean section or hysterotomy as a reasonable alternative, and note that there are risks to the woman for both D&E and D&X. If this is accepted from a medical point of view, abandonment of both these two categories of abortion is possible. This position would result in the live birth of many of the malformed or disabled but viable infants that could have been aborted under Option 2, and morbidly abnormal fetuses would die as a result of their condition rather than from abortion. Such a policy would have to address whether or not early induced delivery to reduce viability would be permissible.

Although these types of arguments, types of circumstances and types of policy option may help clarify

discussion, they do not lead to one clearly preferred ethical position. All these options could receive coherent ethical justification if the relevant principles are invoked. All these options could be logically compatible with existing AMA policy on other abortion procedures and circumstances. All options are, from the viewpoint of ethics reasoning, compatible with the Roe v. Wade Supreme Court decision, under which third term abortion for a normal pregnancy can be banned by state action. All positions leave open the question of state versus federal legislative action.

May 1997

TO: Delegates and Alternate Delegates
Executive Directors
State Medical Associations
National Medical Specialty Societies.

FROM: Nancy W. Dickey, MD
Chair, Board of Trustees

Included in this package is the Report of the Board of Trustees on Late-Term Abortion responding to Substitute Resolution 208. This report represents the cumulative work of many groups and individuals over the last several months. It should be evaluated as the science based treatise it was intended to be.

However, everyone is aware of the pending and peripherally related legislation. I am writing you this memorandum to share with you the thinking of the Board on this issue and to ask you to evaluate the legislative/political questions separately from, though very impacted by, the science issues.

Legislation addressing abortion procedures is currently pending in many state legislatures as well as the Congress. Action in the US Senate could come within the next two weeks. The Board's report on late-term abortion, developed by an expert panel, with representatives from AMA councils (Scientific Affairs, Ethical and Judicial Affairs, Medical Education, and Legislation), recognized medical specialty societies with expertise in this area (the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics), the AMA Board of Trustees and state medical associations, recommends severe restrictions on the use, at any time, of the abortion procedure known as intact dilation and extraction (intact D&X). In addition, the Report recommends that physicians "generally" not use abortion procedures for terminating pregnancies in the third trimester, other than in extraordinary circumstances or where severe fetal anomalies inconsistent with life exist, because abortion is rarely necessary to preserve the life or health of the mother at this stage.

Generally, AMA policy calls for opposition to legislation controlling or criminalizing medical practice or procedures. However, AMA has supported legislation where the procedure(s) was narrowly defined, and not medically indicated such as prohibition of female genital mutilation.

For the AMA to support any legislation impacting medical decision-making the legislation would have to:

- Provide a formal role for medical peer determination (through the appropriate state medical licensing bodies or some similar process) in any enforcement proceedings under a bill.

- Retain for physicians the ability, using their best clinical judgment at the time, to use the procedure in an extraordinary circumstance where the patient would otherwise be seriously endangered.

- Use correct medical terminology so that it is clear on the face of the legislation what act is to be prohibited.

The AMA Board has determined that legislation regarding intact D&X would have to meet the above requirements to be supported. However, the strong concerns about intact D&X provided in the scientific report leave little basis for opposition if the legislative requirements were met. The widely debated, strongly supported, fast moving legislation in this area leads AMA to urge Congressional leaders on both sides of the debate to move forward and develop legislation consistent with these views.

Abortion- partial birth- medical statements

AMWA

AMERICAN MEDICAL WOMEN'S ASSOCIATION

For Immediate Release

Contact: Anne Pritchett
703-838-0500

Statement of the American Medical Women's Association on Abortion Legislation in the 105th Congress

Alexandria, VA (May 20, 1997)—The American Medical Women's Association, "is committed to protecting the reproductive rights of American women and has opposed any legislative intervention for medical and or surgical care decisions," says current AMWA President Debra R. Judelson, MD. This week, AMWA reiterated its opposition to H.R. 1122 and S. 6, which seek to ban a particular medical procedure.

It is the opinion of AMWA's Executive Committee that legislative efforts to regulate abortion have been flawed. Concerns in the following areas have prevented AMWA from taking a position on recent legislative efforts focusing on abortion in the 105th Congress.

