

UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEBRASKA

LEROY CARHART, M.D., WILLIAM G. FITZHUGH, M.D., WILLIAM H. KNORR, M.D., and JILL L. VIBHAKAR, M.D.,
on behalf of themselves and the patients
they serve,

Plaintiffs,

v.

JOHN ASHCROFT, in his official capacity
as Attorney General of the United States,
and his employees, agents and successors
in office,

Defendant.

CIVIL ACTION

NO: 4:03-cv-03385

**BRIEF OF *AMICI CURIAE*
PHYSICIANS FOR REPRODUCTIVE CHOICE AND HEALTH®
AND SIXTY-TWO INDIVIDUAL PHYSICIANS
IN SUPPORT OF PLAINTIFFS**

David S. Cohen - PA 88811
WOMEN'S LAW PROJECT
125 South Ninth Street, Suite 300
Philadelphia, PA 19107
(215) 928-9801

Susan Frietsche - PA 65240
Stacey I. Young - PA 91453
WOMEN'S LAW PROJECT
345 Fourth Avenue, Suite 904
Pittsburgh, PA 15222
(412) 227-0301

Counsel for Amici Curiae

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STATEMENT OF INTEREST OF THE *AMICI CURIAE*

Amici Curiae Physicians for Reproductive Choice and Health[®] (PRCH) and sixty-two individual physicians¹ have specialized knowledge and expertise in the field of reproductive health care. They seek to assist the Court by illuminating the damage that the challenged Act will inflict on the ability of reproductive health care providers to perform safe abortion procedures and to develop safer abortion methods.

Founded in 1992, Physicians for Reproductive Choice and Health is a national non-profit organization whose mission is to improve the delivery of the full range of reproductive health services. Physician members of PRCH number more than 2,800. The active membership and board of PRCH consist of some of the most nationally-renowned academic, research, and clinical physicians. PRCH physicians provide cutting-edge educational resources in a variety of areas of reproductive health, such as contraception, sexuality, and abortion. PRCH has developed a physician training curriculum on reproductive health issues for dissemination and use at medical colleges across the country. PRCH is committed to the expansion of reproductive health research and to ensuring that all people have the knowledge, access to high quality services, and freedom they need in order to make their own reproductive health decisions.

The sixty-two individual physicians who join this Brief all have a direct connection to the clinical provision of abortion services or the development of safer abortion methods. They include department heads of major hospitals, professors at prominent medical schools, and leaders in the field of obstetrics and gynecology. Thirty-seven of the individual *Amici* teach or have taught obstetrics and gynecology at medical schools. Thirty-nine currently provide or have in the past provided abortion services or ancillary medical care to patients undergoing abortions;

¹ A full list of the individual physician *Amici Curiae*, together with their institutional affiliations, is appended to this Brief.

an additional twenty-one refer their patients for abortion procedures; and thirty-five are Obstetrician/Gynecologists, including thirty-three Fellows of the American College of Obstetricians and Gynecologists. Sixteen are members of the National Abortion Federation.²

Several of the individual *Amici* rank among the nation's foremost leaders in the field of abortion practice. For example, *Amicus* Eugene Glick, M.D., M.P.H., is the author of a publication on abortion methods entitled *Surgical Abortion*, a highly respected text on abortion procedures; Dr. Glick has also lectured extensively on this topic at symposia throughout the country for almost thirty years. He is an Emeritus Clinical Professor of Obstetrics and Gynecology at the University of Nevada Medical School in Reno, Nevada. *Amicus* Philip G. Stubblefield, M.D., authored a chapter entitled "First and Second Trimester Abortion" in the authoritative medical handbook, *Gynecology, Obstetrics, and Related Surgery*. Dr. Stubblefield currently chairs the Department of Obstetrics and Gynecology at the Boston Medical Center and serves as Professor and Chairman of Obstetrics and Gynecology at the Boston University School of Medicine. *Amicus* Jane E. Hodgson, M.D., widely regarded as a leading expert in the field of obstetrics and gynecology, currently serves as Emeritus Professor at the University of Minnesota School of Medicine. Dr. Hodgson was a founding Fellow of the American College of Obstetricians and Gynecologists and has published and edited numerous articles and textbooks on reproductive health care, including *Abortion and Sterilization: Medical and Social Aspects*.

