



## Roe versus Reality — Abortion and Women's Health

Alexi A. Wright, M.D., and Ingrid T. Katz, M.D., M.H.S.

Sandra Jones was on her way to a Nebraska operating room to have an abscess drained when she learned that, once again, she had defied medical odds. Six months earlier, doctors had diagnosed

breast cancer in the 31-year-old mother of two. Because her test results were positive for the breast cancer susceptibility gene 1 (*BRCA1*) and she was at high risk for ovarian cancer and recurrent breast cancer, they had recommended bilateral mastectomy, chemotherapy, and a hysterectomy, but Jones (whose name has been changed to protect her privacy) was not ready to give up child-bearing. Her doctors warned that though it would be extremely difficult for her to conceive after chemotherapy, she should actively avoid pregnancy for at least six months, since it would complicate her disease and the drugs would increase the risk of serious birth defects. After struggling

through treatment, Jones returned home to find that her husband had left her. Now, a few weeks later, routine preoperative tests revealed that she was pregnant.

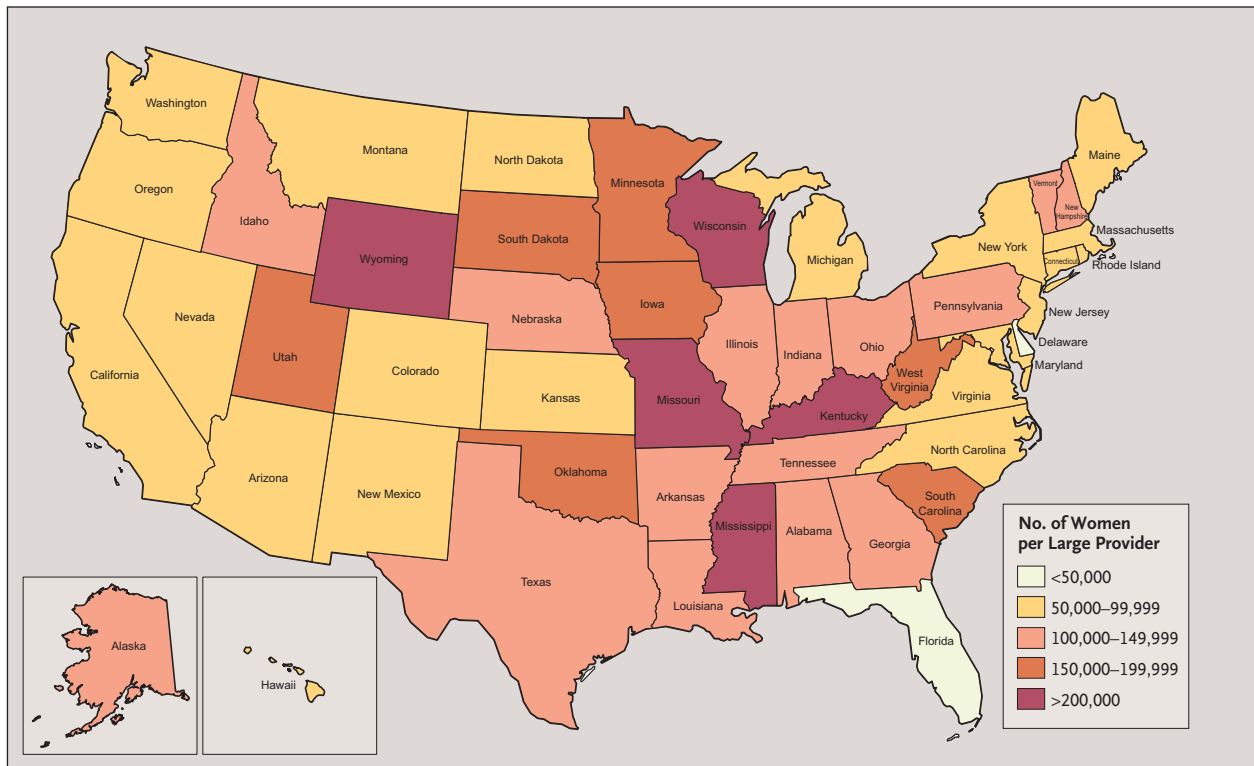
Jones wanted to terminate the pregnancy, but no physician at the hospital was willing to perform an abortion. So several days later, she searched the telephone book and found LeRoy Carhart's Abortion and Contraception Clinic of Nebraska in Bellevue, a small city just south of Omaha.