- AMWA is gravely concerned with governmental attempts to legislate medical decisionmaking through measures that do not protect a woman's physical and mental health, including future fertility, or fail to consider other pertinent issues, such as fetal abnormalities. Physicians and their patients base their decisions on the best available information at the time, often in emergency situations. AMWA strongly opposes governmental efforts to interfere with physician-patient autonomy.
- It is irresponsible to legislate a particular test of viability without recognition that viability cannot always be reliably determined. Length of gestation is not the sole measure of viability because fetal dating is an inexact science.
- AMWA resolutely opposes the levying of civil and criminal penalties for care provided in the best interest of the patient. AMWA strongly supports the principle that

medical care decisions be left to the judgment of a woman and her physician without fear of civil action or criminal prosecution.

Any forthcoming legislation will be carefully reviewed by AMWA based on the criteria outlined above, and AMWA will seek to ensure that there is no further erosion of the constitutionally protected rights guaranteed by *Roe v. Wade*. Says AMWA President Debra R. Judelson, MD, "AMWA firmly believes that physicians, not the President or Congress, should determine appropriate medical options. We cannot and will not support any measures that seek to undermine the ability of physicians to make medical decisions."

AMWA has long supported a woman's right to determine whether to continue or terminate her pregnancy without government restrictions placed on her physician's medical judgment and without spousal or parental interference.

Founded in 1915, the American Medical Women's Association represents more than 10,000 women physicians and medical students and is dedicated to furthering the professional and personal development of its members and promoting women's health.

Abortion - partial birth - medical statements

May 13, 1997

The Honorable Thomas A. Daschle
509 Hart Senate Office Building
Washington, DC 20510

Dear Senator Daschle:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), an organization representing 38,000 physicians dedicated to improving women's health. I am endorsing the legislative language of your substitute amendment to HR 1122. Although it does not take a position on the findings enumerated in your proposal, ACOG believes that by banning abortions on viable fetuses except when continuing the pregnancy threatens a woman's life or risks serious injury to her health, your substitute legislative language provides a meaningful ban while assuring women's health is protected.

ACOG believes this amendment is preferable to HR 1122 for the following reasons:

- It provides a meaningful ban, while allowing an exception when it is necessary for a woman's health. This preserves the ability of physicians to make judgments about individual patients, an issue of critical importance to physicians.
- The amendment does not dictate to physicians which abortion procedures can or cannot be performed.

In conclusion, ACOG supports your amendment and urges the Senate to adopt this language as an alternative to HR 1122.

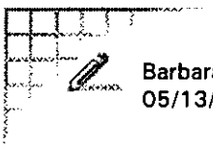
Sincerely,

Ralph W. Hale, M.D

Ralph W. Hale, MD
Executive Director

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW WASHINGTON DC 20024-2188
MAILING ADDRESS: PO BOX 96920 WASHINGTON DC 20090-6920
202/638-5577

Abortion - partial birth - medical statements



Barbara D. Woolley
05/13/97 12:48:28 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: ACOG Position

ACOG is endorsing the legislative language of Daschle's substitute amendment preferable to HR.1122. I have a copy of the letter.

* It provides a meaningful ban, while allowing an exception when it is necessary for a women's health. It preserves the ability of physicians to make judgements about individual patients.
* The amendment does not dictate to physicians which abortion procedures can or cannot be performed.

Message Sent To:

Elena Kagan/OPD/EOP
Jennifer L. Klein/OPD/EOP
Tracey E. Thornton/WHO/EOP
Maria Echaveste/WHO/EOP
John Podesta/WHO/EOP
Robyn Leeds/WHO/EOP
William P. Marshall/WHO/EOP

1.

2. Abortion - partial birth - medical statements

May 1997

TO: Delegates and Alternate Delegates
Executive Directors
State Medical Associations
National Medical Specialty Societies.

FROM: Nancy W. Dickey, MD
Chair, Board of Trustees

Included in this package is the Report of the Board of Trustees on Late-Term Abortion responding to Substitute Resolution 208. This report represents the cumulative work of many groups and individuals over the last several months. It should be evaluated as the science based treatise it was intended to be.