PRCH and the individual physicians joining this Brief have an immediate and substantial interest in this litigation and in protecting women's reproductive health. Together, they augment the existing significant body of medical opinion supporting the proposition that the abortion

² Physicians who are affiliated with Planned Parenthood Federation of America or any of its constituent medical centers are not included among the *Amici*, as Planned Parenthood Federation of America is currently a plaintiff in a related case, *Planned Parenthood Federation of America v. Ashcroft*, C.A. No. C 03-4872 (N.D. Cal. filed Oct. 31, 2003).

procedures banned by the challenged Act may be the safest available procedures under some circumstances.

SUMMARY OF ARGUMENT

As the first federal nationwide ban on safe and widely-accepted abortion procedures, the “Partial-Birth Abortion Ban Act of 2003” (hereinafter “the Act”) suffers from multiple constitutional infirmities. The Act’s vagueness and overbreadth expose physicians to criminal liability for performing almost any second-trimester abortion. *See* Br. Pls. at 23-31. In addition, the Act contains no exception for procedures performed to preserve a woman’s health. Even if the Act could be read to prohibit only intact dilation and evacuation procedures,³ a construction not supported by the statute’s plain language, the lack of a health exception renders the Act unconstitutional: the United States Supreme Court requires an exception “where a significant body of medical opinion believes a procedure may bring with it greater safety for some patients.” *Stenberg v. Carhart*, 530 U.S. 914, 937 (2000). *Amici*, sixty-two individual physicians and a national organization of experts in the field of reproductive health, submit this Brief to demonstrate for the Court that there is substantial medical authority supporting the need for a health exception.

PRCH and the individual physicians that have signed on to this Brief have significant expertise and experience in medical developments related to abortion and women’s health that confirm the necessity for a health exception. The opinion of the *Amici* is supported by published authority including authoritative texts in the field of obstetrics and gynecology, clinical guides to abortion procedures, and public statements from leading medical organizations that indicate that

³“Intact dilation and evacuation” is also sometimes referred to in literature or in this Brief as “intact dilatation and evacuation,” “intact D&E,” “dilation and extraction,” “dilatation and extraction,” or “D&X.”

the intact variation of dilation and evacuation is an accepted medical procedure that is often the safest available. Where such substantial medical authority exists, regardless of divisions within the medical community, the Supreme Court mandates that any abortion restriction include a health exception. Because the Act does not, it fails constitutional scrutiny.

ARGUMENT

I. THE ACT IS UNCONSTITUTIONAL BECAUSE IT LACKS AN EXCEPTION TO ALLOW PHYSICIANS TO PERFORM THE SAFEST PROCEDURE FOR THEIR PATIENTS.

The Act contains no health exception to allow the intact dilation and evacuation procedure to be performed where it is the safest abortion procedure available, *see* 18 U.S.C. § 1531(a) (exception applies only to abortions “necessary to save the life of a mother”), and is thus unconstitutional.⁴ For over thirty years, since the Court first recognized that the right to privacy encompasses the right to abortion in *Roe v. Wade*, 410 U.S. 113 (1973), the United States Supreme Court has required that every statute restricting abortion include an exception for the preservation of the health of the pregnant woman. *See, e.g., Stenberg*, 530 U.S. at 930; *Planned Parenthood of Southeastern Pa. v. Casey*, 505 U.S. 833, 879 (1992) (plurality opinion); *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747, 768-69 (1986), *overruled on other grounds by Casey*, 505 U.S. 833; *Colautti v. Franklin*, 439 U.S. 379, 400 (1979); *Doe v. Bolton*, 410 U.S. 179, 197 (1973). The Court’s unwavering position culminated in *Stenberg v. Carhart*, which permanently enjoined an abortion ban similar to the one at issue

