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File –

Abortion –

Late-term

MARVIN I. WEINBERGER
9 CARLETON ROAD
BELMONT, MASS. 02178

(617) 484-2361

April 2, 1984

Dear Pro-Lifer:

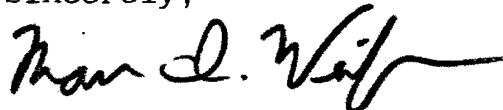
I have been inactive in my pro-life support for the last few years, ever since my participation nationally in the Phillip Becker (Down's Syndrome) controversy. This involvement helped to secure the surgery which Phillip desperately needed, it also earned me a multimillion dollar lawsuit (which I eventually won, but at great personal expense). Prior to the Becker matter, I was principal proponent of the Akron (Ohio) abortion ordinance - which ordinance inspired similar enactments nationwide.

In the wake of this past summer's Supreme Court rulings, I've decided that I must once again let my voice be heard. Find enclosed a packet of information documenting the unspeakable reality of legal, late-term abortions. As you will see, abortion has now become infanticide! This is why I, and the other volunteers who labored six months to prepare the enclosed documentation, refer to our informal organization as ChildSave.

We are providing the enclosed booklet free-of-charge to selected influential citizens nationwide. I hope you will make good use of this material. Please feel free to call upon me if I may be of any assistance. Also, if you come across any important relevant documentation which you would like to see incorporated into future packets, please pass this information along.

Shalom.

Sincerely,



Marvin I. Weinberger

P.S. After having printed up the enclosed packet, I came across an excellent and very timely commentary by columnist Ellen Goodman. Find attached a copy of this article as appeared in The Boston Globe.

P.S.S. Also enclosed is a recent article from The New England Journal of Medicine.

A new compromise needed on abortion as technology advances

ELLEN GOODMAN

For over a decade now, I've seen the abortion controversy keep political opponents frozen at their poles of opinion. Neither side has been eager to publicly discuss the full moral dilemma of an unwanted pregnancy.

The anti-abortion people have downplayed the crisis experienced by a woman who is pregnant when she doesn't want to be. It is easier to describe her plight as a temporary inconvenience. The pro-abortion people have avoided discussing the fetus. It is easier to talk about the termination of a pregnancy.

A few weeks ago, I fell into that trap when I dismissed President Reagan's statement that an aborted fetus feels pain. His phrase was far too sweeping. In the early stages of development, a fetus has the automatic response of a plant or an amoeba. But my response was far too casual. At some midpoint in pregnancy, a fetus undoubtedly experiences what anyone would fairly describe as pain.

The argument about "pain" is not an unimportant one because it takes place at the center of the abortion dilemma. Today, the combat zone for our moral ambivalence is that period smack in the middle of pregnancy when pain and, increasingly, survival becomes possible.

Just 11 years ago, when the Supreme Court legalized abortion, the justices said the state had a legal interest in the fetus only when it was "viable" – when it could survive outside the womb with or without artificial aid. They set that date at 28 weeks.

Even then, "viability" was less a moral term than a technological one. But technology changed, gradually and crucially. In 1973, only half those born at 28 weeks survived. Today the odds are much longer. It is even possible for a fetus born at 22 weeks to survive.

The morally critical fact is that we can save the life of a baby who can be legally aborted.

This collision occurs very rarely. In 1980, only 10 percent of the 1.6 million women choosing abortion were more than 12 weeks pregnant. Only 13,000 women were more than 21 weeks pregnant. Many hospitals have pushed back the cutoff date to 20 weeks.

The number of live births resulting from late abortions is miniscule. Yet they loom large in our ethical structure, and they should. As Dr. Thomas Murray at the Hastings Center for life ethics says, "We knew years ago that when people realized that we can save the lives of babies who can be legally aborted, it was all going to hit the fan. We have to preserve our sense that we are not doing things too morally contradictory."

That preservation is already evident. Far fewer women have late abortions today than in 1973. The conundrum is that these late abortions are primarily performed on teenagers who find it hardest to cope with the reality of pregnancy or, surely, motherhood. They are also chosen by women carrying deformed fetuses because most genetic testing must still be done in the second trimester.

Still, I think a new compromise must be devised to replace the old one. We need a careful formula to raise the threshold for unrestricted abortions, while allowing exceptions. Nancy Rhoden, an assistant professor of law at Ohio State University, has suggested a cutoff date of 20 weeks, except for serious genetic defects or maternal health problems. There are difficulties with such a law – who decides which exceptions? – but it reflects a need to revise our ethical guidelines, acknowledging the claims of both woman and fetus.

In any such revision, we still have to confront this central moral ambivalence about abortion. Compromise is not a cop-out; neither is ambivalence a weakness. It is appropriate.

We are twice as likely to accept abortion if the woman has been raped or carries a deformed fetus than if, as a married woman, her contraceptive has failed.

The age of the fetus is another piece of that "situation." As Frances Kissling, the head of Catholics for a Free Choice, says: "We are always weighing values. As the fetus develops we need more compelling reasons to justify abortion."

There are hard-liners who choose the life of the fetus over the life of the woman. There are hard-liners who regard the fetus with no more concern than a wart. But most of us do factor in a large range of conditions – from the health of the woman to the age of the fetus – when we make this moral decision.

For a long time, we cloaked this ambivalence behind an argument about "viability." But now, at a rare moment of vulnerability in the hardened debate over abortion, we have a chance to openly discuss this process of moral decision-making, to honestly talk about the inherent conflict in an unwanted pregnancy. We have to admit the pain, all the pain, in order to balance it.

Ellen Goodman is a Globe columnist.

SPECIAL ARTICLE

WHEN IS TERMINATION OF PREGNANCY DURING THE THIRD TRIMESTER MORALLY JUSTIFIABLE?

Frank A. Chervenak, M.D., Margaret A. Farley, Ph.D., LeRoy Walters, Ph.D., John C. Hobbins, M.D., and Maurice J. Mahoney, M.D.

Abstract The question whether to terminate pregnancy during the third trimester involves a moral conflict. We argue that such termination is morally justifiable if two conditions are fulfilled: first, that the fetus is afflicted with a condition that is either incompatible with postnatal survival for more than a few weeks or characterized by the total or virtual absence of cognitive function; and second, that highly reliable diagnostic procedures are available for determining prenatally that the fetus fulfills either of the two parts of the first condition.

At present, one entity, anencephaly, clearly fulfills both conditions. We studied 10 cases involving fetuses with sonographically diagnosed anencephaly that were aborted during the third trimester. We also examined other fetal disorders and conclude that they do not clearly fulfill our two conditions for the justifiable termination of pregnancy in the third trimester. (N Engl J Med 1984; 310:501-4.)

