

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

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

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

This article (10.1056/NEJMp078055) was published at [www.nejm.org](http://www.nejm.org) on April 23, 2007.

Professor Charo is a professor of law and bioethics at the University of Wisconsin, Madison, and a member of the board of directors of the Guttmacher Institute.

The views expressed in this article are the author’s and do not necessarily reflect those of the Guttmacher Institute.

1. Finer LB, Henshaw SK. Abortion incidence and services in the United States in 2000. *Perspect Sex Reprod Health* 2003;35:6-15.
2. Kassirer JP. Practicing medicine without a license — the new intrusions by Congress. *N Engl J Med* 1997;336:1747.
3. Bloche MG. The Supreme Court and the purposes of medicine. *N Engl J Med* 2006;354:993-5.
4. Wright AA, Katz IT. *Roe* versus reality — abortion and women’s health. *N Engl J Med* 2006;355:1-3, 5-9.
5. Greene MF, Ecker JL. Abortion, health, and the law. *N Engl J Med* 2004;350:184-6.

Copyright © 2007 Massachusetts Medical Society.

## The Intimidation of American Physicians — Banning Partial-Birth Abortion

Michael F. Greene, M.D.

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

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

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

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

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

delivery? Or as intentionally killing the fetus? Once the prosecutor knocks on the door, the onus will be on the physician to show that there was no intent to perform a banned procedure. Lacking confidence in the judicial system, physicians may choose to avoid performing second-trimester surgical abortions, thus restricting access to them, perhaps even if the mother's life is in jeopardy.

In the same way that it might be difficult to discern the intent of a physician during the conduct of a pregnancy-termination procedure, it is difficult to know the

true intent of the 108th Congress when it passed the partial-birth abortion bill in 2003. Was the intent, as the law claims, simply to ban “a gruesome and inhumane procedure that is never medically necessary”? Or was this law the carefully calculated first step in a larger strategy for the gradual erosion of access to abortion services?

No aspect of medicine seems to attract as much popular and political attention as reproductive medicine. In recent years, our government has restricted women's options for preventing conception and now for coping with

pregnancies that threaten their health or are simply unplanned and undesired. Both health care providers and patients should be alarmed by the current degree of intrusion by our government into the practice of medicine and even more so by the apparent trajectory that it seems poised to follow in the near future.

This article (10.1056/NEJMp078084) was published at [www.nejm.org](http://www.nejm.org) on April 23, 2007.

---

Dr. Greene, an associate editor of the *Journal*, is a professor of obstetrics, gynecology, and reproductive biology at Harvard Medical School and director of obstetrics at Massachusetts General Hospital — both in Boston.

Copyright © 2007 Massachusetts Medical Society.