Lessons for the Prochoice Movement from the ‘Partial Birth Abortion’ Fight

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The fight over the procedure that came to be known as “partial birth abortion” spanned 15 years, beginning in 1992 with a presentation made at a clinical meeting of the National Abortion Federation and ending in 2007 with the Supreme Court upholding the Federal Partial Birth Abortion Ban Act of 2003. During this time, the opposition destabilized the vision of abortion the prochoice movement had framed in terms of rights, shifting the nation’s focus to abortions done later in pregnancy. Seeking to reclaim the agenda, the prochoice movement chose to focus on the women deemed worthy of needing an abortion while shying away from the opportunity to increase the public’s understanding of abortion as a medical service. And buried in the ashes of this legendary battle are the stories of the real lives of the women who need abortions, as well as the potential to advance quality healthcare.

Delineating Worthy and Unworthy Women

In the talk that started it all, a physician from Ohio presenting at a national meeting of abortion providers described a procedure he called dilation and extraction (D&X), now most commonly called intact dilation and evacuation (D&E). During the procedure the woman's cervix is dilated over several days so that the fetus can be removed fully after the skull is collapsed. Believing the audience to be comprised of other physicians who perform abortions, his words were clinical and explicit in nature and clearly not meant for mass consumption. Unfortunately, the meeting was infiltrated by an antiabortion activist who was aghast at what was being discussed. Information about the described technique spread quickly among antichoice activists. After testing out several other names, the label “partial birth abortion” was eventually adopted as the public descriptor—conjuring up images of fully developed babies being killed in the process of being born.

In their responses to the attacks on “partial birth abortion,” prochoice advocates appeared disorganized and uncertain about how to proceed. Some organizational spokespersons claimed that the described procedure was rarely performed, attempting to separate the abortion rights for which they advocated from the maligned technique. Others pointed to the statistic that over 90 percent of abortions occur before the end of the first trimester. After a series of shifting strategies, most advocates decided to focus on women whose wanted pregnancies had gone horribly wrong and thus needed an intact abortion procedure as a lifesaving intervention. These women's stories were used to persuade President Clinton to veto a ban on “partial birth abortion” passed by Congress in 1996 and again in 1997. (The act was eventually signed into
On the occasion of the first veto, President Clinton was flanked by women who aborted under the unusual circumstances described above (less than seven percent of all abortions are performed on women with wanted pregnancies). One woman was holding a framed photo of the hand- and footprints of her aborted child, demonstrating for the camera her sense of loss. In his veto message, President Clinton made a clear delineation between who should and should not have access to the banned procedure. "I cannot support use of that procedure on an elective basis, where the abortion is being performed for non-health-related reasons and there are equally safe medical procedures available.... There are, however, rare and tragic situations that can occur in a woman's pregnancy.... In these situations, in which a woman and her family must make an awful choice, the Constitution requires, as it should, that the ability to choose this procedure be protected."

Focusing on women with wanted pregnancies who end up needing abortions has become the subsequent go-to strategy for prochoice advocates fighting limits on later abortion. Evidence of this shift can be found in the records of state legislative hearings in Nebraska, Ohio and Idaho in 2009, 2010 and 2011. Lost during these state debates, as in the nationwide fight over "partial birth abortion," is any focus on the majority of women who need later abortions (after 20 weeks of pregnancy).

At the University of California, San Francisco, my colleague Diana Greene Foster, PhD, is conducting a nationwide study of women seeking abortion in the US. She recently completed an analysis of the participants who were seeking abortions after 20 weeks of pregnancy. (The results were presented at the American Public Health Association annual meeting in November 2011.) She found that almost three-quarters of the women fit one of six profiles: women with babies under age one; women who report difficulty deciding to have an abortion and also experience logistic or financial troubles accessing abortion; young women who have never been pregnant before; women with a history of substance abuse and/or depression; women who report domestic violence and conflict with their partner over whether to have an abortion; and women with a chronic health condition and income below the poverty line. The prochoice movement lost the opportunity to build support for these women's lives and social circumstances and instead focused on the few women whose abortions are deemed more acceptable. The women in the above categories have complicated lives whose stories take longer to tell and require greater empathy on the part of the listener.

Today's prochoice messaging clearly delineates between worthy and unworthy women in the same way that Clinton's veto message did. And national advocacy groups seem to have no stomach for telling the truth, which is that women need abortions throughout their pregnancies for reasons that reflect the complexity of women's lives. While public opinion polls continue to show limited support for later abortions, prochoice advocates seem ill-equipped to control the cultural conversation and build, rather than simply defend, support for abortion rights in the United States. Prochoicers find it even harder to talk about abortion as a medical service rather than in legal terms.

**Shying Away From Explaining Abortion**

Abortion is indeed a medical procedure, but one that involves private and intimate parts of the female anatomy and blood, mucus and other bodily secretions. The fetus is usually removed in pieces using instruments and/or suction. None of these characteristics makes for pleasant dinner conversation. For years, prochoice advocates could avoid any discussion of the unpleasant side of abortion techniques, pivoting instead to the horrific and graphic stories of illegal abortion.