However, everyone is aware of the pending and peripherally related legislation. I am writing you this memorandum to share with you the thinking of the Board on this issue and to ask you to evaluate the legislative/political questions separately from, though very impacted by, the science issues.

Legislation addressing abortion procedures is currently pending in many state legislatures as well as the Congress. Action in the US Senate could come within the next two weeks. The Board's report on late-term abortion, developed by an expert panel, with representatives from AMA councils (Scientific Affairs, Ethical and Judicial Affairs, Medical Education, and Legislation), recognized medical specialty societies with expertise in this area (the American College of Obstetricians and Gynecologists, the American Academy of Family Physicians, and the American Academy of Pediatrics), the AMA Board of Trustees and state medical associations, recommends severe restrictions on the use, at any time, of the abortion procedure known as intact dilation and extraction (intact D&X). In addition, the Report recommends that physicians "generally" not use abortion procedures for terminating pregnancies in the third trimester, other than in extraordinary circumstances or where severe fetal anomalies inconsistent with life exist, because abortion is rarely necessary to preserve the life or health of the mother at this stage.

Generally, AMA policy calls for opposition to legislation controlling or criminalizing medical practice or procedures. However, AMA has supported legislation where the procedure(s) was narrowly defined, and not medically indicated such as prohibition of female genital mutilation.

For the AMA to support any legislation impacting medical decision-making the legislation would have to:

- Provide a formal role for medical peer determination (through the appropriate state medical licensing bodies or some similar process) in any enforcement proceedings under a bill.

- Retain for physicians the ability, using their best clinical judgment at the time, to use the procedure in an extraordinary circumstance where the patient would otherwise be seriously endangered.

- Use correct medical terminology so that it is clear on the face of the legislation what act is to be prohibited.

The AMA Board has determined that legislation regarding intact D&X would have to meet the above requirements to be supported. However, the strong concerns about intact D&X provided in the scientific report leave little basis for opposition if the legislative requirements were met. The widely debated, strongly supported, fast moving legislation in this area leads AMA to urge Congressional leaders on both sides of the debate to move forward and develop legislation consistent with these views.

pertinent medical specialty organizations to develop clinical practice guidelines appropriate for late term pregnancy termination.

As of April, 1997, the American Academy of Family Physicians (AAFP) and the American Academy of Pediatrics (AAP) have not issued formal policies on late-term abortion. Both organizations, however, sent representatives to the study group convened by the American Medical Association in April, 1997.

The American College of Obstetricians and Gynecologists was the first medical specialty society to oppose the "Partial Birth Abortion Act of 1995" and to develop formal policy on intact dilatation and extraction. In November, 1995, ACOG released a statement in which it expressed its disappointment that the Congress "has attempted to regulate medical decision-making today by passing a bill on so-called "partial-birth" abortion."53 The statement noted that "the College finds it very disturbing that any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman. Moreover, in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community---demonstrating why Congressional opinion should never be substituted for professional medical judgment."53

In January, 1997, ACOG released a Statement of Policy on Intact Dilatation and Extraction. According to the College, intact dilatation and extraction (intact D&X) contains four elements: "Deliberate dilatation of the cervix, usually over a sequence of days; instrumental conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of a living fetus to effect vaginal delivery of a dead but otherwise intact fetus."19 The policy notes that "because these elements are part of established obstetric techniques, it must be emphasized that unless all four elements are present in sequence, the procedure is not an intact D&X."19 The policy further states that "abortion intends to terminate a pregnancy while preserving the life and health of the mother. When abortion is performed after 16 weeks, intact D&X is one method of terminating a pregnancy. The physician, in consultation with the patient, must choose the most appropriate method based on the patient's individual circumstances. . . Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D&X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure, as defined above, would be the **only** option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision-making is inappropriate, ill-advised, and dangerous."19

RECOMMENDATIONS

The Board of Trustees recommends the adoption of the following statements of policy and that the remainder of this report be filed:

1. The American Medical Association reaffirms current policy regarding abortion, specifically policies 5.990, 5.993, and 5.995 (see page 3). In summary:

the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate

facilities;

abortion is a medical procedure and should be performed by a physician in conformance with standards of good medical practice;

support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures;

neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles.