SELECTIVE abortion because of serious fetal disease or defect is currently practiced in many hospitals during the first and second trimesters of pregnancy. However, after 24 weeks of gestation, when the probability of extrauterine survival increases, termination of pregnancy is sometimes denied, even though termination in the third trimester to "preserve the life or health of the mother" was specifically upheld in the landmark *Roe* v. *Wade* decision of the U.S. Supreme Court.[1] In this article, we argue that termination of pregnancy during the third trimester can also be morally justifiable (i.e., permissible) if two conditions are fulfilled: (1) the fetus is afflicted with a condition that is either (a) incompatible with postnatal survival for more than a few weeks or (b) characterized by the total or virtual absence of cognitive function; and (2) highly reliable diagnostic procedures are available for determining prenatally that the fetus fulfills either condition 1a or 1b.

Currently, one entity, anencephaly, clearly fulfills both conditions. We present our experience with the antenatal diagnosis and obstetric management of this condition and discuss ethical considerations in third-trimester termination for this and several other fetal diseases and defects. Our intention is to provide a theoretical justification for the selective termination of pregnancy under specified conditions that are currently fulfilled by one major fetal defect and that may in the future include a small number of additional fetal defects.

Methods

During a five-year period, from 1978 through 1982, fetal anencephaly was diagnosed in 28 cases at the Perinatal Ultrasound Unit of Yale–New Haven Medical Center. The criterion for diagnosis was an absent fetal calvarium. After prenatal diagnosis, the pregnancies were managed at Yale–New Haven Medical Center or at one of several referring institutions.

From the Department of Obstetrics and Gynecology, Mount Sinai School of Medicine; Yale University Divinity School; the Kennedy Institute of Ethics, Georgetown University; and the Departments of Obstetrics and Gynecology and of Human Genetics, Yale University School of Medicine. Address reprint requests to Dr. Chervenak at the Department of Obstetrics and Gynecology, Mount Sinai School of Medicine, One Gustave Levy Pl., New York, NY 10029.

Results

In 18 of the 28 cases of fetal anencephaly, the gestational age at the time of diagnosis was less than 24 weeks. In all these cases, termination of pregnancy was elected by the pregnant woman, and the diagnosis of anencephaly was confirmed after the abortions.

In 10 cases, fetal anencephaly was diagnosed after 24 weeks of gestation. The gestational age was 25 to 28 weeks in three cases, 29 to 32 weeks in four cases, and 33 to 36 weeks in three cases. In each instance, the fetus was alive at the time of diagnosis, and there was no maternal complication necessitating delivery. In all 10 cases, termination of pregnancy was elected by the pregnant women and was induced by a prostaglandin E_2 suppository (seven cases), oxytocin induction (two cases), or elective cesarean section because of previous cesarean section with vertical uterine incision (one case). In no instance was fetal monitoring used. In eight cases a stillbirth resulted, and in two cases neonatal death occurred spontaneously within an hour of birth. In all 10 third-trimester cases, anencephaly was confirmed after birth. There were no maternal complications in this series.

Discussion

The basic moral purpose of obstetrical care is to serve the best interests of both the pregnant woman and the fetus. Both maternal and fetal interests are usually served by active support of both lives. However, there may be instances in which termination of pregnancy to benefit the pregnant woman should be given serious consideration (if the mother so desires), even though this action will end the fetus' life. In circumstances fulfilling conditions 1 and 2, pregnancy termination may benefit the pregnant woman by reducing the period of time during which she would suffer the psychological pain of carrying a fetus with a hopeless prognosis. Termination may also benefit the parents by allowing them to initiate a subsequent pregnancy earlier than if the seriously abnormal pregnancy were allowed to continue to term. Such a decision must, of course, be made in a way that respects

standard criteria for informed consent, with a full discussion of potential benefits and harm from either termination or continuation of the pregnancy. For some women, termination will be the preferred alternative, whereas others may choose to continue their pregnancies.

As a pregnancy progresses, the legal obligations to the fetus of the pregnant woman and of society at large gradually increase, according to the viewpoint enunciated in *Roe* v. *Wade*. From an ethical standpoint, as well, it can be argued that our moral obligations to the third-trimester, possibly viable fetus are stronger than our obligations, for example, to a preimplantation embryo. These obligations are generally thought to be based on the principle of beneficence and to require us to do no harm to the fetus and to provide benefits to it whenever possible. However, there may be cases in which it is difficult to construe one's actions as either harming or benefiting a fetus. Such situations seem to us to occur when a fetus is affected by an irremediable condition that is either incompatible with postnatal survival beyond a few weeks, given available methods of newborn care, or characterized by the total or virtual absence of cognitive function. In such cases the result of full-term development and delivery would be neonatal death or a nearly vegetative existence. In comparison to these alternatives, prenatal death does not constitute a harm, nor does the prenatal termination of the fetus' life through induced abortion constitute an injury. Conversely, allowing fetal or neonatal life to continue in such circumstances — or even intervening vigorously to prolong fetal or infant life — does not benefit the fetus or infant in any customary sense of the term "benefit."

These generalizations apply only when the prenatal condition of the fetus can be diagnosed with certainty. Obviously, a third-trimester fetus mistakenly thought to fulfill the conditions outlined above could be gravely harmed through termination of pregnancy. Acceptance of various diagnostic methods as being certain occurs at different levels of experience, depending on the method. A chromosomal or chemical test for which an abnormal result is entirely distinct qualitatively from a normal result would require only a few verifications before being accepted as reliable. Other methods, for which quantitative differentiation of abnormal from normal results is necessary, might never reach an acceptable level. Today, one of the major means of antenatal diagnosis is sonographic imaging of fetal anatomy. We think that demonstration of reliable sonographic diagnosis by several series from different institutions, in which there are no false-positive diagnoses, would ensure that an unaffected fetus would not be mistakenly aborted.

Anencephaly, a malformation in which an amorphous brain and an absent cranium result from a defect in closure at the anterior portion of the neural groove, fulfills both our conditions. Indeed, Bernard Haering and Paul Ramsey, two ethicists who are conservative in their views on abortion and neonatal care, acknowledge that the anencephalic fetus and newborn constitute exceptional cases.[2-4] Most fetuses with anencephaly are stillborn or, if live-born, die shortly after birth.[5-8] The longest documented survival for an anencephalic infant has been 5½ months.[9] Antenatal sonographic diagnosis of anencephaly was first described in 1964,[10] and by 1972 physicians were sufficiently confident of the antenatal diagnosis to proceed with abortion.[11] Advances in diagnostic ultrasound now permit the reliable diagnosis of anencephaly if the head can be adequately visualized (Fig. 1). Confidence in ultrasonographic diagnosis can be based not only on the 28 cases described here but also on the reported experience of five European centers with 102 correctly diagnosed anencephalic fetuses, with no false-negative and no false-positive results.[12] In our series, once fetal anencephaly was diagnosed, all 10 pregnant women who were in their third trimester elected immediate termination of pregnancy. That elective third-trimester termination could be carried out without maternal complications is consistent with the experience of Osathanondh et al.[13]