Consequently, when confronted with the "partial birth abortion" fight abortion rights activists were unprepared for talking about the medical realities of abortion. And when they did try to use medical arguments, the descriptions were often guarded, defensive and disjointed. Court transcripts from the early litigation against state "partial birth abortion" legislation are filled with awkward silences when lawyers and witnesses searched for the appropriate words and phrases. The discomfort evidenced in the transcripts stands in direct contrast to the clarity with which the issues were discussed in 2003 by the legal team and the witnesses assembled to fight the Partial Birth Abortion Act. By that time, the medical community had explored the value of the intact D&E technique and determined it to have several clinical advantages over disarticulation D&E, which was not banned under the Supreme Court decision. Lawyers found value in defending, not simply the rights of doctors to practice according to what they determine to be medically necessary for the patient, but in specifically rescuing the legal legitimacy of the banned technique. The American Medical Association, which had initially supported a ban on "partial birth abortion," subsequently reversed its position and opposed setting limits on abortion techniques. The American College of Obstetricians and Gynecologists issued strong statements about the potential harms the ban could cause to women's health.

Unfortunately, abortion rights advocates outside of the medical and legal fields still lacked the skills with which to discuss abortion. After the "partial birth abortion" debate, the take-home lesson for these advocates was that talking about the
details of abortion was a losing strategy. The consequence of this avoidance is that the actual effects of the ban are hidden from view.

My colleague Lori Freedman, PhD, is studying the experiences of OB/GYNS who deliver reproductive healthcare in hospital settings. Some physicians whom she interviewed do not routinely provide abortions and don’t consider themselves “abortion providers,” but nonetheless they have been affected by the very existence of the “partial birth abortion” ban. At a recent San Francisco General Hospital Abortion Discussion Group held on January 17 of this year, Dr. Freedman presented the story of one doctor trying to care for a patient who was losing a 22-week pregnancy due to ruptured membranes. In writing this article, I contemplated how much to edit the doctor’s story and decided on modeling the approach I want advocates to take: allowing the real stories of women and providers to reach the general public.

Dr. B: “[The patient] was kind of in the process of delivering but it wasn’t coming fast enough and she’s trying to hemorrhage to death.... So I took her to the OR to basically do a D&E ... so I could get her to quit hemorrhaging. Well, you know the whole thing about the partial birth abortion. I mean, [it’s] being born breach, it’s still kicking, it still has a heartbeat, its head is stuck in her cervix. What would make sense would be to punch a hole in the back of its skull, collapse its brain, get it out of there and save the patient. But you’ve got all these people in the OR that don’t know what the background situation [is].... And it’s just like that would’ve made perfect sense to do that but I didn’t primarily because I was worried that all these, you know, the techs and circulating nurses in the OR are going to think, ‘Oh, Dr. B. is a baby killer,’ you know, ‘And she just did a partial birth abortion and doesn’t everybody know that’s illegal?’”

According to the law, the intervention the physician described would probably not meet the standard for criminal prosecution since the provider did not “intend” to do an intact procedure, but no case law has yet been written on the subject. And regardless of the letter of the law, the effect of the law has been to create a surveillance system in which doctors feel watched, whether or not they actually are. French philosopher Michel Foucault called this phenomenon the “Panopticon.” With this kind of surveillance, physicians make decisions in the operating room based on their fears about who might be watching, worried that onlookers will misinterpret the situation. In this case, the physician was able to complete the disarticulation d&e and the patient recovered, but these kinds of scenarios weigh heavily on the minds of physicians who have the surgical skills to implement lifesaving interventions. Their stories, however, are not told. These physicians are not monsters—rather they are focused on the health of the pregnant woman.

A Renewed Need for an Honest Conversation

The prochoice movement was unprepared for the fight over “partial birth abortion,” in part because it was hindered by its own members’ hesitation about advocating for a healthcare intervention they weren’t comfortable explaining. However, in failing to learn how to talk openly about what abortions look like and why physicians might need to perform them, prochoicers left the issue to be framed by antichoicers. Prochoice advocates then countered by focusing not on the care women need but on the worthiness of the woman obtaining the care. This limited the movement’s ability to develop support for the majority of women who will need abortions later in pregnancy, women whose lives don’t fit neatly into the one box allowed for later abortions.

The House of Representatives is currently debating legislation that would allow hospitals to opt out of providing emergency abortion care (whether the healthcare professionals in those hospitals want to or not). In order to successfully engage in this and subsequent debates, the prochoice movement will need to move away from attention to the worthiness of the patient in need of care. Instead, advocates need to focus on the rights of all patients to obtain the most appropriate healthcare. The attention should be on healthcare professionals being able to use all of their abilities and professional resources and their right not to be limited by either informal surveillance systems or formal institutional policies rooted in politics, not medicine. To oppose laws that determine what kind of care a healthcare professional can offer or that would allow institutions to decide not to take care of patients, advocates need to be able to share medical stories in ways that enhance rather than obscure the realities of medical care.

Abortions are socially complicated and medically unpleasant to describe, as the story in this article demonstrates, but advocates for abortion rights are best served by acknowledging rather than trying to ignore this dimension. The lesson from the “partial birth abortion” debate is not to move away from the conversation but to lean into it, bringing multiple arguments to bear on all women’s worthiness of the right to have a safe abortion.