2. The term 'partial birth abortion' is not a medical term. The American Medical Association will use the term "intact dilatation and extraction"(or intact D&X) to refer to a specific procedure comprised of the following elements: deliberate dilatation of the cervix, usually over a sequence of days; instrumental or manual conversion of the fetus to a footling breech; breech extraction of the body excepting the head; and partial evacuation of the intracranial contents of the fetus to effect vaginal delivery of a dead but otherwise intact fetus. This procedure is distinct from dilatation and evacuation (D&E) procedures more commonly used to induce abortion after the first trimester. Because 'partial birth abortion' is not a medical term it will not be used by the AMA.

3. According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

4. The viability of the fetus and the time when viability is achieved may vary with each pregnancy. In the second-trimester when viability may be in question, it is the physician who should determine the viability of a specific fetus, using the latest available diagnostic technology.

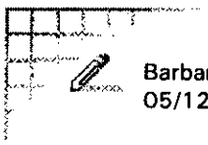
5. In recognition of the constitutional principles regarding the right to an abortion articulated by the Supreme Court in Roe v. Wade, and in keeping with the science and values of medicine, the AMA recommends that abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viability of the fetus argues for ending the pregnancy by appropriate delivery.

6. The AMA will work with the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics to develop clinical guidelines for induced abortion after the 22nd week of gestation. The guidelines will address indications and contra-indications for such procedures, identify techniques which conform to standards of good medical practice and, whenever possible, should be evidence-based and patient-focused.

7. The American Medical Association urges the Centers for Disease Control and Prevention as well as state health department officials to develop expanded, ongoing data surveillance systems of induced abortion. This would include but not be limited to: a more detailed breakdown of the prevalence of abortion by gestational age as well as the type of procedure used to induce abortion at each gestational age, and maternal and fetal indications for the procedure. Abortion-related maternal morbidity and mortality statistics should include reports on the type and severity of both short- and long-term complications, type of procedure, gestational age, maternal age, and type of facility. Data collection procedures should ensure the anonymity of the physician, the facility, and the patient.

8. The AMA will work with appropriate medical specialty societies, government agencies, private foundations, and other interested groups to educate the public regarding pregnancy prevention strategies, with special attention to at-risk populations, which would minimize or preclude the need for abortions. The demand for abortions, with the exception of those indicated by serious fetal anomalies or conditions which threaten the life or health of the pregnant woman, represent failures in the social environment and education. Such measures should help women who elect to terminate a pregnancy through induced abortion to receive those services at the earliest possible stage of gestation.

Abortion – partial birth – medical statements



Barbara D. Woolley
05/12/97 07:04:23 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: AMA Report - Late Term

AMA's Board of Trustees quietly released to selected Members of Congress today a new study reviewing the scientific literature on abortion and making 5 recommendations.

The following are highlights.

* AMA reaffirms current policy regarding abortion: the early termination of pregnancy is a medical matter between the patient and physician subject to the physician's clinical judgement, the patient's informed consent.

* The term 'partial birth abortion' is not a medical term and won't be used by the AMA. They will use the term "intact dilatation and extraction."

* According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X The D&X procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgement, acting within standards of good medical practice and in the best interest of the patient.

* The viability of the fetus and the time when viability is achieved may vary with each pregnancy.

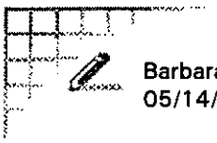
* That abortions not be performed in the third trimester except in cases of serious fetal anomalies incompatible with life. Although third-trimester abortions can be performed to preserve the life or health of the mother, they are, in fact, generally not necessary for those purposes. Except in extraordinary circumstances, maternal health factors which demand termination of the pregnancy can be accommodated without sacrifice of the fetus, and the near certainty of the independent viabiltiy of the fetus argues for ending the pregnancy by appropriate delivery/

* The AMA will work with ACOG, AAP to develop clinical guidelines for induced abortions after the 22nd week of gestation.