Several fetal disorders that are considered by some to provide moral justification for second-trimester selective abortion clearly do not fulfill condition 1. For example, beta-thalassemia, hemophilia, Lesch–Nyhan syndrome, meningomyelocele, sickle-cell anemia, trisomy 21, and Turner's syndrome can all be diagnosed prenatally, and fetuses afflicted with these disorders are frequently aborted during the second trimester. In our view, third-trimester termination for these fetal abnormalities — at the stage when the fetus is or may be capable of independent survival — is not morally justified. Not only could most fetuses affected with these disorders survive infancy and become cognitive beings, they could also have a greater opportunity for a meaningful existence than is generally appreciated.[14-18]

Numerous other fetal disorders fall somewhere between anencephaly, in which beneficence-based obligations to the fetus are negligible, and disorders like trisomy 21, in which beneficence-based obligations are substantial. Several disorders fulfill condition 1a; that is, a fetus afflicted with them cannot survive for more than a few weeks after birth. Among these are renal agenesis, infantile polycystic kidneys with resultant hypoplastic lungs, and Meckel's syndrome. These disorders do not, however, fulfill condition 2; although cases of successful antenatal sonographic diagnosis have been reported, the clinical experience necessary to establish diagnostic accuracy for these fetal disorders is lacking.[19,20]

Certain entities such as trisomy 13, trisomy 18, alobar holoprosencephaly, and hydranencephaly probably fulfill condition 1b, since profound retardation is the rule for the few afflicted infants who survive the neonatal period. Some, however, may judge that condition 1 is not fulfilled in these disorders, since there is

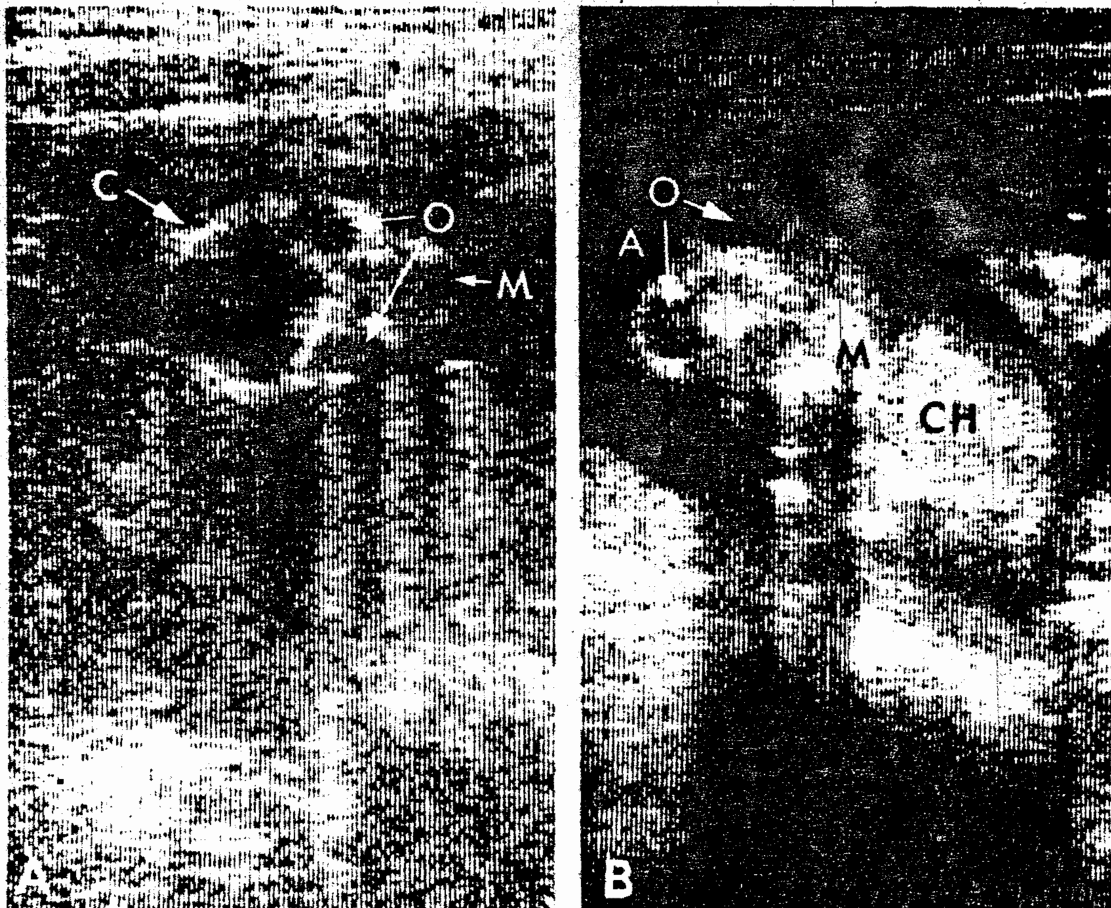


Figure 1. Sonogram of Normal Fetal Head (A) and of Head of Anencephalic Fetus (B). C denotes cranium, O orbits, M mandible, A absent cranium, and CH chest.

the possibility of long-term survival with minimal cognitive function.[21-24] In addition, although trisomy 13 or 18 may be reliably diagnosed by karyotyping of fetal amniocytes, reliable antenatal diagnosis of alobar holopresencephaly[25] and hydranencephaly[26] is unproved.

There are other disorders that may fulfill condition 2 (that is, that can be reliably diagnosed) but that fail to fulfill condition 1. For example, Tay–Sachs disease can be reliably diagnosed by means of biochemical analysis of amniocytes, yet affected infants may have a few months of normal life before rapid deterioration begins.[27]

In cases that do not clearly fulfill both conditions 1 and 2 but rather fall into a kind of gray zone, third-trimester termination of pregnancy is, in our view, not morally justified. However, as in other cases, respect for maternal autonomy does require a detailed disclosure by the physician of the certainties and uncertainties of diagnosis and outcome. In addition, operative delivery would not be mandatory in these cases, even in the face of fetal distress.[28]

In summary, third-trimester termination of pregnancy is an ethically acceptable (i.e., permissible) and humane form of management if beneficence-based obligations to the fetus cannot be established when there is certainty of diagnosis and certainty of a dismal outcome. As antenatal sonography improves through technologic advances and increased clinical experience, other fetal disorders (for example, renal agenesis) will probably join anencephaly in fulfilling both these conditions. Conversely, just as biliary atresia and hypoplasia of the left ventricle were once thought to be untreatable but are now treated, so other neonatal conditions currently considered to be incompatible with survival may one day be remediable.[29,30]

We are indebted to Robert J. Levine, M.D., Yale–New Haven Medical Center, and to Robert Monoson, M.D., Mount Sinai School of Medicine, for assistance in the preparation of this manuscript.

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ChildSave

"It never happens here?!"

Late term abortions in America

Volume 1
Overview

ChildSave

9 Carleton Road, Belmont, Mass. 02178

Marvin Weinberger, Director
Charles White, Editor-in-Chief
Joseph Cosby, Research Coordinator

(617) 484-0933
(617) 484-2361

March 25, 1984

"Abortion on demand is legal only through the first half of pregnancy, viability is the dividing line. Late term abortion is illegal...it never happens here."

