Restricting Second Trimester Abortion: The Implications of Gonzales v. Carhart

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The United States Supreme Court is now directly regulating the practice of medicine. In its recent landmark 2007 decision Gonzales v. Carhart, a 5-4 majority of the Court held that the federal Partial-Birth Abortion Ban Act of 2003 (“the Act”) was constitutional and did not impose an undue burden on the due process right of women to obtain an abortion that was established in Roe v. Wade and Planned Parenthood v. Casey. The precise question before the court was “Whether, notwithstanding Congress’s determination that a health exception is unnecessary to preserve the health of the mother, the Partial-Birth Abortion Act is invalid because it lacks a health exception or is otherwise unconstitutional.” The immediate and direct result of Carhart v. Gonzales was that no physician anywhere in the United States can now perform a “partial-birth” abortion for any indication, even if it is deemed the only safe procedure available to save the life of the mother and even if the fetus is not viable. Federal penalties for physicians include a monetary fine and the risk of imprisonment for up to two years, and in some states an unlawful abortion carries additional penalties.

With this decision the Court overturned a ruling by the United States Court of Appeals for the 8th Circuit in favor of LeRoy Carhart, a physician who ran an abortion clinic in Nebraska. The 8th Circuit had ruled that the federal Partial-Birth Abortion Ban Act was unconstitutional because it lacked a provision allowing the procedure to be performed when necessary to save the life of the mother. This lack was a violation of substantive due process. At the same time the Court also reversed the 9th Circuit’s similar decision against the Act in Gonzales v. Planned Parenthood.

The 2007 Carhart decision would appear to be a clear 180 degree turn from the earlier 2000 U.S. Supreme Court decision in Stenberg v. Carhart which held that Nebraska’s “partial birth abortion” statute violated the U.S. Constitution precisely because its lack of a maternal health exception allowing the procedure to be performed was an undue burden on a pregnant woman’s substantive due process right to an abortion. Writing for the Court in 2000, Justice Breyer found that the Nebraska statute was also void because it was so vaguely worded that the ban on the procedure in question could possibly have been applied to more commonly used surgical abortion procedures for second or first trimester abortion which were not contemplated by the statute. The Republican-dominated U.S. Congress responded to this 2000 Supreme Court decision by passing the federal 2003 Partial Birth Abortion Act. The Act was carefully written to precisely describe the surgical procedure being outlawed to avoid the void for vagueness issue in any

5 Gonzales v. Carhart, supra note 1.
6 Carhart v. Gonzales, 413 F.3d 791 (8th Cir.2005).
7 Planned Parenthood Federation of America, Inc. v. Gonzales, 435 F.3d 1163 (9th Cir. 2006).
subsequent litigation. However, the lack of a maternal health exception, which was the primary reason the Nebraska statute was ruled unconstitutional, was preserved.

The 2007 Carhart decision by the Court was made possible only by the recent departure of Justice Sandra Day O’Connor and her replacement by Justice Samuel Alito. With a shift to the right, the majority of the court lined up behind the medical opinion of Justice Kennedy and found that a direct federal ban on a rarely performed procedure for terminating a second trimester pregnancy now passed constitutional muster. Interestingly, Kennedy wrote that the decision was consistent “under precedents we here assume to be controlling” (i.e. the Roe and Casey decisions), and attempted to distinguish his decision from the apparently opposite one the Court reached in the 2000. Much of the discussion centered around the Justices’ differing interpretations over the expert medical testimony offered to Congress as to whether partial birth abortion was ever really necessary. Justice Kennedy accepted one set of medical arguments that the procedure was never really necessary and that safe, alternative procedures were always available. Under this set of circumstances, a ban on partial birth abortion would not be a violation of the substantive due process right to an abortion because, from a practical point of view, there was no restriction of access to second trimester abortion. Justice Ginsburg embraced the opposing expert medical testimony which claimed that there were unique circumstances where partial birth abortion was the safest procedure, and in an uncharacteristically blistering dissent, ridiculed Justice Kennedy’s attempt to distinguish between the two Carhart cases. In a minority opinion joined by Justices Stevens, Souter, and Breyer, Justice Ginsburg pointed out that the only real difference between the two cases was in the composition of the Court. This difference in the composition of the Court may not make all the difference as far as future abortion cases are concerned.