* AMA urges CDC and state health dept to develop expanded, ongoing data surveillance systems of induced abortions.

* AMA will work with appropriate medical specialty societies, government agencies, private foundation, and other interested groups to educate the public regarding pregnancy prevention strategies.

Abortion - partial birth - medical statements



Barbara D. Woolley
05/14/97 02:06:13 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:
Subject: AMA - Late Term, Daschle

AMA has put out a statement saying they do not support any legislative proposal at this time.

Message Sent To:

Tracey E. Thornton/WHO/EOP
Elena Kagan/OPD/EOP
Jennifer L. Klein/OPD/EOP
Maria Echaveste/WHO/EOP
William P. Marshall/WHO/EOP
John Podesta/WHO/EOP
Ann F. Lewis/WHO/EOP

Send this or an alternative. Nancy A

Abortion - partial birth - official statement

EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF MANAGEMENT AND BUDGET
WASHINGTON, D.C. 20503

March 20, 1997
(House)

STATEMENT OF ADMINISTRATION POLICY

(THIS STATEMENT HAS BEEN COORDINATED BY OMB WITH THE CONCERNED AGENCIES.)

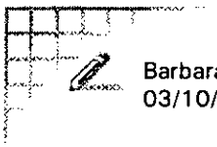
H.R. 1122 - Partial-Birth Abortion Ban Act of 1997
(Solomon (R) NY)

H.R. 1122 contains the same serious flaws as H.R. 1833, an identical bill that was passed during the 104th Congress and vetoed by the President on April 10, 1996.

The President will veto H.R. 1122 for the reasons he expressed in his veto message of April 10, 1996, which is attached.

* * * * * * * * * * *

Partial Birth
Abortion -
ACOG



Barbara D. Woolley
03/10/97 01:23:40 PM

Record Type: Record

To: See the distribution list at the bottom of this message

cc:

Subject: American College of OBGYN's - Partial Birth

ACOG's position statement on this issue has not changed. According to ACOG, "The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous." This is after the Catholic Bishops letter/statement today.

Message Sent To:

Maria Echaveste/WHO/EOP
John L. Hilley/WHO/EOP
Elizabeth A. Myers/WHO/EOP
Elena Kagan/OPD/EOP
FOLEY_M @ A1 @ CD @ LNGTWY
John P. Hart/WHO/EOP
Todd Stern/WHO/EOP
Pauline M. Abernathy/OPD/EOP
Peter G. Jacoby/WHO/EOP
Sylvia M. Mathews/WHO/EOP
Tracey E. Thornton/WHO/EOP

File — Abortion — Partial birth — Dose Medical statements

PHACT

Physicians' Ad Hoc Coalition for Truth

1150 South Washington Street
Suite 230
Alexandria, VA 22314
(703) 683-5004

Communications Counsel:
C. ... Tuma, Michelle Peterson

January 29, 1997

Fredric D. Frigoletto, Jr. M.D.
President of the Executive Board
American College of Obstetricians and Gynecologists

Dear Dr. Frigoletto:

We write to you on behalf of the hundreds of doctors nationwide who are members of the Physicians' Ad hoc Coalition for Truth (PHACT). PHACT was formed to address expertly one issue: partial-birth abortion. While the coalition includes physicians from all medical specialties, the vast majority of its members are obstetricians and gynecologists. Of these, a sizeable number are also Fellows of the American College of Obstetricians and Gynecologists (ACOG).

With this in mind, we are writing to express our surprise and concern over a recent statement issued by ACOG, dated January 12, 1997, on the subject of partial-birth abortion. Surprise, because those of us who are fellows were never informed that ACOG was even investigating this subject, with the goal of issuing a public statement, presumably on behalf of us and the others within ACOG's membership. And concern, because the statement that was issued, by endorsing a practice for which no recognized research data exist, would seem to be violating ACOG's own standards.

Let us address the latter concern -- content -- first.