Carhart is famous among abortion providers. He first made national headlines in 2000, when he helped to overturn a Nebraska law banning "partial-birth" abortion. In a five-to-four decision in *Sternberg v. Carhart*, the

U.S. Supreme Court declared the law unconstitutional because it provided no exception for the woman's health and its vague definition of the banned procedure placed an "undue burden" on women.

Despite this decision, in 2003 President George W. Bush signed the federal Partial-Birth Abortion Ban Act. Carhart and a nonprofit legal organization called the Center for Reproductive Rights filed a lawsuit in Nebraska, as did others in New York and California; in all three states, district and appeals court judges ruled the ban unconstitutional. This past February, however, after Justice Samuel Alito was appointed, the Supreme Court decided to hear *Gonzales v. Carhart*. Oral arguments will take place this fall.

Carhart is one of the few doctors in Nebraska who performs abortions. Although 35 percent of women in the United States



Availability in Each State of Providers Who Perform 400 or More Abortions per Year.

Map is based on special tabulations of data from the Guttmacher Institute's 2002 Abortion Provider Survey.

undergo an abortion before they are 45 years of age, providers are increasingly scarce. Each year, 1.3 million women in the United States undergo an abortion, but in 2000 only 3 percent of rural areas in the United States had an abortion provider, and 87 percent of U.S. counties had none. Eighteen states had fewer than 10 doctors willing to perform abortions (see map).<sup>1</sup>

In the United States, nearly 20 percent of hospital beds are in facilities with religious affiliations, most of which prohibit physicians from providing abortions.<sup>2</sup> According to the Guttmacher Institute, although nationwide about 1 in 14 abortions is sought for health reasons, only two hospitals in Nebraska offer pregnancy terminations, and they do so only under rare circumstances, such as intrauterine fetal

death; each of these hospitals performs fewer than 10 pregnancy terminations per year. Nevertheless, in 2004, women from many other states traveled to Nebraska for abortions — at Carhart's clinic. Occasionally, when a hospital refuses, Carhart is asked to terminate a pregnancy that threatens a woman's health. In a recent case, a woman with severe pregnancy-associated renal failure traveled 200 miles by ambulance for an abortion. She arrived with her hospital identification bracelet and an intravenous line in place, underwent the procedure, and was shipped back to her hospital bed.

Similar events have occurred in many other states. In 1998, the Louisiana State University Medical Center in Shreveport refused to provide an abortion for Michelle Lee, a woman with cardiomyopathy who was on the waiting list

for a heart transplant, despite her cardiologist's warning that the pregnancy might kill her. Hospital policy dictated that to qualify for an abortion, a woman's risk of dying had to be greater than 50 percent if her pregnancy was carried to term; a committee of physicians ruled that Lee did not meet this criterion. Since her cardiomyopathy made an outpatient abortion too dangerous, she traveled 100 miles to Texas by ambulance to have her pregnancy terminated.

Some women cross continents to find Carhart's clinic, a small, brown building on the edge of Bellevue. Last year, Carhart and his 10 staff members performed 1250 abortions there. The clinic has three rooms, each equipped with an examination table, an ultrasound machine, and a pulse oximeter. Carhart performs most

first-trimester and early second-trimester abortions with a curette and a vacuum cannula, removing the pregnancy sac under ultrasound guidance. He performs abortions up to 24 weeks after conception, the legal limit.

A shy man, Carhart speaks softly and rarely smiles or makes eye contact, except when speaking with his patients. Nearly six feet tall, with thick, white hair, he is a quietly imposing figure. Outside the examination room, almost every sentence he speaks is interrupted by his cell phone — on which he is available around the clock since he stopped using an answering service. “I couldn’t find enough pro-choice operators,” he explained. “We lost a lot of calls from patients because the service wouldn’t put them through.”

