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Second Trimester Abortion Provision: Breaking the Silence and Changing the Discourse

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Abstract: *How do abortion providers determine how late in pregnancy they will provide abortion services? While law, training and socio-political factors likely play a part, this essay considers additional factors, including: personal and psychological aspects, visceral responses to the fetus and fetal parts at later gestations, feelings that second trimester abortion is violent, and ethical concerns with second trimester abortion. Providers may censor themselves with respect to these issues, fearing that honest acknowledgement of difficult aspects may be dangerous to the pro-choice movement; that is, such acknowledgements could appear to legitimise the anti-abortion stance that second trimester abortion is gruesome and morally unacceptable. I argue that this silence is harmful to providers, the pro-choice movement and the women who need abortion services. I make the case for pro-choice discourse that is honest about the nature of abortion procedures and uses this honesty to strengthen abortion care, including second trimester abortion. ©2008 Reproductive Health Matters. All rights reserved.*

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HOW do doctors come to provide second trimester surgical abortion services (or how do they decide not to), and how do they balance its unique burdens with its rewards? We do not know as no study has specifically explored these questions. Like it or not, the need for second trimester abortion will not go away. In the United States (US), approximately 10% of abortions occur in the second trimester, and that proportion has been stable for the past decade. Many of the factors that lead women to have second trimester abortions are not readily reversible (for example, difficulty with the abortion decision, not recognising pregnancy earlier).¹⁻³ We must ask, therefore, how doctors determine how late in pregnancy they will provide abortion services.

Truthfully, we don't know how any physician chooses his/her practice limits. Law clearly has a role in defining practice boundaries in medicine generally and obviously in abortion as well. The

law may define the upper time limit for abortion, but doctors still need to sort out for themselves whether or not they will practise to that limit. In the United States (US), states may prohibit abortion only in the third trimester, though even then abortion may not be prohibited if the life or health of a woman is threatened.⁴ Despite this, only 20% of abortion providers offer services at 20 weeks of pregnancy, and only 8% of providers offer services at 24 weeks.⁵ Why do most clinicians not provide services to the extent permitted?

Training is clearly relevant to the decision to provide second trimester abortions. In the US, greater number of second trimester abortions performed during residency training predicts later provision.⁶ Physicians who practise in an urban rather than rural setting are also more likely to provide second trimester abortion. However, other predictors of second trimester abortion provision have not been identified. Abortion

providers report they would perform abortions at later gestational ages if they could get adequate training (Kate Cosby, Second Trimester Project Coordinator, Advancing New Standards in Reproductive Health Project, personal communication, 22 July 2008). This sentiment is understandable, given that performing first and second trimester surgical abortion requires different instruments and skills. Second trimester abortion by dilatation and evacuation (D&E) uses large forceps with destructive teeth to remove the fetus, generally in parts. While complications are rare, when they happen in the second trimester they can be significant. Of 68 abortion-related deaths in the US in a recent ten-year period, 49 were in the second trimester.⁷ While training is clearly important in the decision to provide abortion, we also know that 38% of residents who are trained do not ultimately provide abortion services.⁸

Other factors are likely at play, therefore, and many can be readily enumerated: national policy, socio-cultural norms, practice group restrictions, hospital or office staff discomfort; malpractice considerations, insurance reimbursement, personal beliefs, etc. But I wish to push a little more, and begin to account for issues that have an impact on provider provision of second trimester services which are not as easy to list – or perhaps more provocatively – *are* easy to list, but about which abortion providers censor themselves.