⁴ The only exception to the ban is for a procedure “that is necessary to save the life of a mother whose life is endangered by a physical disorder, physical illness, or physical injury” *See* 18 U.S.C. § 1531(a). Often, however, before a medical condition worsens to the point of endangering a patient’s life, it first manifests itself as a danger to the patient’s health, albeit not yet a life-threatening danger. The absence of a health exception thus places physicians in the untenable position of having to delay appropriate treatment for patients whose health is declining until the patient’s condition deteriorates to the point of being life-threatening.

here because it, like the Act, included only an exception to save a woman's life and "lack[ed] any exception for the preservation of the . . . health of the mother." 530 U.S. at 930.

The Supreme Court specifically rejected Nebraska's claim, like the claim of Defendant in this case, that a health exception was unnecessary. *Id.* at 933-38. The Court instead held that where, as here, "a significant body of medical opinion believes a procedure may bring with it greater safety for some patients," *id.* at 937, the law must contain a health exception.

Accordingly, it held that a ban on "partial-birth abortion" that "altogether forbids D&X creates a significant medical risk [and therefore] must contain a health exception." *Id.* at 938. The Court instructed future legislators that when "*substantial medical authority* supports the proposition that banning a particular abortion procedure could endanger women's health," such a ban must include a health exception. *Id.* (emphasis added).

In so holding, the Court stated that the fact that medical professionals are divided over intact dilation and evacuation does not obviate the need for a health exception. *Id.* at 937. Given the debate over abortion in this country, disagreements within the medical community over intact dilation and evacuation are hardly surprising. *See Roe*, 410 U.S. at 141-46 (noting medical community's various views on abortion, but nonetheless holding Texas statute banning abortions unconstitutional). In acknowledging the medical debate around intact dilation and evacuation, the Court in *Stenberg* explained:

Where a significant body of medical opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view, we cannot say that the presence of a different view by itself proves the contrary. Rather, the uncertainty means a significant likelihood that those who believe that [intact dilation and evacuation] is a safer abortion method in certain circumstances may turn out to be right. If so, then the absence of a health exception will place women at an unnecessary risk of tragic health consequences.

Stenberg, 530 U.S. at 937. As *Amici*—sixty-two individual physicians and a national organization of experts in the field of reproductive health—demonstrate, there continues to be a significant body of medical opinion asserting that intact dilation and evacuation may bring with it greater safety for some women. Thus, according to *Stenberg*'s controlling standard, the Act is unconstitutional because it does not contain a health exception.

A. Intact Dilation and Evacuation Offers Unique Safety Advantages Over Other Second-Trimester Abortion Procedures.

The intact dilation and evacuation procedure is a variant of the most common form of second-trimester abortion, dilation and evacuation. In a dilation and evacuation, a physician first dilates the cervix. The physician then inserts an instrument into the uterus and grasps a portion of the fetus and pulls that portion down through the cervix and into the vagina. As the physician continues to pull on the fetal part, it is often the case that that part will disjoin from the rest of the fetus. The physician then removes that part from the woman's body and repeats this process as many times as is required until the entire fetus has been removed. The physician must often compress or collapse the calvarium in order to remove it through the cervix. See Maureen Paul et al., *A Clinician's Guide to Medical and Surgical Abortion* 133-35 (1999). In some dilation and evacuations, there is little or no disarticulation. Sometimes, a physician may be able to bring the fetus intact or largely intact through the cervix. In a breech presentation, the head, which is usually the largest part of the fetus, may not fit through the cervix. In these situations, as with dilation and evacuations involving disarticulation, the physician must then compress or collapse the cranium to complete the evacuation of the uterus. See *Stenberg*, 530 U.S. at 924-28; Paul, *A Clinician's Guide*, *supra*, at 131-37.

As the Supreme Court recognized in *Stenberg*, intact dilation and evacuation is an abortion procedure recognized by mainstream medicine. See *Stenberg*, 530 U.S. at 925-38.