It’s hard to imagine him as a robust young surgeon in the Air Force, where he practiced for two decades — until you witness his dogged determination to keep abortion available and safe. After leaving the military, Carhart opened a clinic for emergency surgery. Abortions were a small part of his practice until 1991, when, on the day the Nebraska Parental Notification Law was passed, his house and stables burned down, killing 17 horses, his dog, and his cat. Although the fire had started in seven different locations on his property, it was never declared arson, and no one was charged with a crime. “Everything we owned except the clothes on our backs and the cars we were driving was destroyed,” said Carhart. “The following morning, I received a letter from someone claiming responsibility, likening the murder of my horses to the murder of children.”

The fire transformed Carhart’s life. Determined not to “cede a

victory to the antis,” he began providing abortions full-time. For a few years, he worked in six states, leaving each day at 6 a.m. and returning home at 11 p.m. Now he moonlights in a Kansas abortion clinic to keep his practice afloat, but his primary office is in Bellevue, situated between a gas station and an antiabortion counseling center for pregnant women called A Woman’s Touch. The Catholic school across the street erected a granite tombstone after Carhart moved in; engraved with an image of Jesus holding a baby with angel’s wings, it reads: “In Memory of the Unborn Child.” From the outside, Carhart’s clinic looks almost abandoned; its windows were boarded up after people shot through them. Nevertheless, cars are parked outside and protestors cluster together at the edge of the parking lot. A large sign on the building reads: “Abortion and Contraception Clinic of Nebraska.”

Next door, an even larger billboard above A Woman’s Touch advertises free pregnancy testing and confidential counseling. Nationally, such centers outnumber abortion clinics six to one.<sup>3</sup> Most are staffed by volunteers and funded by churches, private citizens, or state governments. Thirteen states sell “Choose Life” license plates that help to support these facilities. The Bellevue center was started by Liz Miller, a middle-aged woman with a degree in Biblical studies and training as a licensed practical nurse who used to protest outside Carhart’s clinic. A Woman’s Touch has an annual budget of \$100,000 and serves approximately 60 women per month, free of charge, with the stated aim of providing complete information. “We feel strongly,” said Miller, “that women

are not receiving all of the information they need to make their decision.”

The center is a two-story pink building that looks airy and inviting. Although it is not a clinic, it offers pregnancy tests and employs a nurse to counsel patients. It has a waiting room and several consultation rooms, including one with an examination table and an ultrasound machine. One of the many brochures available in the entryway suggests that abortion is associated with an increased risk of breast cancer and that “a woman diagnosed with breast cancer while pregnant has a significantly longer life expectancy if she gives birth rather than aborting.” According to the National Cancer Institute, there is no credible evidence to support these claims; indeed, a recent large meta-analysis found no such link.<sup>4</sup>

Signs advertise workshops and retreats for women with “post-abortion stress syndrome.” This diagnosis is not recognized by the American Psychiatric Association or the American Psychological Association; a study of women’s responses to abortions indicated that distress is greatest before the procedure and that there are few severe negative responses afterward.<sup>5</sup> The center also offers prenatal parenting classes, baby clothes, and postabortion Bible studies. If a woman is “abortion-minded,” it offers fetal ultrasonography. “Most of the women who see ultrasounds choose to parent,” reported Miller. “Once you watch that little heart beating or see fingers and toes, a sense of regret develops.”

Each day, the same protestors assemble outside Carhart’s clinic. With signs showing Jesus on one side and mutilated fetuses on the other, they approach each car

## Plan B, Reproductive Rights, and Physician Activism

Rebekah E. Gee, M.D., M.P.H.

Last year, I gave one of my patients a prescription for emergency contraception. When she presented it at a Wal-Mart pharmacy, she was turned away empty-handed. This mother of three, struggling to pay her bills, routinely shopped for groceries and diapers at Wal-Mart. She felt humiliated and judged by the pharmacist, and her access to needed medication was delayed. Through her experience, I became aware of Wal-Mart's refusal to stock Plan B (levonorgestrel).

