Shots assist in aborting fetuses - Lethal injections offer legal shield; [3 Edition]
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In response to the Supreme Court decision upholding the Partial-Birth Abortion Ban Act, many abortion providers in Boston and around the country have adopted a defensive tactic. To avoid any chance of partially delivering a live fetus, they are injecting fetuses with lethal drugs before procedures.

That clinical shift in late-term abortions goes deeply against the grain, some doctors say: It poses a slight risk to the woman and offers her no medical benefit.

"We do not believe that our patients should take a risk for which the only clear benefit is a legal one to the physician," Dr. Philip D. Darney, chief of obstetrics at San Francisco General Hospital, wrote in e-mail. He has chosen not to use the injections.

But others, although they do not perform the banned procedure, feel compelled to do all they can to protect themselves and their staff from the possibility of being accused. Upheld in April, the federal ban is broadly written, does not specify an age for the fetus, and carries a two-year prison sentence.

In Boston, three major Harvard-affiliated hospitals - Massachusetts General, Brigham and Women's, and Beth Israel Deaconess - have responded to the ban by making the injections the new standard operating procedure for abortions beginning at around 20 weeks' gestation, said Dr. Michael F. Greene, director of obstetrics at Mass. General.

"No physician even wants to be accused of stumbling into accidentally doing one of these procedures," Greene said.

Boston Medical Center, too, has begun using injections for later surgical abortions, said Dr. Phillip Stubblefield, professor of obstetrics and gynecology at Boston University Medical School. The decision came "after a lot of anguish about what to do," he said.

The banned method involves partially delivering a live fetus, then intentionally causing its death. Even before it was banned, the procedure was exceedingly rare, accounting for a fraction of 1 percent of all abortions.

Instead, doctors typically cause the fetus's death surgically while it is still inside the womb and then remove it.

But now, if the fetus is not dead as it begins to emerge, a provider may be accused of violating the law.

So the lethal injections beforehand, carefully documented, are aimed at precluding an accusation and prosecution. Greene said that in the experienced hands of hospital staff, the injections add no risk and are "trivially simple," compared with other obstetrical procedures. The main downside, he said, is that "it is yet another procedure that the patient has to endure."

Patients have not objected to the injections, he said.

"They all are appreciative of what we do for them and understand the circumstances under which we work," Greene said.

The injections are generally done in abortions after 18 or 20 weeks gestation. (Massachusetts bans virtually all abortions at and beyond the 24th week, except to protect the life or health of the mother.)

Medical staff inject either the heart drug digoxin or potassium chloride, a potentially poisonous salt also used in state executions.

San Francisco's Darney and colleagues have studied both chemicals, long used in late-term abortions that involve simply inducing labor. Darney said his group concluded that digoxin was safe but offered no advantages in the actual abortion procedures, despite some clinical experience suggesting it made them easier.

They found no safety record for potassium chloride, but a few case reports suggested that it could be dangerous if accidentally injected into the woman instead of the fetus.

They decided that whether to have an injection should be up to the patient; some are comforted by the idea that the fetus has died before it is removed.

Interest in using digoxin has been so strong in recent months that the National Abortion Federation, the professional association of abortion providers, developed a protocol for its members on how to use it, and is conducting training as well.

It is not clear what proportion of providers are newly switching to digoxin, said Vicki Saporta, the federation's president. "That's still shaking out," she said.

But Dr. Mark Nichols, professor of obstetrics and gynecology at Oregon Health & Science University, said he has the impression that the majority of providers of later-term abortions are making injections routine.

At his own clinic, the new rule is that any patient with a fetus over 20 weeks' gestation must have an injection, he said.

He deeply respects Dr. Darney and his point of view, Nichols said, "but at the same time I guess I'm a little bit more concerned about the risk for the faculty and staff here."

That concern is so great in his clinic, he said, that the ban is having an impact on medical education: Medical students and nursing students are no longer invited to watch later-term abortions, for fear one might misinterpret the procedure and lodge a criminal complaint.

Abortions are performed at a wide range of facilities, from major hospitals to small, tightknit family planning clinics, and the setting can greatly influence the decision about injections, said Dr. Laurent Delli-Bovi, medical director of Women's Health Services, a private family planning facility in Chestnut Hill.

In large hospitals, she said, there is likely to be a range of feeling for and against abortion and so more need for providers to act defensively.

Women's Health Services, for example, decided against the injections because it does not perform the banned procedure and the risk of an accusation seemed low. But in another common response to the ban, the clinic has changed its counseling and informed consent procedure for later abortions, to spell out more clearly to patients that the fetus is dead before it is removed from the uterus.

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