Is this statement accurate? Eleven years ago the Supreme Court established different rules governing abortion during the different stages of pregnancy. These rules have raised many questions. Advances in medical practice, as well as legislation and litigation following the Court's original decision have further complicated the situation.

A late abortion terminates a pregnancy involving a viable fetus. It is performed any time after the middle of the second trimester. Many health-care providers have been terminating second- and third-trimester pregnancies for several years, but few outside the specialty have understood either the law or the prevalence of the procedure. In its most recent ruling on the subject, the Court reaffirmed the legality of these late abortions.

This packet of reprints documents the newly-clarified situation. We will show that:

1. Late abortions are legal.

2. Late abortions occur frequently.

3. Late abortions involve viable fetuses.

4. Late abortions cause the fetus pain.

5. Late abortions are usually done for reasons other than to prevent the birth of handicapped infants.

6. Late abortion techniques designed to prevent live births pose greater risk to the mother than non-lethal abortion techniques.

7. Late abortions raise new ethical issues.

8. Late abortions raise new legal issues.

ChildSave is a non-profit volunteer organization.

Overview

Document #1 is a letter from the Surgeon General of the United States, C. Everett Koop, to Congressman Christopher Smith of New Jersey, summarizing the findings which this packet documents. Document #2 is a recent New York Times article on the topic which touches on many of the issues mentioned in this packet.

1. Late abortions are legal.

On June 15, 1983 the Supreme Court handed down its ruling on two controversial abortion-regulatory statutes. In Akron Center for Reproductive Health v. City of Akron and Planned Parenthood Association of Kansas City v. Ashcroft, the Court struck most of the provisions of the Missouri and Akron (Ohio) laws, effectively blocking efforts to limit abortion through regulation. This then makes more powerful the Court's decision (as Document #3 portrays) to uphold the Missouri provision requiring that:

> An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or adducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion...(Mo. Rev. Stat. sec. 188.030.3)

The Court went on to acknowledge Mo. Rev. Stat. sec 188.030.1 which forbids the use of abortion procedures fatal to the viable fetus unless alternative procedures pose a greater risk to the health of the woman.

The Court's ruling endorses the legality of late abortion. It also recognizes the "reality" since the Supreme Court would not rule upon (let alone uphold) a moot regulation. The ruling flows from the Court's Roe v. Wade decision (as recapitulated in Ashcroft). Roe held that "the state...may, if it chooses, regulate, and even proscribe, abortion [of a viable fetus] except where it is necessary...for the preservation of the life or health of the mother." Under Missouri law, late-term abortions are permitted only to preserve maternal life or health (which is the maximum restriction permitted under Roe). On its face, this seems to only permit abortions for "medical reasons" after viability. However, as Document #4 points out, the key words are "health of the mother." In Roe's companion case, Doe v. Bolton, the Court construed "preservation of the mother's life or health" to include "all factors -- physical, emotional, psychological, familial and the woman's age -- relevant to the well being of the patient." Indeed, the "health" exception permits late abortions performed solely to prevent the birth

of handicapped infants and for other reasons (as discussed below) completely unrelated to the mother's medical condition. Moreso, under Roe, states are free not to restrict late abortions at all, which is the case in numerous states (particularly where older abortion-prohibition laws have been ruled unconstitutional and never replaced). Documents #5 and #6 relate to the decision of a California judge striking down that state's attempt to out-and-out prohibit late abortions. Document #7 provides further evidence of the unconstitutionality of older state laws which too-severly restrict late abortions.

2. Late abortions occur frequently

While late abortions make up only a small percentage of the total number of abortions performed in the United States, they are not infrequent. Document #8 is a report based on information from the Center for Disease Control showing the reported frequency of late abortions in eight states. It also extrapolates the data from those eight states to estimate that almost 30,000 late abortions (post-twenty weeks) were performed and comments that these figures probably are low.

Another indication of the prevalence of late abortions is the advertised willingness of clinics to perform them. Document #9 quotes a Kansas clinic's advertisement offering to terminate 26-week pregnancies.

A third indication of the frequency of late abortions comes from pathologists' reports on the remains of aborted viable fetuses. Document #10 contains such a report. Note that the physician also mentions autopsies he performed on ten other viable fetuses in the last year. Document #11 reports autopsies performed on aborted fetuses found in California, showing that some were viable at the time of their termination.

3. Late abortions involve viable fetuses

A. Some abortion attempts have resulted in live births.

Document #12, which won a Pulitzer Prize, is a comprehensive look at "the dreaded complication" of live births resulting from abortion. Documents #13 and #14 give more information on cases of viable fetuses who survived abortion procedures. Document #15 reports 14 cases of live births occuring in a single hospital within a two-year period.

B. After 20 weeks fetuses may be considered viable.

With improving medical knowledge and technology, the age of

fetal viability continues to decrease. Document #16 shows that as long ago as 1975 the World Health Organization set the limit of viability at 22 weeks. But, as Dr. Koop's letter and a recent medical textbook (Document #17) show, viability can be set as early as 20 weeks. Indeed, Justice O'Connor points out (in her dissent from Justice Powell's Akron ruling), "It is certainly reasonable to believe that fetal viability in the first trimester of pregnancy may be possible in the not too distant future" (Document #18). Even now, the number of extremely early infants who survive is increasing. Document #19 is the report of a Cincinnati physician on 21 premature infants, 9 of whom were born during the second trimester. Documents #20, #21, and #22 give fuller details on other second-trimester infants who have survived.

4. Late abortions cause the fetus pain

Document #23 reports the findings of 26 physicians, including two past-presidents of the American College of Obstetricians and Gynecologists, affirming that fetuses feel pain during abortions. This is reported in a letter to President Reagan, upholding his contention that abortions cause pain, (as well as death), to fetuses. The President's statement had been challenged by Dr. Ervin E. Nichols, who later admitted that he lacked both "expertise" and "intimate knowledge" of the science of fetology.

5. Late abortions are usually done for reasons other than to prevent the birth of handicapped infants

While one would think that late abortions are performed in large part to prevent the birth of a massively handicapped infant, this is not so. The latest edition of Induced Abortion (Document #24) reports that of the 30,000 post-viability abortions only about 1,500 were performed to prevent the birth of a handicapped infant. Of those 1,500 late abortions, many were performed to prevent the birth of an infant with Down's syndrome. But, as Document #25 shows, many people with Down's syndrome are capable of meaningful life. Indeed, it is estimated that only 1-2 percent of Down's syndrome children are severely retarded, and some are not retarded at all (as reported in The Boston Globe, December 11, 1983; permission to reprint this article was denied). Document #26 reports that some late abortions are performed because the fetus was found to be female and the family did not want any more little girls.