The refusal by individual pharmacists to fill prescriptions is a contentious issue, and state laws governing such acts vary. But Wal-Mart was running the only national pharmacy chain that categorically refused to stock emergency contraception in its stores. Soon after my patient's run-in, Julie Battel (a nurse-midwife), Katrina McCarty (a policy analyst who works to combat sexual assault and domestic violence), and I each obtained a prescription for Plan B and presented it at a Wal-Mart pharmacy. As expected, the pharmacists refused to fill our prescriptions. So, on February 7, 2006, with the aid of a Boston law firm and two reproductive-rights organizations, we filed a lawsuit against Wal-Mart under a Massachusetts regulation requiring pharmacies to stock all "commonly prescribed medications" necessary to "meet the needs of the community."<sup>1</sup>

By the next day, the story had been reported by media outlets worldwide, and several women's advocacy organizations and lawmakers announced their support. The image of women being denied a medication prescribed by their

doctors received broad exposure. Within two days, Wal-Mart announced that it was "rethinking" its policy.

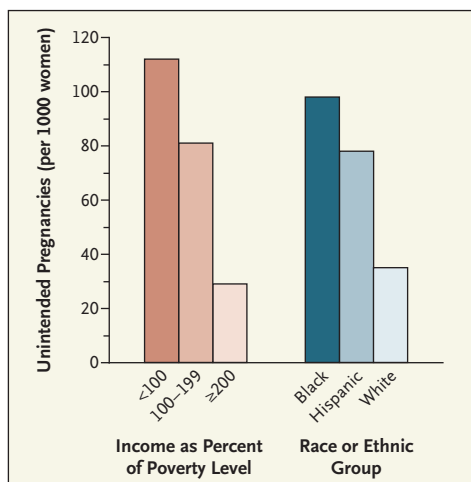
On February 14, the Massachusetts Board of Registration in Pharmacy voted unanimously that its regulation required Wal-Mart to stock Plan B. In early March, after we threatened to pursue legal action in state after state until the national policy was changed, Wal-Mart declared that it would stock the product in all stores (as it now reportedly does).

Many low-income women have few affordable alternatives to shopping at Wal-Mart for their daily needs. In rural areas, Wal-Mart may also provide the only accessible pharmacy. The store's refusal to provide patients with needed medication obstructs timely medical care and puts them at risk for unintended pregnancy. In the United States, half of all pregnancies are unintended, and half of these end in abortion.<sup>2</sup> A recent study by the Guttmacher Institute found that unintended pregnancy disproportionately affects low-income and minority women, who face the greatest barriers to care (see graph). Among women living below the poverty line, the rate of unintended pregnancy increased by 25 percent from 1994 to 2001.<sup>3</sup>

Given concerns about unintended pregnancies, it is striking that Plan B has been so controversial. Wal-Mart's politically motivated refusal to stock it was probably predicated on the debate over the mechanism of action of Plan B, which is often confused with the abortifacient mifepristone. In reality, Plan B

is thought to operate in a manner similar to hormonal contraceptives, which can prevent ovulation and possibly render the endometrial environment less habitable for implantation. These methods do not interrupt an intrauterine pregnancy after implantation and thus do not cause an abortion according to any common definition. The American College of Obstetricians and Gynecologists (ACOG) defines pregnancy as beginning at implantation, as does the U.S. government.<sup>4</sup> Some who take issue with Plan B believe that life begins at fertilization and that any interference with implantation therefore constitutes an abortion — or is, at least, equally reprehensible.

But Plan B is not all that is under attack. Limiting access to all contraception appears to be the goal of a growing U.S. movement. Anticontraception organizations cite concern about promiscuity, which they argue is promoted by open access to contraception. This movement is bolstered by the refusal of the Bush administration to seek realistic solutions to the U.S. and global epidemics of unintended pregnancy. One of this administration's first actions was to cut funding to international family-planning groups. Our government has been burying its head in the sand, pretending that sex does not happen. This agenda sets women back decades, threatening their right to achieve equality in society by robbing them of options for planning their childbearing. The women of my mother's generation, who fought so hard for these rights, never foresaw this debate.