The Case at Hand

Partial-birth abortion, also know as “intact D & E” (dilatation and evacuation) or “D & X” (dilatation and extraction), was the perfect surgical technique for anti-abortion activists to go after. Rarely used, performed by only a handful of practitioners, not described in any standard medical textbooks, and gruesome in its details, D & X was unsupported by any substantial safety or efficacy data from randomized, prospective trials comparing it to alternative procedures for termination of similar-gestational age pregnancies. D & X was defended only by a small number of academicians and the American College of Obstetricians and Gynecologists, which had until recently managed to keep the practice of the radar screen of public opinion. For all of these reasons, the procedure was easy to marginalize, and was the perfect “wedge” to pry under the tent of abortion rights. The medical profession’s testimony before Congress when the Act was

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10 Id.
11 Id.
12 Id.
being debated probably didn’t help, with physicians from the same medical school offering opposing views on the legitimacy and necessity of the procedure.

Exact figures on the number of D & X procedures performed in the United States, the number of individuals who routinely perform such procedures, and the number of women (if any) for whom the procedure is either the only method of termination available or deemed the safest given the gestational age of the fetus are unknowns. There is consensus agreement that all of these numbers are very small.

Alternative procedures for termination of second trimester pregnancy include (1) the traditional dilatation and evacuation (D & E) procedure; (2) direct injection of a prostin-saline solution into the amniotic fluid to terminate the pregnancy and produce labor which delivers the fetus intact; (3) early induction of labor without intrauterine injection to terminate the life of the fetus; (4) hysterotomy pre-viability or (5) Cesarean section post-viability. The risks for any of these procedures include infection, bleeding, uterine perforation or injury, damage to the urinary or intestinal tract, and possible hysterectomy. The surgical complication rates for all second trimester procedures are very low in skilled hands, but greater than that for first-trimester terminations where there is no chance of fetal viability and the size of the fetus is much smaller.

**Abortion in Texas: Where It Is and Is Likely to Go**

Opponents of abortion have pursued a two-fold strategy over the past two decades. On the one hand restrictive state laws have been passed which have directly outlawed either abortion itself or select abortion procedures. Usually the focus is on those performed in the second trimester where there is a balance between the rights of the mother and the legitimate increasing interest in the rights of the fetus as the number of weeks gestation increases. At present four states only permit abortions only to save the life of the mother, while other states do not even provide exceptions to the abortion prohibition in cases of rape or where the life of the mother is in jeopardy.

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14 Telephone Interview with Charles Lockwood, M.D., Chairman of the Department of Obstetrics and Gynecology, Yale University School of Medicine, October 6, 2007. Dr. Lockwood correctly pointed out that past a certain gestational age in the second trimester, cesarean section remains a reasonable alternative if it is necessary to end the pregnancy to save the mother’s life. It is not always necessary to terminate the life of a gestating fetus simply because the pregnancy must end for maternal indications.


17 Id.

18 Id.


20 Id.

The second trend in state abortion legislation has been to steadily chip away at the edges of Roe v. Wade by passing laws which place increasing numbers of administrative or medical hurdles in the way of women who are determined to end their pregnancies by elective abortion. Such barriers range from requirements to obtain either parental consent, forced viewing of the pregnancy on ultrasound, or requiring pre-abortion counseling to discuss carrying the pregnancy to term so the child may be put up for adoption.\textsuperscript{22} The point of these restrictive laws is to make it more difficult, psychologically and/or administratively, for a woman to go through with a planned abortion.

Recent abortion legislation places Texas squarely within this second category. Currently in Texas there are six “anti-choice laws” which restrict access for Texas women seeking either a first or second trimester abortion.\textsuperscript{23} Restrictions include limitations on use of public monies to pay for low-income women’s access to abortion except in cases of rape or incest or to preserve the life of the mother; counseling and mandatory 24 hour delay requirements which stipulate that a woman may not undergo an abortion until at least 24 hours have passed since she was provided information on gestational age of the fetus and possible complications of an abortion; mandatory parental consent requirements for unmarried women under age 18; limitations on which physicians may perform an abortion in Texas; and opt-out provisions for health care providers who disagree with a woman’s decision to have an abortion.\textsuperscript{24} Texas also has a post-viability restriction on abortion in the third trimester, restricting the procedure only to situations in which it is necessary to either save the life of the mother or avoid substantial risk of physical or mental impairment.\textsuperscript{25} Additional restrictions introduced in the Texas legislature which have yet to be filed or passed include “Choose Life” license plates and mandatory requirements for ultrasound, and ultrasound viewing, even if not medically necessary.\textsuperscript{26}

Where This Decision May Lead in the Immediate Future

The Carhart decision places the U.S. Supreme Court squarely in the middle of day-to-day medical decision-making by physicians. Direct government interference with the practice of medicine is something the Court has tried to avoid since its decision in Roe v. Wade.

