

# CRS Report for Congress

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## Abortion Procedures

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### Summary

The Partial-Birth Abortion Ban Act of 1997, H.R. 1122 was vetoed by President Clinton on October 10, 1997. This legislation would have made it a federal crime, punishable by fine and/or incarceration, for a physician to perform a partial birth abortion unless it was necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury. The bill permitted a defendant to seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother. H.R.1122 defined a partial birth abortion as "an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery." In his veto message to Congress, the President indicated that he vetoed H.R. 1122 for "exactly the same reasons" he vetoed similar legislation, H.R.1833, in April 1996. With that 1996 veto, the President asserted that if Congress presented him with a bill amended to add an exception for partial birth abortions for "serious health consequences," to the mother, he would sign it. Congress did not attempt to override the veto of H.R.1122 before it adjourned, but do intend to try to override it in the second session. The partial-birth abortion legislation has stimulated a great deal of controversy. Disputes about what the procedure should be called (such as, partial-birth abortion or intact dilation and extraction), how and when it is performed, at what point in the procedure the fetus dies, and what abortion procedures would be prohibited by the legislation have been debated. However, little, if any, data have been published in the medical literature about the procedure. This report provides a brief overview of the abortion methods currently in use for which data have been published and some positions on the partial birth abortion legislation.

### Background

*Dorland's Medical Dictionary* defines an abortion as the premature expulsion from the uterus of the products of conception—of the embryo, or of a nonviable fetus.<sup>1</sup> Expulsion that occurs naturally is known as a spontaneous abortion, or miscarriage.

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<sup>1</sup> Dorland's Illustrated Medical Dictionary, W. B. Saunders Co. (Philadelphia, etc.), 1994, p. 4.

Termination of pregnancy before viability to protect the life or health of the mother is considered by the medical community to be a therapeutic abortion, while interruption of pregnancy before viability at the request of the patient, but not for reasons of maternal risk or fetal disease, is referred to as elective, or voluntary, abortion.<sup>2</sup> Termination of pregnancy after viability is called a delivery.<sup>3</sup> In 1973, the U.S. Supreme Court ruled that the state's important and legitimate interest in potential life becomes "compelling" at the point of fetal viability. After viability, the state's interest allows it to regulate and even prohibit all abortions, with the exception of those necessary to preserve the life or health of the mother. Viability was signified as the point at which the fetus is "potentially able to live outside the mother's womb albeit with artificial aid," and presumably capable of "meaningful life outside the mother's womb." The Court indicated that this point, at that time, "is usually placed" at about 7 months or 28 weeks, but may occur earlier (see CRS Issue Brief 95095). The Court further ruled that a state may regulate the abortion procedure in ways that reasonably relate to preserving and protecting maternal health during the gestation period following approximately the end of the first trimester (after 12 weeks of gestation). However, for the period before this point (up to 12 weeks), the abortion decision and its effectuation must be left to the pregnant patient and the medical judgement of the her attending physician.

The gestation age of viability has been lowered since 1973, with improvements in health care. Doctors at Johns Hopkins University, in 1993, reported on the outcome of 142 infants born at 22 to 25 weeks gestation over a period of 3 years and 4 months (from May 1988 through September 1991).<sup>4</sup> Results indicated that survival gradually improves with increasing gestational age from 23 weeks gestation to 25 weeks, however, none of the 29 infants born at 22 weeks gestation survived.<sup>5</sup> Fifteen percent (6 of 40) of infants born at 23 weeks gestation, 56% (19 of 34) born at 24 weeks, and 79% (31 of 39) born at 25 weeks survived. A greater percentage of such infants are expected to survive in the near future with additional advances, however, doctors believe that there is as an "anatomical threshold" for fetal survival of approximately 23-24 weeks of gestation (about 1 pound).<sup>6</sup> This anatomical threshold occurs because the fetal lung does not mature sufficiently to allow normal or mechanically assisted respiration before the 23-24 week of gestation.

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<sup>2</sup> Gant, M.D., N. F. and F. G. Cunningham, M.D. Basic Gynecology and Obstetrics, Appleton & Lange (Norwalk, CT/San Mateo, CA), 1993, p. 75.

<sup>3</sup> Encyclopedia of Bioethics, Warren T. Reich, Editor in Chief, Georgetown University, The Free Press, N.Y., 1978, p. 2-3.