Unintended Pregnancies in 2001 According to Women's Income and Race or Ethnic Group.

Data are from the Guttmacher Institute.

Faced with common misunderstandings about Plan B, many clinicians are trying to educate the public and to make this medication more widely available through a three-pronged strategy: preemptively providing prescriptions to patients, creating protocols to allow pharmacists to dispense the medication without a prescription, and supporting over-the-counter availability. ACOG recently launched a national "Ask Me" campaign to encourage patients to ask for Plan B and physicians to provide advance prescriptions. Nine states currently provide "behind-the-counter" access,<sup>5</sup> but the Food and Drug Administration rejected the manufacturer's application for over-the-counter status, despite the support of its own advisors.

Impediments to contraception can be legal as well as procedural and financial. In our current cultural climate, the right of women to obtain contraceptives is being called into question. Given the threats that unplanned pregnancies pose to public health — in poor prenatal care, increased maternal morbidity, and increased rates of abortion —

we need to decide whether we are willing to even put this right up for debate.

During the past decade, our patients' need for our advocacy has expanded in unexpected ways. As physicians, we are coaxed into involvement in areas of public life that are tangential to medicine; we find ourselves wrangling with insurance companies, retail corporations, and pharmacists who interfere with our responsibility to patients. These new roles present challenges. Because of the Wal-Mart lawsuit, I received threatening e-mail messages, letters, and telephone calls at home and at work. I was called "Hitler" by a letter writer who accused me of trying to "depopulate" the human race. On national radio, Rush Limbaugh insulted those of us who filed the lawsuit. Derogatory comments still appear on "pro-life" Web pages.

Yet advocacy on behalf of patients is part of our mission as physicians. We are all patient advocates in the examination room, the research laboratory, the media, and Congress. We may not choose such embroilments for ourselves, but more and more, our engagement in them is what our patients require.

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1. Massachusetts Board of Pharmacy Regulation 247 C.M.R. § 6.02(4)
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3. *Idem*. Disparities in rates of unintended pregnancy in the United States, 1994 and 2001. *Perspect Sexual Reprod Health* 2006;38:90-6.
4. Code of federal regulations: public welfare — protection of human subjects. Washington, D.C.: Department of Health and Human Services, 2005. (Accessed June 15, 2006, at <http://www.hhs.gov/ohrp/humansubjects/guidance/45cfr46.htm>.)
5. Pharmacy Access Partnership. State profiles. (Accessed June 15, 2006, at <http://www.go2ec.org/StateProfiles.htm>.)

pulling into the driveway, urging women to visit the center next door instead. "Don't let them destroy the most precious thing inside of you," they shout. The protestors and Carhart's staff have known each other for years and exchange daily barbs; in March, after sending employees threatening letters, protestors began showing up at their homes as well.

The clinic's entryway is flanked by two sets of doors that can lock instantly if the office is threatened. Like most abortion providers, Carhart takes precautions to protect himself and his staff. Each day, he and his wife, Mary, who works with him, drive a different route to work. When they are indoors, they sit away from windows, facing the door. After Barnett Slepian — an abortion provider in suburban Buffalo, New York — was murdered in 1998, police brought the Carharts bulletproof vests. They wore them until, as Carhart drily noted, "we realized that the antis usually shoot providers in the head."

Inside Carhart's office, the atmosphere changes: the walls are covered with thank-you letters from patients, national awards, and portraits of the horses that were killed in the fire. The members of the staff are full of camaraderie. During abortions, they console women, explaining the procedure and chatting with them about their pets, work, or families. The conversation continues in the recovery room, where women sit in recliners while assistants provide antibiotics, postoperative instructions, and contraceptive counseling. Some patients write in the clinic's diary, which was started by a 14-year-old girl who wrote a letter to future patients, sharing her story and reassuring them about the procedure. Before each woman leaves, she must void her

bladder, circle the hallway 15 times, and show that her bleeding is slowing; since many patients live hours away, Carhart's staff makes sure that they are stable before they depart.