If one is concerned about either the relative level of surgical aesthetics (i.e. is the procedure gruesome or distasteful), or concerned about fetal pain,\textsuperscript{27} a strong argument can be made that the more commonly used D & E procedure which is still legal is worse in all aspects. The D & E procedure is a fragmentation procedure in which the fetus is literally torn into pieces and removed in sections using crushing instruments. If one is

\begin{footnotesize}
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\item \textsuperscript{22} Id.
\item \textsuperscript{23} Id.
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\item \textsuperscript{25} Id.
\item \textsuperscript{27} Katherine E. Engelman, Fetal Pain Legislation: Protection Against Pain is Not an Undue Burden, 10 QUINNIPIAC L. J. 279 (2007).
\end{itemize}
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concerned about possible psychological damage to a woman from either a description of
the procedure or the procedure itself\textsuperscript{28} (as Justice Kennedy seemed to be), it is difficult to
see how a more destructive procedure could be any less emotionally devastating. The D
\& X procedure at least has the virtue of first destroying the brain via suctioning the
calvarium, thus lessening the likelihood of fetal pain (if such a thing actually exists)\textsuperscript{29} and
sparing the physician the need to rummage through chunks of fetal material to identify
critical structures. As Justice Ginsburg correctly points out,\textsuperscript{30} there is little practical
difference among all of the surgical options for second trimester abortion, and the moral
qualms Justice Kennedy has about partial birth abortion are readily transferable to the
others.

The relentless logic of Kennedy’s reasoning essentially mandates that alternative
procedures for second trimester termination must also fall if similar challenges to these
procedures reach the court. The only reason for not ruling the abolition all of these
procedures constitutional would now appear to be to simply draw an arbitrary line and
say that abolishing all second trimester termination procedures unduly burdens a
woman’s right to an abortion. So long as one safe surgical option is preserved, the Court
could chip away at abortion procedures other than D \& X.

The Potential Outer Limits of Future Decisions

Where all of this is going to end up is anybody’s guess now that the Supreme Court has
elected to micromanage the medical profession. Although it might be easier for the Court
to simply outlaw all procedures above a certain gestational age because of viability
concerns without attempting to draw meaningless distinctions among similar surgical
procedures all of which result in the death of a fetus and have the potential to be either
gruesome and/or psychologically damaging, this approach does not seem practical. The
Court has already indicated a willingness to ban a procedure regardless of the gestational
age of the fetus. And, if psychological distress is another of Kennedy’s tests for a
procedure, some experts have already suggested that even a first trimester abortion may
may have some psychological impact on some women.\textsuperscript{31}

More importantly, the right-to-life movement may continue to push for expansive
definitions of when meaningful life begins. Carrying the rights of the unborn to its logical
conclusion would not only mean that abortion should be banned outright but that due
process and other rights should be extended to “any human being from the moment of
fertilization.”\textsuperscript{32} Such language is already contained in a proposed amendment\textsuperscript{33} to the
Colorado Constitution which will be on the ballot next year. Could Texas be far behind?

\textsuperscript{28} Gonzales v. Carhart, 550 U.S.____ (2007), supra.
\textsuperscript{29} Hannah Stahle, Fetal Pain Legislation: An Undue Burden, 10 QUINNIPIAC HEALTH L. J. 251 (2007).
\textsuperscript{30} Gonzales v. Carhart, 550 U.S.____ (2007), supra
\textsuperscript{31} David C. Reardon, Thomas W. Strahan, John M. Thorp, Jr. and Martha W. Shuping, Deaths Associated
with Abortion Compared to Childbirth- A Review of New and Old Data and the Medical and Legal
\textsuperscript{32} Kirk Johnson, Proposed Colorado Measure On Rights for Human Eggs, N.Y. TIMES, November 18,
\textsuperscript{33} Id.