6. Late abortion techniques designed to prevent live births pose greater risk to the mother than non-lethal abortion techniques

As reported in Medical News, November 14, 1977 ("Avoiding Tough Abortion Complication: A Live Baby," reprint permission denied), intra-amniotic injection of prostaglandin is the method most commonly used to induce late-term abortions. The Upjohn Company, which makes prostaglandin, acknowledges that live births can result from the use of prostaglandin. Indeed, as this article reports, the prostaglandin package insert advises using it "only in hospitals with certain intensive care facilities." Since prostaglandin stimulates near-natural labor, an Upjohn representative (cited in the article) noted that the product has been used experimentally to induce labor at term. According to Dr. Wing K. Lee (Director of Fetal Medicine at Mt. Sinai Hospital in Hartford, Connecticut) as reported in the same article, physicians have been understandably reluctant to reveal the number of their late-term abortions. "But Dr. Lee feels that detail is important - and troubling - enough to justify making it public" which he did at an annual Planned Parenthood Federation of America meeting. To get around the live-birth problem (as the article still further reports), physicians have been turning to other methods of abortion, including the use of hypertonic saline injections. This, despite the fact that "a 1977 statement by the American College of Obstetricians and Gynecologists said prostaglandins cause rapid induction of labor and fewer cardiovascular and fluid-balance side effects than does saline."

Document #27 is a portion of Justice Powell's majority opinion in the Ashcroft decision. He discusses another, very lethal, abortion technique - dilation and extraction ("D&E"). He concludes "there is no recorded evidence that D&E ever will be the method that poses the least risk to the woman...." Despite this fact, Document #28 reports that some physicians prefer the D&E method, (in which the fetus is dismembered with a scalpel and removed piecemeal through the uterus), in order to guarantee against live births.

7. Late abortions raise new ethical issues

Document #29 illustrates the ethical conflict late abortions raise for some health care professionals. Documents #30 and #31 ask whether there is an ethical distinction between late abortion and infanticide.

8. Late abortions raise new legal issues

While the Supreme Court made clear the right to choose late abortion, its decision raised several new and difficult legal issues. As Justice O'Connor states in her Akron dissent (Document #32):

> Just as improvements in medical technology inevitably will move forward [towards birth] the point at which the State may regulate for reasons of maternal health, different technological improvements will move backward the point of viability at which the State may proscribe abortions except when necessary to preserve the life and health of the mother....The Roe framework, then, is clearly on a collision course with itself."

Justice O'Connor raises yet another difficult legal issue in her dissent. In Document #33 she argues that the Court's choice of viability as the point at which to permit the regulation of abortion is arbitrary. She states, "At any stage in pregnancy, there is the potential for human life....Accordingly, I believe that the state's interest in protecting potential human life exists throughout the pregnancy."

List of Documents

1. C. Everett Koop, "Letter" to Congressman Christopher Smith, February 24, 1984.

2. Dena Kleiman, "When Abortion Becomes Birth: A Dilemna of Medical Ethics Shaken by New Advances," The New York Times, February 15, 1984, p. B1, B4.

3. Planned Parenthood Association of Kansas City v. Ashcroft, The United States Law Week, 6-14-83, 4784-6.

4. "Memorandum: Present Constitutional Law Provides for 'Elective' Abortion Throughout the Full Nine Months of Pregnancy," prepared by Americans United for Life.

5. The Superior Court of the State of California for the County of Los Angeles, Case no. C 413,606.

6. Paul Jacobs, "Legality of State Abortion Law Doubted," The Times (Los Angeles), February 26, 1982.

7. Robert Dorr, "Abortion-Law Charges Dismissed," The World Herald (Omaha), July 23, 1983.

8. Charles A. Akemann, "Late Abortion Statistics," Human Life Review, Fall, 1981.

9. "Clinic Advertises Late Abortion Services, Prices," Minnesota Citizens Concerned for Life Newsletter, September, 1983.

10. Mike Masterson, "Life's Cruelty Leads to Postmortem for Infant Doe," The Sentinel-Record (Arkansas), May 7, 1983.

11. Nick Thimmesch, "Bizarre Cases of Abortions Gone Awry," St. Louis Globe-Democrat, June 19-20, 1982.

12. Liz Jeffries and Rick Edmonds, "Abortion: The Dreaded Complication," The Philadelphis Inquirer, August 2, 1981.

13. Mike Masterson, "Born Too Soon," Arkansas Magazine, June 26, 1983.

14. Rick Edmonds, "Life After Abortion: A Moral Dilemma in Del.," The Philadelphia Inquirer, June 10, 1979.

15. "Live Births-Midtown Hospital, Atlanta, GA," Nancy Creger, compiled from the Georgia Department of Human Resources, Department of Vital Records.

16. "Fetal Viability Floor Placed at 22 Weeks," Medical Tribune, April 2, 1975.

17. Raymond Gasser, "Embryology and Fetology," in Leslie Iffy and Harold A. Kaminetzky, eds., Principles and Practice of Obstetrics and Perinatology, 1981, p. 142-3.

18. City of Akron v. Akron Center for Reproductive Health, The United States Law Week, 6-14-83, 4778.

19. "21 Premature Babies," compiled by J. C. Willke, Cincinnati, Ohio.

20. Nancy Griffin, "Frankie Pulls Through at Bethesda," Navy Times, February 26, 1979.

21. United Press International, "2 'Miracle' Babies Beat Odds," The Boston Herald, March 31, 1983.

22. United Press International, "Smallest Human Alive Breathing on Her Own," The Post (Houston), June 9, 1983.

23. "Two A.C.O.G. Past Presidents, 26 Physicians Affirm Fetal Pain," Doug Badger and Norm Bendroth, "News Release," February 13, 1984.

24. Christopher Tietze, Induced Abortion: A World Review, 5th ed., 1983, p. 65-7.

25. J. Robert Nelson, "Stepping Out of Down's Syndrome," The Christian Century, August 12-19, 1981, p. 790.

26. John Elliott, "Abortion for 'Wrong' Fetal Sex: An Ethical-Legal Dilemma," Journal of the American Medical Association, October 5, 1979.

27. Planned Parenthood Association of Kansas City v. Ashcroft, The United States Law Week, 6-14-83, 4785.

28. Liz Jeffries and Rick Edmonds, "Abortion: The Dreaded Complication," The Philadelphis Inquirer, August 2, 1981.

29. Dick Conklin, "Nurse to Senate: 'Ashamed' of Profession," The Voice (Miami), May 25, 1979.

30. Joan Beck, "Must Infanticide be Tolerated as Part of Abortion?" The Herald (New York), June 18, 1979.

31. William Raspberry, "A Baby's Death Raises Questions: Is There no Longer any Difference?" A.L.L. About Issues, December, 1983.

32. City of Akron v. Akron Center for Reproductive Health, The United States Law Week, 6-14-83, 4778.

33. City of Akron v. Akron Center for Reproductive Health, The United States Law Week, 6-14-83, 4779.

DEPARTMENT OF HEALTH & HUMAN SERVICES

Document #1

The Surgeon General of the
Public Health Service
Washington DC 20201

February 24, 1984

The Honorable Christopher H. Smith
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Smith:

Following your inquiry by telephone and our subsequent discussion, I am pleased to put some of my thoughts on paper concerning late abortion in the United States. Of course, this is not a complete consideration of the moral, ethical, legal, and social implications of late abortion, but rather some facts that just highlight some of these concerns.