<sup>4</sup> Allen, M.D., M. C. et al. The Limits of Viability - Neonatal Outcome of Infants Born at 22 to 25 Weeks' Gestation. New England Journal of Medicine. Nov. 25, 1993, p. 1597-1601.

<sup>5</sup> The authors note that occasional survival of infants born at 22 weeks gestation have been reported. Doctors at Case Western Reserve University School of Medicine, in 1989, described one infant who survived at 22 weeks gestation in a group of 396 infants born before 28 weeks between July 1982 and June 1988. Hack, M.B., CH.B., M. and Fanaroff, M.B.B.CH., AA, "Outcomes of Extremely -Low\_Birth-Weight Infants Between 1982 and 1988, NEJM, Dec. 14, 1989, p.1642-1647.

<sup>6</sup> The American College of Obstetrics and Gynecology Public Health Policy Implications of Abortion, Kathryn G. Moore, Editor, 1990.

## Abortion Prevalence

The latest statistics on abortions published by the federal Centers for Disease Control and Prevention (CDC) indicate that a total of 1,267,415 legally induced abortions were performed in 1994.<sup>7</sup> The 1994 CDC number represents a 4.7% decrease from the 1,330,414 abortions reported for 1993. The women who had abortions in 1994 were more likely to be young (53.7% were 24 years old or younger), white (60.5%), and unmarried (80.1%). Many of the more than one million women had no prior live births 46.2%, or 585,546. Most of the abortions were performed in the first trimester of pregnancy (12 weeks or less gestation).<sup>8</sup> A total of 680,602, or 53.7%, were performed at or before the eighth week of gestation and 88.1% (1,116,592) before the thirteenth week, while 1.3%, or 16,476, were induced at 21 weeks or later, in late second trimester and the third trimester. The abortion procedure used most frequently, for 99.1% of the abortions, was curettage (suction and sharp curettage; curettage means scraping of the interior of the uterus.). The intrauterine instillation method was used in fewer than 1% of abortions; 0.5% (6,337). A total of 0.4%, or 5,070, were performed using other procedures, including hysterotomy and hysterectomy. No data was reported by CDC on the partial-birth abortion, or intact dilation and extraction, method.

## Abortion Techniques<sup>9</sup>

Abortion methods can be described as surgical and medical techniques. The surgical include curettage, suction dilation and curettage, dilation and evacuation, hysterectomy and hysterotomy. Medical methods include instillation of drugs like saline, urea, and prostaglandins to stimulate uterine contractions and cervical dilation. These methods will be discussed in the context of weeks of gestation. Hysterotomy and hysterectomy, which, according to CDC accounted for 0.4%, or less, of the abortions performed in 1994, will not be discussed in this report. The American College of Obstetrics and Gynecology has stated that hysterotomy (incision of the uterus), comparable to a cesarean section, and hysterectomy (removal of the uterus) should be used as a primary abortion technique only in unique situations. In general, risks associated with performing abortions rise with

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<sup>7</sup> For each year since 1969, the CDC of the Department of Health and Human Services (DHHS) has compiled abortion data received from the 50 states, as well as the District of Columbia and New York City. The most recent statistics were published in January 1997. *Abortion Surveillance: Preliminary Data—United States, 1994*, MMWR, v. 45, Nos. 51&52, January 3, 1997, p. 1123-7.

<sup>8</sup> In humans, the beginning of pregnancy is marked from the last menstrual period (LMP). Pregnancy has an average duration of 280 days counting from the LMP, with a normal range of 266 to 294 days, or 37 to 42 completed weeks. *Gynecology & Obstetrics*, Moore, T. R. et al (editors), Churchill Livingstone (NY), 1993, p. 235. The first trimester of pregnancy refers to the first 12 weeks of pregnancy, or 12 weeks gestation; the second trimester to weeks 13 through 24, and the third trimester to weeks 25 to term.

<sup>9</sup> The following references were used for this section: Castadot, M.D., M. P. H. *Pregnancy termination: techniques, risks, and complications and their management*, Fertility and Sterility, v. 45, no.I, Jan. 1986, p. 5-17; *Basic Gynecology and Obstetrics; Abortion and Sterilization: Medical and Social Aspects*, Jane E. Hodgson, editor, Academic Press, Grune and Stratton (London); and *Family Planning at Your Fingertips*. Robert A. Hatcher et al (editors), Essential Medical Information Systems Inc. & Irvington Publishers, Inc. New York, NY, 1993.

increasing gestational ages as the size of the fetus enlarges. A number of delayed complications show up in some patients, depending on factors such as duration of gestation, experience of the health care provider, the technique used, and how carefully the products of conception are examined after the procedure ends. Heavy bleeding (hemorrhage) frequently occurs for 3 to 6 days after abortions performed in the first trimester. Although concern has been raised from some research studies about possible diminished fertility after abortion, most studies have not observed this.