When we met Carhart one recent morning, he had already performed two abortions and had eight more scheduled. His next patient was a woman who had come in the previous day and been sent home because the staff did not think she was emotionally ready. She returned with her brother, who spent most of the time outside with the protestors, coming in occasionally to remind her that she was going to hell. In her purse, she carried protestors' pamphlets featuring pictures of developing fetuses. Before starting, Carhart asked her if she was sure she wanted to do this. She nodded. Throughout the procedure, though, she cried quietly. Afterward, Carhart asked whether the protestors had gotten to her. "No," she sobbed. "The guilt did."

That day, Carhart saw high-school students, housewives, a patient with breast cancer, and a Native American woman from a South Dakota reservation 12 hours away. Carhart has many patients from South Dakota, which has only one abortion clinic and mandates a 24-hour waiting period for abortions, parental notification for minors who are seeking pregnancy terminations, and state-scripted counseling. The last South Dakota abortion provider retired 10 years ago, so a doctor from Minnesota flies to South Dakota one day each week to perform only first-trimester abortions at the remaining clinic.

In March, South Dakota Governor Mike Rounds went one

step further, signing into law an outright ban on abortion. The measure, intended as a direct challenge to *Roe v. Wade*, would make it a felony for a doctor to perform an abortion unless it was necessary to save a woman's life. The bill has no exception for rape, incest, or health — and does not define what constitutes a life-threatening condition. The ban was scheduled to go into effect on July 1, until a grassroots coalition collected the signatures required to send it to a voter referendum in November. Early signs suggest the ban may be overturned: in a survey of registered voters, 57 percent said they would vote against it, 35 percent said they would vote to uphold it, and 8 percent were undecided.

At the federal level, in *Gonzales v. Carhart*, the Supreme Court will decide whether to uphold the Partial-Birth Abortion Ban Act that restricts second-trimester abortions to women with life-threatening conditions. A central question is whether the Court will accept the law's definition of "partial-birth" abortion, a term used by antiabortion forces to describe intact dilation and extraction (D&X).

In the act, the definition of "partial-birth" abortion reads:

The person performing the abortion deliberately and intentionally vaginally delivers a living fetus until, in the case of a head-first presentation, the entire fetal head is outside the body of the mother, or, in the case of breech presentation, any part of the fetal trunk past the navel is outside the body of the mother for the pur-

pose of performing an overt act that the person knows will kill the partially delivered living fetus.

Physicians who violate the law could face up to two years of imprisonment, be subject to civil lawsuits, and be held responsible for financial compensation of "all injuries, psychological and physical." Defendants could appeal to their state medical board for a hearing to prove that the abortion was necessary to save the woman's life. However, Carhart notes that "most physicians are not going to risk their careers to prove a woman's condition is life-threatening — not if the only backup they have is a state medical board."

Some abortion-rights activists and physicians, including Carhart, argue that the definition of "partial-birth" abortion is so vague that the law would apply to dilation and evacuation (D&E), the procedure routinely used for second-trimester abortions. In *Sternberg v. Carhart*, Justice Stephen Breyer wrote: "Even if the [Nebraska] statute's basic aim is to ban intact D&X, its language makes clear that it also covers a much broader category of procedures." But anti-abortion activists insist that the federal law targets intact D&X exclusively. Clarke Forsythe, the former president of Americans United for Life, said that far from being too broad, the law "is so narrowly drafted that it may never be enforced."

Much media coverage has focused on the rarity of intact D&X; in 2000, for example, this procedure accounted for 0.17 percent of all abortions. Introduced as a method for reducing



LeRoy Carhart's Abortion and Contraception Clinic of Nebraska, Bellevue.

A slideshow is available with the full text of this article at [www.nejm.org](http://www.nejm.org).

complications in late second-trimester abortions, it is usually performed over the course of two to three days, beginning with the insertion of a laminaria. Once the cervix is sufficiently dilated, the fetus is removed intact; this often requires collapsing the fetal calvaria so the fetal skull can pass through the patient's cervix. In contrast, D&E is a destructive procedure that involves evacuation of the fetus and placenta, usually in pieces, with forceps and a vacuum. Many abortion providers try to keep the fetus as intact as possible while removing it, though, in order to minimize the retention of products of conception. Some abortion providers argue that intact D&X is safest for the woman, since it minimizes the risk of uterine injury, cervical tears, and retained products of conception. However, the procedure is controversial, even among abortion-rights supporters.