Late abortions are legal in the United States and the Supreme Court made that especially clear last June when they struck down most of the content of the Missouri and Akron laws which sought to limit abortion by regulation. It is of interest that abortion after thirteen weeks or so is usually not performed in countries behind the Iron Curtain.

Abortion after twenty weeks according to CDC figures, probably occurs 30,000 times per year in the United States (by extrapolation). Probably (CDC estimate) 4,000 of these are in the third trimester. Less than five percent of that number have induced abortion because of a known defect in the fetus.

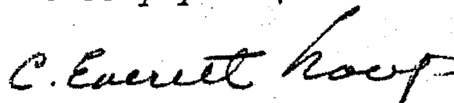
The tragic part of late abortions is that the fetuses are viable. In a sense the woman's right to abortion has become the right to a dead fetus. The unpleasant part of abortion of viable fetuses is that in keeping with the desire not to have the embarrassment of a live "abortion," the methods of abortion are usually those designed to kill the fetus as well as to remove it from the uterus (fragmentation or saline). Even those who argue (incorrectly) that younger fetuses feel no pain, cannot deny that viable fetuses certainly do.

When is a fetus viable? Viability grows closer to conception all the time. In the last decade it has slipped earlier by about two weeks to the region of approximately twenty weeks of gestation.

Obviously I haven't touched upon ethical and legal issues that are raised by late abortion as well as maternal medical concerns in regard to the health of the mother.

I trust that this has been helpful for your purposes.

Sincerely yours,



C. Everett Koop, M.D., Sc.D.
Surgeon General

When Abortion Becomes Birth: A Dilemma Of Medical Ethics Shaken by New Advances

By DENA KLEIMAN

A woman went to Beth Israel Medical Center in Manhattan for an abortion. When it was done, the doctors told her she had just given birth to a daughter.

The child, though seriously brain-damaged, was saved by new techniques of caring for extremely premature infants, and the techniques get better every year. The number of children surviving abortions is still tiny, and their chances of leading healthy lives are still small, but they are posing extraordinarily troubling problems for doctors and hospital administrators.

In effect, medical technology has leaped beyond both the law on abortion and the assumptions of medical ethics. At many hospitals, policies have been thrown into turmoil.

Doctors are grappling with whether a child born as a result of an abortion should be given the same extraordinary care as one born of a miscarriage. Hospital ethics committees are confronting the question of whether late abortions should be moved out of operating rooms and into the obstetrical wings holding the latest life-saving equipment. Women requesting late abortions at some hospitals are being told that a fetus born alive will be given all chances to survive.

'One of Our Most Difficult Areas'

"The area of late abortions is one of our most difficult areas," said Dr. Alan Rosenfield, acting director of obstetrics and gynecology at Columbia-Presbyterian Medical Center. "There are no easy answers, given our technology now."

In its landmark 1973 decision, the United States Supreme Court upheld a woman's right to abortion until the point of fetal viability and said that point was generally at about 28 weeks after conception. In New York State, the law allows abortions through the 24th week of pregnancy. But a decade of advances in medical science have made it possible to sustain the lives of infants earlier — as early as 23 weeks.

Live births after abortions are still extremely rare. Of the more than 160,000 abortions performed in 1982 in New York, there were 18 live births, according to statistics maintained by the State and City Health Departments. No statistics are maintained nationwide.

But the very possibility — a possibility most hospitals are reluctant to discuss openly — has stirred internal hospital discussions of when and how abortions are performed, whether late pregnancies should be screened for defects, and what specific procedures should be taken if a child is born live.

And there are difficult new legal issues. When an abortion becomes a birth, it is unclear who must decide what procedures are in the infant's best interest or who is financially responsible.

Because infants born of abortion are injured in the abortion process, legal scholars are asking whether it would be possible for such a seriously injured infant to make a claim of "wrongful life" against a hospital.

Differing Approaches To the Problem

Policies vary dramatically.

Some hospitals are now only performing elective abortions until the 20th week — a point where it is still impossible to sustain fetal life — except in cases where a fetus has been determined to suffer from major defects.

Others, refusing to make even that exception, are declining to perform amniocentesis, the genetic screening of the amniotic fluid surrounding the fetus. The test is generally recommended for women over the age of 35 and undergone by countless others to detect fetal abnormalities.

Some hospitals are switching to an abortion procedure that eliminates any possibility that a fetus might live.

Warnings to the Families

At still others, families are routinely being advised that an abortion may result in a live birth.

"We have to warn the families," said Dr. Hugh R. Barber, chief of obstetrics and gynecology at Lenox Hill Hospital in Manhattan, where abortions are performed until the legal limit of 24 weeks. "You have to tell them there is a slight possibility the fetus may live."

Dr. John Parente, director of obstetrics and gynecology at the Bronx-Lebanon Hospital Center, said that amniocentesis is not available there and that the hospital did not want to do late abortions.

"It's an emotional problem," he said. "We just don't want to do it."

"We decided to cut back to 20 weeks," said Dr. Fritz Fuchs, professor and former chairman of the department of obstetrics and gynecology at New York Hospital-Cornell Medical Center, where an exception is made for major defects. "In this manner, we have avoided getting into any difficulties with the law."

Fear Inspires Caution

The subject is rife with emotion and debate. Much of the discussion is taking place behind closed doors for fear of publicity and lawsuits.

Told about the subject of this article, many doctors declined to return telephone calls. In one case, the director of obstetrics at a major New York hospital spoke in detail of an aborted infant's survival last year and the traumatic impact this event had on the hospital's staff. The next day, he called back to deny the incident had ever occurred.

The questions of when abortions should be performed, by what method, and what kinds of infants should be saved are answered differently by different physicians.

While publicly the great majority of hospitals agree that any infant who survives an abortion or miscarriage should be kept alive, doctors acknowledge privately that this practice varies widely from hospital to hospital.

Circumstances of Procedure

"It's necessary to remember that these days abortion is done on request and therefore not a procedure you undertake in the interest of the fetus," said Dr. Gordon W. Douglas, the chief of obstetrics and gynecology at New York University Medical Center, where abortions are performed only until the 20th week of pregnancy except in cases of fetal abnormality.

"What most of us try to do is to try to remain within the law and not generate problems for anyone," Dr. Douglas said. "The hospital requires any live fetus to be given full supportive services and full resuscitation regardless of prognosis. But the delivery of a living fetus carries no guarantee of a surviving adult of any competence."

Complicating the problem for doctors at many hospitals are advances that have been made in detecting defects long before birth. Many of these procedures, including amniocentesis and sonography, cannot be performed until relatively late in the pregnancy, so often decisions about such abortions are made just at the edge of fetal viability.

Working at Cross Purposes

"It makes us all schizophrenic," said Dr. Richard Hausknecht, an associate clinical professor of obstetrics and gynecology at Mount Sinai Hospital who specializes in high risk pregnancies. "Nowadays we are asked to terminate a pregnancy that in two weeks doctors on the same floor are fighting to save."