Abortion is different from other surgical procedures. Even when the fetus has no legal status, its moral status is reasonably the subject of much disagreement. It is disingenuous to argue that removing a fetus from a uterus is no different from removing a fibroid. Pregnancy itself is different from other bodily states. It is an ambiguous, liminal border-state that is neither one nor two people. Doing second trimester abortions is clinical care at the boundary between life and death and in the context of political and social controversy and, likewise, commitment. To reflect seriously on the question of how providers determine their limit for abortion, one must be willing to cross borders and boundaries (including seemingly inflexible ones like “pro-choice” and “pro-life”). Therefore, speaking as a provider, I will focus on aspects of abortion care that we don’t normally talk about, issues for which no room has been made in current pro-choice abortion discourse, many of which may frankly

be too dangerous for pro-choice movements to acknowledge. They are:

- personal and psychological aspects of second trimester abortion provision
- visual and visceral dimensions of second trimester abortion
- violence inherent in abortion, especially apparent in the second trimester
- legitimate ethical and moral issues providers may have with second trimester abortion, as distinct from first trimester abortion.

There are reasons for the noticeable silence on these more difficult aspects of abortion service provision, as I will discuss. However, ultimately, I argue that this silence is harmful to individual providers, to the abortion rights movement itself, to public opinion around abortion, and perhaps most importantly, to the women and couples who need our services. I will make the case for a new kind of abortion and pro-choice discourse – one which is honest about the nature of abortion procedures – and which uses this honesty to strengthen abortion care.

Personal and psychological considerations

The evidence for how providers determine how late in pregnancy they will provide abortions comes from memoirs and sociological and clinical investigations of North American abortion workers.^{9–11} Most are narratives of activism, commitment, stories of the personal rewards that come from caring for memorable patients. Often they are “life on the front line” stories – tales of conflict with anti-abortion forces, and the personal and family sacrifices, including harassment, death threats and violent attacks – made to support women’s right to choose abortion. In accounts of abortion prior to its legalisation, the need for doctors to offer the service was made obvious by the unnecessary suffering and death of women who had unsafe self-induced or illegal abortions. The question of whether or not to provide second trimester abortions was not prominent in those accounts, probably because second trimester abortion was accomplished primarily by labour induction. Labour and delivery nurses caring for women throughout the process, not doctors, were the caregivers most burdened.¹² The shift to surgical second trimester abortion care did not begin until 1977, when David Grimes and colleagues published a pivotal study documenting the safety of D&E.¹³

As D&E became increasingly accepted as a superior means of accomplishing second trimester abortion compared to labour induction, a small amount of research on provider perspectives on D&E resulted. Kaltreider et al found that some doctors who provided D&E had “disquieting” dreams and strong emotional reactions.¹³ Hern found that D&E was “*qualitatively a different procedure – both medically and emotionally – than early abortion*”.¹⁴ Many of his staff members reported:

“...serious emotional reactions that produced physiological symptoms, sleep disturbances (including disturbing dreams), effects on interpersonal relationships and moral anguish.”

One very recent personal account of abortion provision features the distinction between first and second trimester abortion prominently. This doctor writes, after observing her first second trimester procedure at 21 weeks:

“Seeing an arm being pulled through the vaginal canal was shocking. One of the nurses in the room escorted me out when the colour left my face. . . Not only was it a visceral shock; this was something I had to think deeply about. . . Confronting a 21-week fetus is very different. It. . . cannot feel pain or think or have any sense of being, but the reality is, this cannot be called ‘tissue’. It was not something I could be comfortable with. From that moment, I chose to limit my abortion practice to the first trimester: 14 weeks or less.”¹⁵

Clearly there can be legitimate feelings that first and second trimester abortions are qualitatively and emotionally different. However, I take issue with the stance that this difference means categorically avoiding abortion practice in the second trimester. I am seeking a different kind of space – a middle ground in which we can acknowledge that there may be important differences between first and second trimester abortion, but without choosing to limit abortion practice to the first trimester. This moves me to consider the undeniable visual and visceral ways in which first and second trimester abortions are different.