The statement correctly notes at the outset that the procedure in question is not recognized in the medical literature. The same, it should be noted, can be said of the name you have chosen to call it -- "Intact Dilatation and Extraction," or "Intact D&X" -- and all the other names proponents of this procedure have concocted for it. We have closely followed the issue of partial-birth abortion -- again, it is the *only* issue PHACT addresses -- and the term Intact Dilatation and Extraction is new to us and would appear to be unique to you. The late Dr. James McMahon, until his death a leading provider of partial-birth abortions, called them "Intact Dilation and Evacuation (Intact D&E)" while another provider, Dr. Martin Haskell of Ohio, calls them "Dilation and Extraction (D&X)." Planned Parenthood, for example, calls them D&X abortions, while the National Abortion Federation prefers Intact D&E, so there is no agreement, even among proponents of this procedure, as to what to call it. Indeed, in its January, 1996 newsletter, ACOG then referred to it as "intact dialation (sic) and evacuation." Your new coinage would seem to be a combination of these various "names" floating about, but to what end is not clear. What is clear is that none of these terms, including your own "Intact D&X" can be found in any of the standard medical textbooks or databases.

It is wrong to say, as your statement does, that descriptions, at least the description in last year's Partial-Birth Abortion Ban Act, are "vague" and "could be interpreted to include elements of many recognized" medical techniques. The description in the federal legislation is very precise as to what is being proscribed and is based on Dr. Haskell's own descriptions. Moreover, the legislation is so worded as to clearly distinguish the procedure being banned from recognized obstetric techniques, and recognized abortion techniques, such as D&E, which would be unaffected by the proposed ban.

By far, however, the most disturbing part of ACOG's statement is the assertion that "An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of the mother."

On what possible basis does ACOG make this rather astounding assertion?

Many of our members hold teaching positions or head departments of obstetrics and gynecology or perinatology at universities and medical centers. To our knowledge there are no published peer-reviewed safety data regarding the procedure in question. It is not taught as a formally recognized medical procedure. We can think of no data that could possibly support such an assertion. If ACOG or its "select panel" has such data, we would, as teachers and practicing ob/gyns, certainly like to review it.

The best that your statement does to back this claim is the very vague assertion that "other data show that second trimester transvaginal instrumental abortion is a safe procedure." While this may be true, it is, as surely you must be aware, totally beside the point. Such data may exist regarding, e.g., second trimester D&E abortion, but this is irrelevant to the fact that no similar data, at least to our knowledge, exists with respect to partial-birth abortion (or, as you prefer, "intact D&X" or whatever other medical-sounding coinage supporters of this procedure may use). To include such an assertion that can only refer to second trimester abortion procedures *other* than partial-birth is deceptive and misleading at best.

ACOG clearly recognizes that in no circumstances is partial-birth abortion the only option for women. In other words, ACOG agrees that there are other, *medically recognized,* and standard procedures available to women other than partial-birth abortion. Given ACOG's acceptance of this medical fact, your claim that a totally unrecognized, non-standard procedure, for which no peer-reviewed data exist, can nonetheless be the safest and most appropriate in certain situations, simply defies understanding.

If ACOG is truly committed to standing by this claim, then it would appear to be violating its own standards by recommending the use of a procedure for which no peer-reviewed studies or safety data exist.

In contrast, our research of the subject leads us to conclude that there are no obstetrical situations that would necessitate or even favor the medically unrecognized partial-birth abortion procedure as the safest or most appropriate option. Indeed, we have concerns that this procedure may itself pose serious health risks for women.

Ordinarily, we would agree that the intervention of legislative bodies into medical decision making is usually inappropriate. However, when the medical decision making *itself* is inappropriate, and may be putting women at risk by subjecting them to medically unrecognized procedures, then the intervention of a legislative body, such as the U.S. Congress, may be the only way to protect mothers and infants threatened by the partial-birth abortion procedure.

In addition to these concerns over the content of the statement, we are also concerned as to the procedure by which it came to be issued.