Very premature infants, with low

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birth weight, suffer from myriad problems. Recent advances have helped prevent lung collapse in these tiny infants and have made it possible to nourish them with new formulas.

Nevertheless, serious handicaps persist. The cost of producing a survivor from a fetus of less than 28 weeks' gestation — whether it is a result of an abortion or of natural miscarriage — can run into the tens of thousands of dollars, not including medical costs from later complications of premature birth.

Three Methods Of Abortion

Much debate concerns the method by which late abortions are performed. Generally, there are three methods.

Injecting saline into the amniotic sac to induce labor in the mother is still the most commonly used procedure in late abortions. While it generally results in fetal death, it has been associated with harmful side effects in women and doctors have increasingly turned to the use of prosteglandin in late abortions.

Prosteglandin is a substance that also induces labor, but it does not poison the fetus. Of all abortion methods, prosteglandin — while believed to be the safest for women by some doctors — is also the most likely to result in a live birth.

The third and most controversial of the methods is dilation and evacuation. Known as D and E, it involves dismembering the fetus while still in the womb, which eliminates any possibility of live birth. It is a relatively new procedure in late abortions, and is generally believed to be among the safest for women and the least psychologically painful. However, it is also generally considered the most traumatic for doctors and staff.

The suction and curettage method, in which the cervix is dilated and the fetus is extracted through a suction tube, is generally applicable only in the early stages of pregnancy.

New Procedure Is Gaining

According to the Centers for Disease Control in Atlanta, the use of dilation and evacuation in second-trimester abortions has increased greatly in recent years, as more physicians have learned to perform the procedure and it has gained in acceptance.

Division abounds among gynecologists about who is willing to perform late abortions and by what method.

"I think every obstetrician struggles with this and makes his mind up what his threshold is," said Dr. David Grimes, a gynecologist with the division of reproductive health at the center in Atlanta. "Some do it until 12 weeks. Some will do it until 24."

"It would not be worth it to me to take even a small risk to the mother's life to avoid possibility of a live birth," said Dr. Bruce Young, director of maternal-fetal medicine at New York University Medical Center, where the policy also is to perform abortions until the 20th week of pregnancy except in cases of fetal deformities. The method of choice at New York University Medical Center is the use of prosteglandin.

"A woman comes to me for a late abortion and I do it the best way I know how," said Dr. E. Wyman Garrett, an obstetrician in Newark who is among a growing number of physicians who have developed expertise in performing D and E's through the 24th week of pregnancy.

He said he prefers this method because it is safer for the woman and because it avoids the agonizing decision of what to do when an child is born alive — a situation he confronted only last year.

In that instance, Dr. Garrett performed a saline abortion on a young woman at University Hospital in Newark. The infant that emerged weighed about 1 pound 10 ounces and was alive. It was born Jan. 13 and died April 29 after developing meningitis.

"I do D and E's because I think it is safer," said Dr. William Rashbaum, a gynecologist affiliated with Beth Israel who also specializes in this method. "It is a horrible procedure. Staff burnout is a major problem. But are you functioning in the interests of taking care of your staff or taking care of your patients?"

Theories Founder On Reality

A serious problem physicians confront in performing late abortions is the gap between abstract theories on fetal viability and the realities of medical practice.

In the case of the fetus born alive during an abortion at Beth Israel, for example, the infant was believed to have been only 22 weeks in gestation, but it was in fact 25 or 26 weeks, according to one doctor.

"The baby turned out to be older than we thought," the doctor said. Beth Israel officials said that the infant suffered extensive brain damage but would not discuss the incident further.

Pregnancy due dates, dates of conception and fetal viability are still uncertain areas. They depend on the skills of the doctor, the technical currentness of the hospital and individual development of the child.

Method of Determining Age

When a woman in the second trimester of pregnancy approaches a physician for an abortion, she is asked to undergo a sonogram, which produces an image of the fetus. It is the best — though still far from perfect — way for doctors to determine gestational age, since recollections about last menstrual periods are highly imprecise.

The age is estimated by measuring the diameter between two points on the fetus's skull. In theory, the wider the diameter, the older the fetus. But accuracy depends on the machinery used and on the skill of the technician using it. Congenitally small children make estimations of fetal age even more difficult.

"Sonograms are very subjective," said Jeffrey Karaban, a sonographer at one of the largest abortion clinics in New York City, the Eastern Women's Center in Manhattan, where 8,000 abortions are performed a year. "Certainly there are a lot of bad sonograms done. We have patients come from seemingly reputable places and yet their sonograms don't jibe with what we see."

Viability is even more difficult to assess. Once a highly premature infant is born — either as a result of abortion or of miscarriage — its gestational age is determined by how much it weighs and a number of other physical characteristics: the condition of its eyes, the state of its skin, how much cartilage it has developed in its ears. This, too, is highly subjective.

Characteristics of Fetus

A 24-week fetus physically appears to resemble a child, but its lungs and brain are still not fully developed, nor are its eyelids open.

If a decision has been made to resuscitate the baby, a mask may be placed over its mouth and nose and a needle placed through its navel to measure blood pressure and body chemistry. The baby is then weighed and further examined to determine whether to continue treatment.

Some doctors do not believe an infant is "viable," and thus a subject for the most advanced and agressive treatment, if it is seriously deformed or has been determined to have less than a 20 percent chance of survival. Other doctors will try to save any infant with a heart beat.

"I have never been called to deal with such a case, but if I were, I would vigorously treat that baby," said Dr. John Driscoll, director of the neonatal intensive care unit at Columbia-Presbyterian. "If the baby was anomalous, there would be a whole other set of dilemmas. If I were asked about a Down's syndrome baby, I believe everything should be done. I differ with some people's thoughts about quality-of-life issues."

Continued Need Raises Troubling Question

The underlying question that many doctors ask in confronting these difficult medical problems is why late abortions are still necessary, given the availability of contraceptives and the comparative ease with which abortions can now be obtained.

Indeed, over the past 10 years, elective abortions have been performed at progressively earlier stages of pregnancy nationwide, and the great majority are now carried out within the first trimester.

Of the 1.6 million abortions performed in the United States in 1980 — the last available figure from the Centers for Disease Control in Atlanta — more than 90 percent were done within the first 12 weeks. Only about 13,000 — less than 1 percent of all abortions performed nationwide — were performed on women pregnant more than 21 weeks.

According to statistics compiled by the Centers for Disease Control, the largest group of these women is between the ages of 15 and 19.

Many of these are believed to be unwed teen-agers who do not know they are pregnant until they feel the baby kick. Quickening — as fetal movement is called — usually first occurs between the 17th and 20th weeks of pregnancy. About 10 percent of all second-trimester abortions — less than 1 percent overall — are performed on women who have discovered they are carrying infants with serious defects.

Amniocentesis is usually performed during the 14th through 16th weeks of pregnancy. Results take at least three to four weeks, so that a woman choosing to abort a fetus with birth defects may not be able to do so until the 17th or as late as the 20th week of pregnancy. If there are problems with culturing the fluid, it may have to be performed even later.