Visual and visceral differences

When I was a little over 18 weeks pregnant with my now pre-school child, I did a second trimester abortion for a patient who was also a little over 18 weeks pregnant. As I reviewed her

chart I realised that I was more interested than usual in seeing the fetal parts when I was done, since they would so closely resemble those of my own fetus. I went about doing the procedure as usual, removed the laminaria I had placed earlier and confirmed I had adequate dilation. I used electrical suction to remove the amniotic fluid, picked up my forceps and began to remove the fetus in parts, as I always did. I felt lucky that this one was already in the breech position – it would make grasping small parts (legs and arms) a little easier. With my first pass of the forceps, I grasped an extremity and began to pull it down. I could see a small foot hanging from the teeth of my forceps. With a quick tug, I separated the leg. Precisely at that moment, I felt a kick – a fluttery “thump, thump” in my own uterus. It was one of the first times I felt fetal movement. There was a leg and foot in my forceps, and a “thump, thump” in my abdomen. Instantly, tears were streaming from my eyes – without me – meaning my conscious brain – even being aware of what was going on. I felt as if my response had come entirely from my body, bypassing my usual cognitive processing completely. A message seemed to travel from my hand and my uterus to my tear ducts. It was an overwhelming feeling – a brutally visceral response – heartfelt and unmediated by my training or my feminist pro-choice politics. It was one of the more raw moments in my life. Doing second trimester abortions did not get easier after my pregnancy; in fact, dealing with little infant parts of my born baby only made dealing with dismembered fetal parts sadder.

The point is that, visually and viscerally, doing an 18-week abortion is different from doing an eight-week abortion. Removing a microscopic fetus and gestational sac is visually and viscerally different from removing what looks like a fully formed but small baby. Though I focus on D&E here, similar difficulties hold true for second trimester medical abortion.

What do you do with experiences and sensations like mine? Providers of second trimester abortions see things that most people don’t. What kind of dissociative process inside us allows us to do this routinely? What normal person does this kind of work? This brings me to the issue of violence.

Violence

There is violence in abortion, especially in second trimester procedures. Certain moments

make this particularly apparent, as another story from my own experience shows. As a third-year resident I spent many days in our hospital abortion clinic. The last patient I saw one day was 23 weeks pregnant. I performed an uncomplicated D&E procedure. Dutifully, I went through the task of reassembling the fetal parts in the metal tray. It is an odd ritual that abortion providers perform – required as a clinical safety measure to ensure that nothing is left behind in the uterus to cause a complication – but it also permits us in an odd way to pay respect to the fetus (feelings of awe are not uncommon when looking at miniature fingers and fingernails, heart, intestines, kidneys, adrenal glands), even as we simultaneously have complete disregard for it. Then I rushed upstairs to take overnight call on labour and delivery. The first patient that came in was prematurely delivering at 23–24 weeks. As her exact gestational age was in question, the neonatal intensive care unit (NICU) team resuscitated the premature newborn and brought it to the NICU. Later, along with the distraught parents, I watched the neonate on the ventilator. I thought to myself how bizarre it was that I could have legally dismembered this fetus-now-newborn if it were inside its mother's uterus – but that the same kind of violence against it now would be illegal, and unspeakable. Yes, I understand that the vital difference between the fetus I aborted that day in clinic, and the one in the NICU was, crucially, its location inside or outside of the woman's body, and most importantly, her hopes and wishes for that fetus/baby. But this knowledge does not change the reality that there is always violence involved in a second trimester abortion, which becomes acutely apparent at certain moments, like this one. I must add, however, that I consider *declining* a woman's request for abortion also to be an act of unspeakable violence.

Currently, the violence and, frankly, the gruesomeness of abortion is owned only by those who would like to see abortion (at any time in pregnancy) disappear, by those who stand outside clinics and in front of sports arenas holding placards with pictures of fetal parts and partially dismembered fetal bodies. The pro-choice movement has not owned or owned up to the reality of the fetus, or the reality of fetal parts. Since the common anti-abortion stance is that the fetus has a right to life, those who support abor-

tion access necessarily deny such a right. However, in doing so, the fetus is usually neglected entirely, becomes unimportant, nothing. Instead of acknowledging what is on the placards, abortion rights activists may say in response to them that they are fake pictures or that abortions don't really look like that. However, to a doctor and clinic team involved in second trimester abortion, they very well may. Of course, acknowledging the violence of abortion risks admitting that the stereotypes that anti-abortion forces hold of us are true – that we are butchers, etc.