As mentioned, the vast majority of PHACT members are specialists and sub-specialists (i.e. perinatologists) in obstetrics and gynecology, and many of these are also fellows of ACOG. After them, our membership consists largely of family practitioners and pediatricians. Former Surgeon General C. Everett Koop, perhaps the nation's leading pediatric surgeon, has been associated with PHACT and his public statements on partial-birth abortion are in agreement with PHACT. Our membership is open to any doctor, regardless of his or her political views on the larger question of abortion rights, precisely because our focus is strictly on the medical realities that relate to this procedure. (In fact, doctors who are pro-choice have publicly stated their opposition, on medical grounds, to the use of this abortion method).

We cannot recall receiving any notification whatsoever that the American College of Obstetricians and Gynecologists was even reviewing the issue of partial-birth abortion toward the end of issuing a statement of policy. We cannot recall ever being informed that ACOG was going to convene a "select panel" to accomplish this. We find it unusual that PHACT, a coalition of doctors formed for no other reason than to investigate medical claims made about partial-birth abortion, was not invited to participate in these deliberations. Those of us who are fellows of ACOG were kept completely in the dark as to what ACOG's leadership was doing in regard to this issue.

In truth, this statement is the product of a panel -- whose membership ACOG has not made public -- that was working behind closed doors and with no real participation from ACOG's membership itself. In crafting this statement, ACOG simply ignored its own members. There is the danger that in issuing this statement, ACOG is giving the larger public the impression that the statement somehow represents the thinking of its members on this subject. It does not. ACOG members had no knowledge of this statement until it was issued as a *fait accompli*.

In conclusion, this statement clearly does *not* represent a consensus among the nation's obstetricians and gynecologists as to the safety or appropriateness, under any circum[illegible] of the partial-birth abortion method. We ask you to provide the medical data, re[illegible] all other relevant materials which could possibly have led to such an assertion you also make available the names of those on the select panel who arrived conclusion. We would also ask that the leadership of ACOG officially withd statement until the matter at issue -- partial-birth abortion -- has been subj and open discussion among the members of ACOG and those doctors in rela who have significant knowledge regarding this issue. We look forward to y

Sincerely:

Denis Cavanagh, M.D.
Professor of Ob/Gyn
Director, Division of Ob/Gyn
University of South Florida
College of Medicine
FACOG

Curtis Cook, M.D.
Maternal–Fetal Medicine
Michigan State College
of Human Medicine
FACOG

Joseph DeCook, M.D.
Ob/Gyn
FACOG

Don Gambrell Jr., M.D.
Clincal Prof. of Endocronology
and Ob/Gyn
Medical College of Georgia,
Augusta
V. President, South Atlantic Assoc.
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Hans E. Geisler, M.D.
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Clinical Staff, Dept. of Ob/Gyn
Indiana University Medical Center
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Nancy Romer, M.D.
Clinical Prof., Ob/Gyn
Wright State University
Chairman, Dept. of Ob/Gyn
Miami Valley Hospital, OH
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Pamela Smith, M.D.
Director of Medical Education
Dept. of Ob/Gyn, Mt. Sinai
Medical Center, Chicago
Member, Assoc. of Professors of
Ob/Gyn
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William Stalter, M.D.
Clinical Assoc. Prof., Ob/Gyn
Wright State University
FACOG

Stephen H. Cruikshank, M.D.
Nicholas J. Thompson Professor and Chairman
Deptartment of Obstetrics and Gynecology
Wright State University, OH

CC: Vicki L. Seltzer, M.D.
George Wilbanks, M.D.
Philip N. Eskew, Jr. M.D.
John Gibbons, M.D.
John Boyce, M.D.
John Choate, M.D.
Jan Schneider, M.D.
Dale L. Taylor, M.D.
James W. Gell, M.D.
Lance A. Talmadge, M.D.
Dennis J. Lutz, M.D.
Daniel A. Chester, M.D.
Thomas F. Purdon, M.D.
William J. Peters, M.D.
Vivian M. Dickerson, M.D.
W. Gordon Peacock, M.D.
John D. Nash, Capt, MC USN
Nathana L. Lurvey, M.D.
Sarah S. Brown, MPH
American Medical Association (AMA) Task Force on "Intact Dilatation and Extraction" [Partial-Birth] Abortion