Williams Obstetrics, one of the authoritative medical texts in its field, includes intact dilation and evacuation in its list of medically-accepted surgical abortion techniques. See F. Gary Cunningham, *Williams Obstetrics* 871 (21st ed. 2001) (listing “dilatation and extraction” or “D&X” under surgical abortion methods). Another text includes descriptions of two different versions of the intact procedure. See *Gynecologic, Obstetric, and Related Surgery* 1043 (David H. Nichols & Daniel L. Clarke-Pearson eds., 2d ed. 2000). A preeminent guide to medical and surgical abortion for practitioners includes the procedure as well. See Paul, *A Clinician’s Guide* 136-37.

The American College of Obstetricians and Gynecologists (ACOG) also supports physicians’ use of the procedure. See American College of Obstetricians and Gynecologists Executive Board, *Statement on Intact Dilation and Extraction* (Jan. 12, 1997), cited in *Stenberg*, 530 U.S. at 928. As ACOG stated, “[d]epending on the physician’s skill and experience, the D&X procedure can be the most appropriate abortion procedure for some women in some circumstances.” Brief for American College of Obstetricians and Gynecologists et al. at 21-22, *Stenberg v. Carhart*, 530 U.S. 914 (2000), available at 2000 WL 340117 (hereinafter *ACOG Brief*). Furthermore, *Amici*, with their unique expertise in the field of women’s health and surgical abortion techniques, recognize the procedure as one that falls within accepted medical practice.

Intact dilation and evacuation has certain distinct safety advantages over non-intact dilation and evacuation. For example, intact dilation and evacuation reduces the number of times a physician must insert an instrument through the cervix into the uterine cavity. With non-intact dilation and evacuation, a physician must repeatedly insert an instrument through the cervix into the uterine cavity until the entire fetus is removed; in contrast, in an intact dilation and

evacuation procedure, the need for insertion of any instrument is vastly reduced. *See Paul, A Clinician's Guide, supra*, at 136. “The aim of intact D&E is to minimize instrumentation within the uterine cavity” *Id.*; *see also id.* at 135 (“When possible, intact delivery in pregnancies over 18 weeks reduces the number of instrument passes necessary for extraction.”). Reducing the number of times the physician must pass a sharp instrument through the cervix and into the uterine cavity reduces the risks of uterine perforation or cervical laceration and thus increases the safety of the abortion procedure.⁵ Reducing these risks is important for the health of all women, but it is particularly important for women with prior uterine scars, where the uterus is more vulnerable to rupture. *See Stenberg*, 530 U.S. at 926, 929.

The procedure also has other safety advantages. For instance, removing fetal parts intact also prevents sharp fetal fragments from passing through the cervix and vagina without the protective covering of fetal tissue, further reducing the risk of laceration. Moreover, physicians can typically perform an intact dilation and evacuation in less time than other post-first trimester procedures because the fetus is removed altogether in one pass. Reducing operating time means less time under anesthesia and a reduced risk of blood loss and infection. An intact removal also reduces the chances of tissue or bone fragment remaining in the uterus, and thus reduces the risk of infection. *See ACOG Brief* at 21-22.

Amici's experience as well as the sources cited here demonstrate that a substantial body of medical opinion supports the proposition that intact dilation and evacuation offers safety advantages over other available methods. The Supreme Court has consistently struck down

⁵ Uterine perforation is a complication in which an instrument inserted into the uterus punctures the uterine wall, sometimes reaching other organs in the abdomen; in limited circumstances, uterine perforation can require hospitalization or major surgery, such as a bowel resection, colostomy, or hysterectomy. *See Williams Obstetrics, supra*, at 872-73; Paul, *A Clinician's Guide, supra*, at 178; Edward Trott et al., *Major Complications Associated With Termination of a Second Trimester Pregnancy: A Case Report*, 67 Del. Med. J. 294, 296 (1995). Cervical laceration occurs when an instrument or fetal part tears the cervix when it passes through it; cervical laceration can also require hospitalization or major surgery. *See Paul, A Clinician's Guide, supra*, at 178.

statutes that force women to trade off their health for the sake of advancing the state's interest in fetal protection.⁶ As the Supreme Court emphasized, “the governing standard requires an exception where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother, for this Court has made clear that a State may promote but not endanger a woman's health when it regulates the methods of abortion.” *Carhart*, 530 U.S. at 931 (internal citation and quotations omitted). Like other laws that have been overturned for endangering women's health, this Act is unconstitutional.