**First Trimester.** — The most frequently used method for pregnancy termination in the first trimester is the suction dilation and curettage (D and C) technique, the method used in 99% of all the abortions reported to CDC for 1994. The technique can be done using local anesthesia and in an outpatient setting. The pregnant woman usually requires little cervical dilation; however, a dilator may be inserted into her uterus for up to 24 hours before the procedure. For the procedure, a vacuum aspirator curette is placed into the uterus and the products of conception are evacuated. A sharp curette may be used to confirm complete evacuation. The evacuated tissue should be examined to confirm that the uterus has been emptied. Possible complications include uterine perforation, cervical laceration, incomplete removal of the fetus and placenta, and infection, however, the risks of these are relatively small.

**Second Trimester.**—The dilation and evacuation (D & E) method, also referred to as dilation and dismemberment, is used for most abortions performed in the second trimester (gestation week 13 through 24). For the procedure, local or general anesthesia is given to the patient. The cervix requires more dilation than with the dilation and curettage method, because the products of conception are larger. Generally, a series of laminaria tents which are osmotic dilators, are used to develop a gradual, less painful and less traumatic dilation of the cervix.<sup>10</sup> Most of the uterine emptying of products of conception is done with instruments such as forceps. Complications such as those indicated for D & C like uterine perforation and cervical laceration, are more serious in D & E. Other problems like venous thrombosis and pulmonary emboli, and depression may also occur.

Instillation methods like saline and others are sometimes used to perform second trimester abortions, but their use has decreased significantly during the last decade or so, in part, because D & E has been shown to be safer. The CDC found that instillation procedures were used in only 0.5% of the abortions performed in 1994. Most hypertonic instillation methods usually cause fetal demise. Hypertonic saline, the most frequently used method for second trimester abortions from the mid-1960s to the mid-1980s, can be used to activate uterine contractions and cervical dilation. In the procedure, about 200 milliliters of amniotic fluid is removed from the patient and is replaced with the same amount of saline solution. An osmotic dilator may also be used. Labor develops about 24 hours later and requires another day to result in abortion. The procedure causes the uterus to evacuate its conception contents, however, the placenta often has to be surgically

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<sup>10</sup> Usually a number of laminaria tents, which are stems of seaweed that come in different sizes, are inserted into the cervix. Laminaria is strongly hygroscopic (absorbs liquids) and are believed to work by drawing water from substances in the cervix, thereby causing them to separate and thus causing the cervix to soften and dilate.

extracted. In addition to the costs associated with hospitalization, a number of complications sometimes occur.

Instillation of a solution of urea with prostaglandins has improved the safety and decreased the waiting period compared to saline. Abortions take only an estimated 12 hours, however, surgical placenta delivery is often necessary. Prostaglandins alone have been administered effectively as an abortion procedure in the second trimester. However, they are associated with numerous side effects, including asthmatic attacks, vomiting and diarrhea. Instillations with prostaglandins usually do not cause fetal demise, whereas hypertonic instillations do.

### **Partial-birth Abortion/ Intact Dilation and Extraction**

Little information, if any, has been published in the medical literature on the this procedure. Although referred to as partial-birth abortion in the legislation, the two doctors who first publicly acknowledged using it, Dr. Martin Haskell and Dr. James McMahon, referred to it as intact dilation and extraction, or, intact dilation and evacuation (IDE).<sup>11</sup> Dr. Haskell, in 1992, described the dilation and extraction procedure as one that can be performed in a doctor's office under local anesthesia. In it, the doctor, using forceps, pulls the extremities (lower and upper), torso, and shoulders of the fetus through the cervix into the vagina. The fetus is oriented in a back or spine up position and its skull lodges in the internal cervical os (the opening into the uterus) because there is usually insufficient dilation for it to pass through. The doctor forces a pair of blunt scissors into the base of the skull creating a hole where a suction catheter is then inserted and the contents of the skull are removed through the catheter, followed by removal of the fetus.