The antiabortion movement argues that the Court's decision regarding *Sternberg v. Carhart* does not reflect the people's will. More than half of the states have passed "partial-birth" abortion bans,

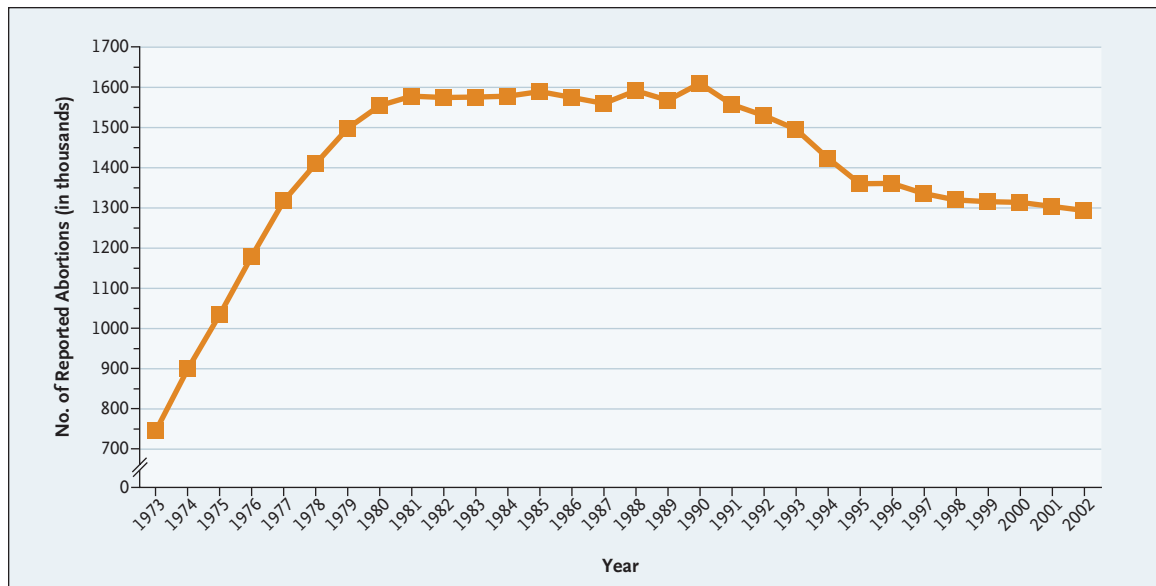
but the Supreme Court's decision made them unenforceable. "Seventy to 80 percent of the public thinks that this is a barbaric procedure," argues Forsythe. "Despite this, the Supreme Court swept away 30 state laws." Forsythe opposes the inclusion of a health exception in the law, arguing that "there is no ban if there's a health exception." In pre-*Roe* days, many hospitals offered abortion to women with life-threatening or high-risk pregnancies, despite state laws against it. Physician committees decided who was eligible for abortions and often granted them on psychiatric grounds; poor women had limited access to these procedures.

Today, many antiabortion activists believe that late second-trimester abortions should be performed through labor induction so that the fetus will die of prematurity, rather than be killed. But "that is a fine line with a long history," said Kenneth Edelin, who was convicted of fetal manslaughter in 1975 for performing a second-trimester abortion two years after *Roe v. Wade*. Edelin, now an emeritus profes-

sor of obstetrics and gynecology at the Boston University School of Medicine, was a resident in 1973, when a mother brought her pregnant 17-year-old daughter to the hospital requesting an abortion. Edelin attempted to terminate the pregnancy by infusing saline into the amniotic sac but was unable to reach it because of a low-lying anterior placenta. The mother begged him to try another method. She explained that her abusive husband might hurt their daughter if he discovered she was pregnant. After conferring with his attending physician, Edelin performed a hysterotomy, making a small incision in the uterus and removing the fetus and placenta in a procedure similar to a cesarean section.