B. Intact Dilation and Evacuation May Also Be the Most Medically Appropriate Abortion Procedure for Certain Fetal Anomalies and Maternal Health Conditions.

Many women who opt for abortion further into their second trimester of pregnancy, when intact dilation and evacuation may be the safest procedure available, do so because of severe fetal anomalies or maternal health conditions. For some of these women, an intact dilation and evacuation may be safer than available alternatives.

Some fetal anomalies typically remain undetected until well into the second trimester, as the safest and most common test used to detect anomalies, amniocentesis, is usually performed after fifteen weeks of pregnancy. *See Williams Obstetrics, supra*, at 989-90; Paul, *A Clinician's Guide, supra*, at 159-60. Conditions that are typically detected in the second trimester include, among others, Trisomy 13 and 18, conditions in which chromosomes 13 and 18 fail to separate and which often result in fetal death, *see Williams Obstetrics, supra*, at 942; open spina bifida, which causes parts of the neural system to develop outside of the body, *see id.* at 959; anencephaly, another invariably fatal condition in which the fetal brain develops partially or not

⁶ Because the Act does not forbid abortion altogether, the Act does not even advance the purpose of fetal protection. *Cf. Stenberg*, 530 U.S. at 930 (“The Nebraska law, of course, does not directly further an interest ‘in the potentiality of human life’ by saving the fetus in question from destruction”); *Hope Clinic v. Ryan*, 195 F.3d 857, 880 (7th Cir. 1999) (Posner, J., dissenting) (“These statutes [] are not concerned with saving fetuses, with protecting fetuses from a particularly cruel death, with protecting the health of women, [or] with protecting viable fetuses”), *rev'd*, 249 F.3d 603 (7th Cir. 2001).

at all, *see id.* at 958; and hydrocephaly, which causes an excessive accumulation of fluid around the brain of the fetus, *see* David A. Grimes, *The Continuing Need for Late Abortions*, 280 JAMA 747, 748 (1998). Women carrying fetuses with conditions such as these that result in little or no chance of survival may choose to terminate their pregnancies to avoid giving birth to dead fetuses or enduring the trauma of giving birth only to watch their newborns suffer and die. Paul, *A Clinician's Guide*, *supra*, at 160. For the reasons stated already in the previous section, intact dilation and evacuation can be the safest alternative in these circumstances.

Furthermore, in some cases, an intact dilation and evacuation is the most appropriate procedure for reasons specific to the fetus' medical condition. For instance, when the fetal head is enlarged by an anomaly such as severe hydrocephalus, intact dilation and evacuation may allow the physician to retain greater surgical control while reducing the size of the head for safe removal through the cervix. Grimes, *The Continuing Need*, *supra*, at 748. In other cases involving possibly recurring anomalies, removing the fetus intact allows physicians to evaluate the fetus, allowing for more accurate diagnosis of the anomaly and assessment of the risk that the problem will recur in future pregnancies. Paul, *A Clinician's Guide*, *supra*, at 136; *see also id.* at 160 (noting that an intact fetus is sometimes needed "for further analysis").⁷ In addition to *Amici*, medical organizations such as the American College of Obstetricians and Gynecologists, the American Medical Women's Association, and the American Nurses Association have recognized the safety advantages intact dilation and evacuation presents in these situations. *See ACOG Brief*, *supra*, at 22-23.

⁷ Moreover, in cases of severe fetal anomalies, some physicians consider the emotional impact pregnancy loss can have on women when deciding which abortion procedure is most appropriate and conclude that an intact fetus can "aid . . . patients grieving a wanted pregnancy by providing the opportunity for a final act of bonding." Paul, *A Clinician's Guide*, *supra*, at 136; *see also id.* at 160 (noting that "the need for an intact fetus [arises] for grieving purposes").