It is worth considering for a moment the relationship of feminism to violence. In general feminism is a peaceful movement. It does not condone violent problem-solving, and opposes war and capital punishment. But abortion is a version of violence. What do we do with that contradiction? How do we incorporate it into what we are as a movement, in particular a feminist movement? In feminist sociological and anthropological literature, the permissibility of acknowledging the legitimacy of any "pro-life" arguments is in dispute. Some scholars consider the possibility that understanding the anti-abortion side of things is all right, and in fact may lead the way to finding common ground with those who oppose abortion.^{16–18} Others argue that there is no room for compromise or finding a middle ground – that there is no ground to give up in this hard fought battle.¹⁹

But where does that leave the abortion provider and team? What do we do when caught between pro-choice discourse that, while it reflects our values, does not accurately reflect the full extent of our experience of abortion and in fact contradicts an enormous part of it, and the anti-abortion discourse and imagery that may actually be more closely aligned to our experience but is based in values we do not share? Where do we go to talk about it? It is one of the notable gaps, silences in the provision of abortion care – I would argue to the detriment of the pro-choice movement, and in particular to more widespread availability of second trimester abortion.

Reasons for our silence

The reasons for this silence are obvious. First, frank talk like this is threatening to abortion rights. While some of us involved in teaching abortion routinely speak to our trainees about the aspects of care I've described, we don't make

a habit of speaking about it publicly. Essays like this bring the inevitable risk that comments will be misinterpreted, taken out of context and used as evidence for further abortion practice restrictions. Second, writing or speaking frankly about abortion as I am doing may cause a rift with feminist movements. As US sociologists have documented, there already is a history of an uneasy and oftentimes contradictory relationship between feminist activists and abortion providers.²⁰ The feminist health activist seeks to make abortion: “a woman-centred service, with a limited ‘technical’ role for the physicians”. However, the abortion-providing physician, in part as a response to the long history of stigmatisation of abortion as “dirty work”, desires to further medicalise and professionalise abortion services. Sociologist Everett Hughes coined the term “dirty work” to describe work that is perceived as disgusting and degrading, or that has physical, social or moral taint, e.g. the work of gravediggers and garbage collectors.²¹ Hughes says that society delegates certain people to do dirty work and then stigmatises them, effectively disowning and disavowing the very work it has delegated to them, resulting in their social isolation and loss of self-esteem, among other consequences. To focus on the difficult aspects of second trimester abortion may further entrench abortion as morally tainted, allowing further disavowal and marginalisation of it. Even within the ranks of obstetrician–gynaecologists, there is stigmatisation and marginalisation of those who do abortions. Doing D&E procedures is viewed by some gynaecologists in South Africa, for example, as being “below them,” akin to lowering their class position (Daniel Grossman, MD, Senior Associate, Ibis Reproductive Health, personal communication, 24 June 2008).

The last point I want to make on the issue of silence is that I see a hint that this silence may be breaking. The US Fellowship in Family Planning, the post-residency abortion and family planning sub-specialty training programme, has initiated an annual psychosocial workshop for its fellows, aimed at giving light and voice to these and other issues. I wonder if demographic shifts in the cohort of abortion providers, at least in the US, may have something to do with breaking this silence. As the generation of doctors who provided abortions prior to *Roe v. Wade* retires, the cadre of doctors who now provide abortions are no

longer personal witnesses to the horrific sequelae of unsafe illegal abortion. This younger generation of providers may go through a different kind of soul-searching in deciding to provide abortion. They may demand new kinds of discussion on the meaning and nature of abortion provision. Shifting gender roles in the workforce and at home may have a role too. As the US physician workforce becomes increasingly female, more and more providers are facing the issue of doing abortions while pregnant and caring for young infants, and of needing abortions themselves. Similarly, as male physicians assume more infant care at home, some of the same issues may arise.