Four months later, the Boston District Attorney's office discovered the case when it subpoenaed the medical records of 88 women who had undergone abortions. Edelin was indicted. At grand-jury hearings, most of the physicians pled the Fifth Amendment, but Edelin told the truth, believing he was protected by the law. The assistant district attorney who charged him with manslaughter argued that the 20-week-old fetus had become a person once the placenta was detached from the woman and should have been resuscitated. The defense argued that it was stillborn, as indicated at autopsy. Nevertheless, when the case went to trial, Edelin was found guilty.

Newspapers nationwide reported on the trial, and there was an immediate chilling effect. "Once I was indicted, hospitals up and down both coasts stopped performing second-trimester abortions," recalled Edelin. "Many hospital administrators stopped



**Numbers of Reported Abortions in the United States, 1973–2002.**

Data are from the Guttmacher Institute; data for some years were interpolated.

permitting residents to take part in abortion at all.” But there was also an outpouring of support from women who had undergone pregnancy terminations before *Roe v. Wade*. “I received thousands of letters describing women’s experiences — lying on a kitchen table on a sheet of newspaper with a single light bulb overhead, undergoing an abortion alone without anesthesia, antiseptic, or anyone to support her,” said Edelin. “Many women were raped as a part of the process. It’s amazing the indignities — the risk to life and future fertility — these women faced when they were alone and frightened.” Edelin appealed to the Supreme Judicial Court of Massachusetts, and eventually the verdict was reversed.

Abortion veterans like Carhart fear that *Roe* may soon be overturned. If that happens, states will have to choose whether to ban or protect abortion. Most have abortion laws on their books,

but they are superseded by *Roe*, as long as it survives. Antiabortion activists are split on whether they should try to overturn it. After Governor Rounds signed the South Dakota ban into law, his approval rating dropped 12 percent. Most of the public still support some form of abortion: polls show that 66 percent of Americans believe that abortion should be legal in the first trimester and that they overwhelmingly support abortion in cases of rape, endangerment of health, or serious fetal anomalies. Yet in 2006, legislators in 12 states introduced bills that would ban nearly all abortions; as of early June, the governor of Louisiana was poised to sign a ban similar to South Dakota’s, which will go into effect if *Roe* is overturned.

Watson Bowes, emeritus professor of obstetrics and gynecology at the University of North Carolina, is among those who argue that *Roe v. Wade* is a mis-

use of federal authority: “The Supreme Court used raw judicial power to trump state legislators, and the decision should be overturned on those grounds.” Other antiabortion activists advocate incremental changes in state laws to limit the provision of abortion. These changes include parental consent laws, fetal homicide laws (making it two crimes to kill a pregnant woman), strict regulations for abortion clinics, and legislation requiring physicians to offer women fetal ultrasonography before an abortion.

This strategy is already having an effect, argued Katherine Grainger, legislative counsel at the Center for Reproductive Rights. “With each year, more and more restrictions on *Roe* are being passed.” Ultimately, Grainger said, “we’ll see it slowly eviscerated to the point where . . . it’s hollow.”

Many older abortion providers believe that the complacency of

younger women and physicians is partially responsible for the current state of affairs. "They don't remember the thousands of women who died from septic abortions," argued Edelin. "They don't realize that this is a battle to save women's lives — not a battle for choice."

As new legislation is passed, the courts will hear more cases that challenge *Roe*, and physicians may increasingly risk their careers and their lives if they choose to provide abortions. With each new

decision to limit abortion, more American women lose their access. Whether the Supreme Court ultimately upholds or overturns the Partial-Birth Abortion Ban Act, one thing is certain: poor women in rural America are bearing the brunt of these decisions, and some may pay with their lives.

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Dr. Wright is a fellow in hematology–oncology at the Dana–Farber Cancer Institute, Boston, and Dr. Katz is a fellow in infectious disease at the Beth Israel Deaconess Medical Center, Boston. Both are editorial fellows at the *Journal*.

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