Some pregnant women develop severe health conditions or experience a worsening of existing health conditions during their pregnancies. Pregnancy-induced conditions such as severe preeclampsia or eclampsia, which may cause convulsions or coma resulting from high blood pressure, *see Williams Obstetrics, supra*, at 596, can develop later in the pregnancy but before viability and can be cured by terminating the pregnancy. *Id.* at 592, 598; Paul, *A Clinician's Guide, supra*, at 127. Also, HELPP syndrome, which causes certain organ functions to deteriorate and can lead to preterm delivery, fetal growth restriction, and placental abruption, can remain dormant until well into the second trimester of pregnancy. *See Williams Obstetrics, supra*, at 579; Paul, *A Clinician's Guide, supra*, at 127.

Furthermore, some maternal health conditions render intact dilation and evacuation the safest termination procedure. For example, intact dilation and evacuation, which reduces the number of times an instrument is inserted through the cervix and into the uterus, may decrease the risk of hemorrhage, an advantage particularly beneficial to women who suffer from any number of blood-clotting defects. *See Williams Obstetrics, supra*, at 663 (noting risk of hemorrhage during instrumental termination of pregnancy); Paul, *A Clinician's Guide, supra*, at 57-58 (noting risk to women with coagulation defects). Because of the reduced instrumentation, the procedure can be safer for patients at higher risk for uterine perforation, such as those with severe chorioamnionitis, a condition that weakens the uterus and causes the membrane surrounding the fetus to inflame. *See Williams Obstetrics, supra*, at 814. In some of these cases, intact dilation and evacuation is the safest abortion alternative.

II. THE ACT THREATENS WOMEN'S HEALTH BY HINDERING MEDICAL ADVANCEMENT AND INNOVATION.

The Act also endangers women's health by hindering medical advancement in the abortion context. Safe surgical procedures, including abortion methods, evolve over time largely through innovative refinement of standard surgical procedures. In its abortion rulings, the Supreme Court has recognized the importance of permitting medical procedures to evolve. In *Planned Parenthood v. Danforth*, for example, the Court overturned a broad ban on saline instillation, a heavily-used abortion method at the time of the case, because it threatened to preclude "methods that may be developed in the future and that may prove highly effective and completely safe." 428 U.S. 52, 78 (1976).

The safer abortion methods used today exist only because physicians were free to develop them by modifying existing surgical techniques. Vacuum aspiration, the most common abortion procedure performed during the first trimester, was developed in the early 1970s by physicians as an alternative safer than dilation and curettage in most cases. *See Chung Ho Pak, Termination of Pregnancy Between 9 and 14 Weeks, in Modern Methods of Abortion 54 (1995).* Had Congress been allowed to ban this method prior to the publication of randomized, controlled clinical trials, this safe and widely-used technique could not have been developed.

Dilation and evacuation was similarly developed because physicians were legally permitted to improve upon other abortion methods. In the early 1970s, physicians were searching for a surgical alternative to induction abortions, especially before the sixteenth week of pregnancy, before which time inductions are generally ineffective and therefore not performed. *See, e.g., Paul, A Clinician's Guide, supra*, at 123. Physicians developed dilation and evacuation, which soon became the most commonly used post-first trimester abortion method.

The safety of second-trimester abortion improved dramatically as a result of physicians' experience with slightly varying techniques. Eugene Glick, *Surgical Abortion* 46-48 (1998).

The intact dilation and evacuation method, which arose as a minor variant of dilation and evacuation, also resulted from innovative techniques developed during the performance of other abortion procedures. *See, e.g., Paul, A Clinician's Guide, supra*, at 136. Already offering critical safety advantages over other abortion methods in certain circumstances, intact dilation and evacuation could continue to improve or lead to the discovery of other safe abortion techniques. Banning the procedure thwarts the potential for this medical advancement and thus would endanger women's health.