Ethical and moral positions that allow for grey areas

We might conclude at this point that a provider who feels that abortion is violent is simply ambivalent, conflicted, is not really committed to women’s abortion rights, and just shouldn’t be doing this work. “Pro-life” supporters may argue that the kind of stories and sentiments I’ve relayed spell the end of abortion – that honest speech acts regarding the reality of abortion will weaken the pro-choice movement to the point where it cannot sustain itself any longer. I want to make the case that honesty about abortion work can be the basis for a stronger movement – one that makes it easier for providers and the teams they work with to do all abortions, especially second trimester abortions.

There are ethical and moral positions that make complete sense of the position that says women should have full access to abortion – but simultaneously allow for discomfort with aborted second trimester fetuses. Two traditions prevail in philosophical discussions of abortion and the fetus: conservative views based in natural law, which argue for the inviolability of fetal life from the moment of conception; and liberal views based in Enlightenment principles, in which what matters most is an achievement reached – sentience or birth.²²

But there is another position – a gradualist one – that states that the respect owed to a fetus increases as pregnancy advances and the fetus becomes more like a born person.²² There is no bright line here – not even viability – that distinguishes what is morally acceptable or not, or prohibited or not. That is, even as we think that abortion is morally permissible, we are also

permitted increasing discomfort, grief or loss with later abortions. With the gradualist position, we close the gap between pro-choice rhetoric and the reality of doing a second trimester abortion. We need not be afraid to acknowledge the value of early human life – which I would suggest from my perspective on the “front line” is missing from mainstream abortion rights discourse.

A gradualist perspective may require, however, a defence of the need for second trimester abortion, for it makes later abortion more serious than early abortion.²² This may be yet another dangerous idea for pro-choice “abortion on demand” politics. However the reality is that women have all sorts of compelling and legitimate reasons for choosing abortion, and this is particularly true in the second trimester. In the US, the known risk factors associated with presenting for second trimester abortion include: adolescence, drug and alcohol addiction, poverty, difficulty obtaining funding for the abortion, and African-American race.^{1,2,23} Delays in obtaining second trimester abortion come when a woman does not realise she is pregnant (perhaps a surrogate for poor health or lack of education), has logistical delays, experiences denial about the pregnancy, is uncertain about the decision to have an abortion, or has a change in life circumstances or relationships that makes a previously desired pregnancy undesired.^{1,2,23} These factors are all part of the texture and complexity of women’s lives, complexity that the pregnant woman herself best understands. Therefore, rather than see the gradualist demand for “good reasons” as a threat to choice, we can see it as helping to focus the terms of the abortion debate on women themselves, in the contexts of their lives. The gradualist perspective allows us to simultaneously acknowledge the value of early human life *and* be woman-centred, an ideal position for a second trimester provider. Knowing that we help a woman navigate the complexities of her life is the great reward for doing what might otherwise be overly burdensome work.

Organisational challenges of providing a second trimester abortion service

While there are many clinical and political challenges involved in establishing and running a second trimester abortion service, the issues I’ve raised here point to three specific challenges for abortion providers themselves: potentially troubling emotional and visceral and reactions to

dealing with fetal parts; stigmatisation, social isolation and loss of self-esteem from doing “dirty work”; and lack of safe space among colleagues to talk about these issues.

How can we expand second trimester abortion services and foster provider and staff comfort with later procedures? In the absence of published literature, my own experience may be instructive. I trained to do D&E procedures to about 23 weeks as a resident. After completing residency, I began working as a staff physician at a clinic that provided surgical abortion services up to 13 weeks + 6 days gestation. The process of moving the gestational age limit beyond 14 weeks was slow, and is ongoing. While I had the support of the senior leaders of the clinic, some staff members were initially uncomfortable with the prospect of dealing with larger fetal parts. Not all of our Board members were equally eager to proceed with later procedures, due to the possibility that the inexactness of ultrasound dating of pregnancies in the second trimester could lead to aborting viable fetuses (a concern perhaps made more real because one of our Board members had an extremely premature grandchild born around the time that we were having these discussions). However, we eventually earned support after launching evidence-based education about the safety and patient satisfaction associated with D&E, and after doing a series of values clarification exercises with the staff and Board. Then we launched clinical training for staff who would be directly involved in D&E care. Gradually we began scheduling patients at later gestations. We moved up carefully, and though we didn’t plan it this way, increased to about one week later in pregnancy every year, ending up at 20 weeks. We are still in the process of inching up to 22 weeks.