The National Abortion Federation (NAF), an organization that represents abortion service providers, reported in 1995 that Drs. Haskell and McMahon both performed about 500 such procedures each year and it was used at gestation periods as early as 12 weeks and sometimes in the third trimester, but most frequently in the second trimester between 20 and 24 weeks gestation. More recent newspaper reports, in which some doctors who perform partial birth abortions were interviewed, indicate that 2,000 or more are done annually and most of these procedures are done on fetuses that are 20-24 weeks gestation.<sup>12</sup> In a 1993 interview, Dr. Haskell contended that he performed this procedure "up until about 25 weeks" gestation and that most of them were elective. Dr. McMahon

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<sup>11</sup> Dr. Martin Haskell first publicly, described (in a speech and paper) what he "coined" as the Dilation and Extraction, or D&X procedure, in September 1992, at a seminar sponsored by the National Abortion Federation (NAF); Second Trimester Abortion: From Every Angle, Fall Risk Management Seminar, Sept. 13-14, 1992, Dallas, Texas, NAF, 1992, 1436 U St. NW, Suite 103, Washington, D.C. 20009. During Dr. Haskell's presentation, he indicated that Dr. James T. McMahon was performing a procedure conceptually similar to D&X. Dr. McMahon reportedly referred to it as "intact D&E" (intact dilation and evacuation); American Medical News, AMA (Publisher), July 5, 1993.

<sup>12</sup> Brown, D. Late Term Abortions. The Washington Post, September 17, 1996, p. A12. Padawer, R. The Facts on Partial-Birth Abortion. The Sunday Record, Review & Outlook, September 15, 1996, p. RO-4.

(now deceased) reportedly performed such abortions through all 40 weeks of pregnancy. However, he indicated that he performed no elective abortions after 26 weeks gestation and approximately 80% of those abortions done after 21 weeks were non-elective.<sup>13</sup> It is unclear what indications would be considered to be elective and non-elective, however, the presumption, based on some newspaper reports, is that elective abortions are those done on normal fetuses carried by healthy mothers.

Critics of the partial birth legislation, such as the NAF, stated that the fetus dies at the beginning of the procedure while it is still in the womb as a result of anesthesia that the mother received.<sup>14</sup> Dr. McMahan, in a letter submitted to the House Judiciary Subcommittee on the Constitution in June 1995, stated that as a result of the anesthesia given to the mother, the fetus feels no pain as part of this procedure, and that “a medical coma is induced in the fetus,” which causes “a neurological fetal demise.” However, this claim was disputed by the American Society of Anesthesiologists, whose President, Dr. Norig Ellison testified that local anesthesia administered to pregnant women does not reach the fetus.<sup>15</sup> He claimed that when general anesthesia is administered, only a portion reaches the fetus, which may provide some pain relief to the fetus, but does cause death to the fetus. Explanations given by some abortion rights supporters, such as NAF and the National Coalition of Abortion Providers, for why women obtain partial birth abortions included: to prevent morbidity and mortality in the mother with conditions, such as rapidly advancing cancer; to abort a fetus diagnosed with serious deformities, many of which are so severe that they are incompatible with life; lack of money or health insurance; because of social-psychological crises; and, due to lack of knowledge about human reproduction. Discussions with some doctors who perform the partial birth procedure indicate that a significant number of their patients have this procedure done for medical reasons, such as serious defects in the fetus, illness in the patient, rape and incest. However, they assert that the majority of the procedures are elective.

Critics have raised concerns about the potential impact of enacting criminal penalties for an abortion procedure which in some cases is performed before the fetus is viable. Some doctors performing this method argue that the procedure is safer than alternative methods, however, evidence has yet to be published to support this claim. While members of medical organizations like the American College of Obstetrics and Gynecology (ACOG) and the American Medical Association (AMA) acknowledge that it is difficult, if not impossible, to evaluate this procedure with no published peer-reviewed data, the AMA endorsed the version of H.R. 1122 vetoed by President Clinton in October.

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<sup>13</sup> American Medical News. Op. Cit.

<sup>14</sup> H.R. 1833, medical Questions and Answers, Fact Sheet prepared by Mary Campbell, MD, Medical Director, Planned Parenthood of Metropolitan Washington, Fellow of the American College of Obstetricians and Gynecologists, Member, National Abortion Federation.

<sup>15</sup> Testimony was given by Dr. Norig Ellison before the Senate Judiciary Committee at the Nov. 17, 1995 hearing, H.R. 1833 — “Partial-Birth Abortion Ban Act of 1995, and the House Committee on the Judiciary at the March 21, 1996 hearing, Effects of Anesthesia During A Partial-Birth Abortion.