CONCLUSION

For the foregoing reasons, as well as the reasons contained in Plaintiffs' pleadings, *Amici Curiae* respectfully urge this Court to declare the Act unconstitutional and permanently enjoin it.

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Respectfully submitted,

Susan Frietsche - PA 65240*
Stacey I. Young - PA 91453*
WOMEN'S LAW PROJECT
345 Fourth Avenue, Suite 904
Pittsburgh, PA 15222
(412) 227-0301

David S. Cohen - PA 88811*
WOMEN'S LAW PROJECT
125 South Ninth Street, Suite 300
Philadelphia, PA 19107
(215) 928-9801

Counsel for Amici Curiae

*Application for admission pro hac vice pending

APPENDIX

INDIVIDUAL PHYSICIANS* JOINING AS *AMICI CURIAE*

Matthew Belmont, Anesthesiologist, New York Presbyterian Hospital

David B. Bingham, OB/GYN, retired, Salem, CT

Robert L. Blake, Jr., Emeritus Professor of Family and Community Medicine, University of Missouri-Columbia

Sherry L. Blumenthal, OB/GYN, Abington Memorial Hospital, Pennsylvania

Lynn Borgatta, OB/GYN, Clinical Associate Professor, Boston University, Boston Medical Center

Debra Bright, General Pediatrician, Pediatric and Internal Medicine of Richmond, Indiana

Herbert P. Brown, OB/GYN, Clinical Associate Professor, University of Texas at San Antonio

Adam P. Buckley, OB/GYN, Beth Israel Medical Center of Pediatric and Internal Medicine Center of Richmond, Indiana

Paula M. Castaño, OB/GYN, Family Planning Fellow, Columbia University, New York, NY

Maria Castillo, Anesthesiologist, New York Presbyterian Hospital Department of Anesthesiology

Dennis Christensen, OB/GYN, Medical Director, Madison Abortion Clinic; Clinical Assistant Professor, Department of OB/GYN, University of Wisconsin Medical School

Arnold W. Cohen, OB/GYN, Chairman, Department of Obstetrics and Gynecology, Albert Einstein Medical Center, Philadelphia, PA

Philip A. Corfman, OB/GYN, Medical Consultant, Bethesda, MD

Takey Crist, OB/GYN, Director, Christ Clinic for Women; Clinical Professor of OB/GYN, University of North Carolina, Jacksonville, NC

Sona I. Degann, OB/GYN, New York Presbyterian Hospital

Lisa A. Feintech, Anesthesiologist, University of California at Los Angeles; Board of Governors, Cedar Sinai Medical Center

* The institutional and organizational affiliations of the individual *Amici* are included for identification purposes only.

Jill Fong, Anesthesiologist, Associate Clinical Professor, New York Presbyterian Hospital

Stanley Friedell, OB/GYN, Assistant Professor of Obstetrics and Gynecology, Northwestern Memorial Hospital, Chicago, IL

Eugene Glick, OB/GYN, Emeritus Clinical Professor of Obstetrics and Gynecology, University of Nevada Medical School, Reno, NV

Patricia T. Glowa, Family Practitioner, Assistant Professor of Community and Family Medicine and Pediatrics, Dartmouth Medical School, Lebanon, NH

Melanie A. Gold, Pediatrician, Associate Professor Pediatrics, University of Pittsburgh School of Medicine

Wayne L. Goldner, OB/GYN, Private Practice, Manchester, NH

Matthew C. Gomillion, Anesthesiologist, Associate Professor of Clinical Anesthesiology, New York Presbyterian Hospital, Weill Medical College of Cornell University

Nerissa Guballa, OB/GYN, New York Presbyterian Hospital

Dana Gurritch, Anesthesiologist, Weill Medical College of Cornell University, New York, NY

Jacqueline N. Gutmann, Reproductive Endocrinologist, Jefferson Hospital; Women's Institute for Fertility Endocrinology & Menopause, Philadelphia, PA

W. Benson Harer, Jr., OB/GYN, retired (Past President of the American College of Obstetricians and Gynecologists), Riverside, CA