Our primary failure, I learned only recently, is that we did not account for the need for ongoing team-building around some of the difficult aspects described here. I came to learn through informal discussions that staff craved the opportunity to discuss their perspectives on second trimester abortion. This fits with the literature on “dirty work”, which shows that a positive work culture can mitigate the stigma and psychological distress that comes from being labelled with it. Hern described this need two decades ago, but there does not appear to have been a coordinated effort on the part of pro-choice organisations

to address this.¹⁴ We therefore launched a six-week focus group intervention with a skilled facilitator to provide staff with formal opportunities to explore their experiences and build team cohesion. (This intervention will be presented elsewhere.)

In conclusion, we need research focused on provider perspectives on second trimester abortion. Though I have focused primarily on the burdens of this work, robust evaluation of these perspectives should focus on the unique rewards it brings as well. Along with this, we need legitimate, formal and informal spaces and places for the varying perspectives of abortion team members to come to light. Abortion rights discourse

itself needs to take these perspectives seriously. I am tired of “pro-life” representation of the work we do. It’s time for the pro-choice movement to claim abortion fully and use the experiences of providers to strengthen our movement.

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Résumé

Comment les soignants qui pratiquent les avortements déterminent-ils jusqu'à quel stade ils accepteront d'interrompre une grossesse? Si la législation, la formation et les facteurs sociopolitiques jouent probablement un rôle, cet essai envisage d'autres facteurs, notamment de nature personnelle et psychologique, des réactions viscérales au fœtus et aux parties fœtales dans les gestations avancées, le sentiment que l'avortement du deuxième trimestre est violent, et les préoccupations éthiques qu'il suscite. Les soignants peuvent s'autocensurer car ils craignent qu'une prise en compte honnête de ces questions difficiles ne soit dangereuse pour le mouvement en faveur du libre choix, c'est-à-dire que cette reconnaissance paraisse légitimer le discours anti-avortement selon lequel l'avortement du deuxième trimestre est horrible et moralement inacceptable. J'estime que ce silence gêne les soignants, le mouvement pour le libre choix et les femmes qui souhaitent avorter. Je préconise un discours pour le libre choix qui aborde honnêtement la nature des procédures d'avortement et utilise cette honnêteté pour renforcer les services d'avortement, y compris au deuxième trimestre.

Resumen

¿Cómo determinan los prestadores de servicios de aborto hasta qué semana de gestación proporcionan servicios de aborto? Aunque la ley, capacitación y factores sociopolíticos probablemente influyen en esta decisión, en este ensayo se consideran otros factores, como los aspectos personales y psicológicos, respuestas viscerales al feto y las partes fetales en gestaciones más avanzadas, creencias de que el aborto en el segundo trimestre es violento e inquietudes éticas respecto al mismo. Algunos prestadores de servicios se censuran al respecto, temiendo que el reconocer abiertamente los aspectos difíciles podría ser peligroso para el movimiento pro libre elección: por ejemplo, afirmar que el aborto en el segundo trimestre es horripilante y moralmente inaceptable, podría interpretarse como una forma de legitimar la postura contra el aborto. Sostengo que este silencio es perjudicial para los prestadores de servicios, el movimiento pro libre elección y las mujeres que necesitan servicios de aborto. Expongo los argumentos a favor de un discurso pro libre elección, que sea sincero respecto a la naturaleza de los procedimientos de aborto y utilice esta sinceridad para fortalecer los servicios de aborto, incluidos los del segundo trimestre.