Paula J. Adams Hillard, OB/GYN, Professor, University of Cincinnati College of Medicine

Steven Hockstein, OB/GYN, Weill Medical College of Cornell University, New York, NY

Jane E. Hodgson, OB/GYN, Regions Hospital, St. Paul, MN; Emeritus Professor, University of Minnesota School of Medicine

Lauren Johnson, Family Practitioner, Private Practice, Chapel Hill, NC

Maureen P. Kelly, Reproductive Endocrinology, Jefferson Hospital; Women's Institute for Endocrinology & Menopause, Philadelphia, PA

David Kopman, Anesthesiologist, New York Presbyterian Hospital

John J. LaFerla, OB/GYN, Private Practice, Chestertown, MD

Ruth Lesnewski, Family Practitioner, Medical Director, Institute for Urban Family Health, New York, NY

Danielle Ludwin, Anesthesiologist, New York Hospital-Cornell

Rachel Masch, OB/GYN, New York University Hospital

George M. Miks, Family Practitioner, retired, Chisholm, MN

Scott Moses, OB/GYN, Assistant Professor of Obstetrics and Gynecology, Northwestern University, Chicago, IL

Elizabeth Pirruccello Newhall, OB/GYN, Medical Director, Portland Downtown Women's Center, Portland, OR

Paul Norris, OB/GYN, Assistant Professor of Obstetrics and Gynecology, University of Miami

Katharine J. O'Connell, OB/GYN, Clinical Instructor, Department of Obstetrics and Gynecology, Columbia University Medical Center, New York, NY

Deborah Oyer, Family Practitioner, Medical Director, Aurora Medical Services; Professor, University of Washington School of Medicine, Seattle, WA

Suzanne T. Poppema, Family Practitioner, Director, Internal Medicine, Aurora Medical Services, Aurora, IL

Jeanne Rabin, OB/GYN, Director of Urogynecology, Albany Medical College, Albany, NY

Mary E. Raum, Gynecologist, Munroe Regional Medical Center, Ocala, FL

Eve Rittenberg, Primary Care Physician, Medical Instructor, Brigham and Women's Hospital, Boston, MA

Paul L. Sibley, Gynecologist, Medical Director, All Women's Health Center, Gainesville, FL

Irene N. Sills, Pediatrician, Albany Medical Center, Albany, NY

Richard M. Smiley, Obstetric Anesthesiologist, Chief, Obstetric Anesthesia, New York Presbyterian Hospital; Associate Professor, Columbia University

Ann E. Starr, OB/GYN, Clinical Instructor of Obstetrics and Gynecology, Northwestern Memorial Hospital, Chicago, IL

Janet Stein, OB/GYN, Vice Chairman and Residency Program Director, Beth Israel Medical Center, New York, NY

Bruce S. Steir, OB/GYN, retired, San Francisco, CA

Catherine Stika, OB/GYN, Associate Professor of Obstetrics and Gynecology, Northwestern University; Chief, Division of General Obstetrics and Gynecology, Chicago, IL

Andrea Stolar, Psychiatrist, University of South Florida, St. Petersburg, FL

Nada L. Stotland, OB/GYN, Professor of Psychiatry and Obstetrics and Gynecology, Rush Medical College, Chicago, IL

Phillip Stubblefield, OB/GYN, Director of Fellowship in Family Planning and Clinical Investigation, Boston Medical Center

Gina Sucato, Pediatrician, Assistant Professor of Pediatrics, University of Pittsburgh School of Medicine

Albert Thomas, OB/GYN, Associate Professor, Director of Family Planning, Obstetrics, Mount Sinai Medical Center, New York, NY

Abigail Wolf, OB/GYN, Clerkship Director, Thomas Jefferson University, Philadelphia, PA

Sophia Yen, Pediatrician, Clinical Instructor in Adolescent Medicine, Stanford University Medical Center, Stanford, CA

William W. Young, OB/GYN, Associate Professor, Department of Obstetrics and Gynecology, Dartmouth Medical School, Lebanon, NH