In an article to be published by the Georgetown University Law Journal next June, Nancy K. Rhoden, assistant professor of law at Ohio State University in Columbus, points out that advances in neonatology may have made the Supreme Court's Roe v. Wade decision obsolete.

New Cutoff Point Suggested

Miss Rhoden suggests an arbitrary cutoff point of 20 weeks or the halfway mark of pregnancy as a new limit for abortions, with exceptions to be made for women who have found through amniocentesis that their offspring have serious defects.

But as legal scholars, ethicists and others continue to dissect this complicated subject, hospitals and physicians are trying to cope with the human drama of what is appropriate and what is not, whether abortions should now be carried out in the obstetrical wings of hospitals where fetuses can be monitored or whether neonatologists should be present at abortions where a live birth is a possibility.

"Social policy makes the late abortion issue worse," said Dr. Phillip Stubblefield, chief of obstetrics and gynecology at Mount Auburn Hospital in Cambridge, Mass., and an associate professor at Harvard Medical School. "Doing an abortion at 28 weeks is indefensible. I would draw a line at 24." The only exception he would make would be to save the life of the mother.

"But there should be a middle ground," he added. "Some abortions are necessary. What we should do is try to streamline the system so that help can be gotten earlier."

"What are the chances of a 24-week fetus to have a normal life?" asked Dr. William Caspe, the director of pediatrics at Bronx-Lebanon Hospital. "Probably small. Can they survive in terms of their heart and lungs? Yes. In terms of brain survival we are not there. And so a number of us have great qualms about what to do to a teeny tiny baby. For medical and legal reasons, we need to resuscitate. Some feel comfortable at that. Some don't.

"As a society, you shouldn't want us to do that. But as society, you give us no choice."

Mo. Rev. Stat. § 188.025 (Supp. 1982), requiring that abortions after 12 weeks of pregnancy be performed in a hospital;[1] § 188.047, requiring a pathology report for each abortion performed;[2] § 188.030, requiring the presence of a second physician during abortions performed after viability;[3] and § 188.028, requiring minors to secure parental or judicial consent.[4]

After hearing testimony from a number of expert witnesses, the District Court invalidated all of these sections except the pathology requirement. 483 F. Supp. 679, 699–701 (1980).[5] The Court of Appeals for the Eighth Circuit reversed the District Court's judgment with respect to § 188.028, thereby upholding the requirement that a minor secure parental or judicial consent to an abortion. It also held that the District Court erred in sustaining § 188.047, the pathology requirement. The District Court's judgment with respect to the second-physician requirement was affirmed, and the case was remanded for further proceedings and findings relating to the second-trimester hospitalization requirement. 655 F. 2d 848, 872–873 (1981). On remand, the District Court affirmed its holding that the second-trimester hospitalization requirement was unconstitutional. The Court of Appeals affirmed this judgment. 664 F. 2d 687, 691 (1981). We granted certiorari. 456 U. S. 988 (1982).

The Court today in *City of Akron*, *ante*, at 8–12, has stated fully the principles that govern judicial review of state statutes regulating abortions, and these need not be repeated here. With these principles in mind, we turn to the statutes at issue.

II

In *City of Akron*, we invalidated a city ordinance requiring physicians to perform all second-trimester abortions at general or special hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the American Osteopathic Association. *Ante*, at 13. Missouri's hospitalization requirements are similar to those enacted by Akron, as all second-trimester abortions must be performed in general, acute-care facilities.[6] For the reasons stated in *City of Akron*, we held that such a requirement "unreasonably in-

[1] Mo. Rev. Stat. § 188.025 provides: "Every abortion performed subsequent to the first twelve weeks of pregnancy shall be performed in a hospital."

[2] Mo. Rev. Stat. § 188.047 provides:

"A representative sample of tissue removed at the time of abortion shall be submitted to a board eligible or certified pathologist, who shall file a copy of the tissue report with the state division of health, and who shall provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced and the pathologist's report shall be made a part of the patient's permanent record."

[3] Mo. Rev. Stat. § 188.030.3 provides:

"An abortion of a viable unborn child shall be performed or induced only when there is in attendance a physician other than the physician performing or adducing the abortion who shall take control of and provide immediate medical care for a child born as a result of the abortion. During the performance of the abortion, the physician performing it, and subsequent to the abortion, the physician required by this section to be in attendance, shall take all reasonable steps in keeping with good medical practice, consistent with the procedure used, to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman."

[4] Mo. Rev. Stat. § 188.028 provides:

"1. No person shall knowingly perform an abortion upon a pregnant woman under the age of eighteen years unless:

"(1) The attending physician has secured the informed written consent of the minor and one parent or guardian; or

"(2) The minor is emancipated and the attending physician has received the informed written consent of the minor; or

"(3) The minor has been granted the right to self-consent to the abortion by court order pursuant to subsection 2 of this section, and the attending physician has received the informed written consent of the minor; or

"(4) The minor has been granted consent to the abortion by court order, and the court has given its informed written consent in accordance with subsection 2 of this section, and the minor is having the abortion willingly, in compliance with subsection 3 of this section.

"2. The right of a minor to self-consent to an abortion under subdivision (3) of subsection 1 of this section or court consent under subdivision (4) of subsection 1 of this section may be granted by a court pursuant to the following procedures:

"(1) The minor or next friend shall make an application to the juvenile court which shall assist the minor or next friend in preparing the petition and notices required pursuant to this section. The minor or the next friend of the minor shall thereafter file a petition setting forth the initials of the minor; the age of the minor; the names and addresses of each parent, guardian, or, if the minor's parents are deceased and no guardian has been appointed, any other person standing in loco parentis of the minor; that the minor has been fully informed of the risks and consequences of the abortion; that the minor is of sound mind and has sufficient intellectual capacity to consent to the abortion; that, if the court does not grant the minor majority rights for the purpose of consent to the abortion, the court should find that the abortion is in the best interest of the minor and give judicial consent to the abortion; that the court should appoint a guardian ad litem of the child; and if the minor does not have private counsel, that the court should appoint counsel. The petition shall be signed by the minor or the next friend;

. . . . .

"(3) A hearing on the merits of the petition, to be held on the record, shall be held as soon as possible within five days of the filing of the petition. . . . At the hearing, the court shall hear evidence relating to the emotional development, maturity, intellect and understanding of the minor; the nature, possible consequences, and alternatives to the abortion; and any other evidence that the court may find useful in determining whether the minor should be granted majority rights for the purpose of consenting to the abortion or whether the abortion is in the best interests of the minor;

"(4) In the decree, the court shall for good cause:

"(a) Grant the petition for majority rights for the purpose of consenting to the abortion; or

"(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion, setting forth the grounds for so finding; or

"(c) Deny the petition, setting forth the grounds on which the petition is denied;

. . . . .

"3. If a minor desires an abortion, then she shall be orally informed of and, if possible, sign the written consent required by section 188.039 in the same manner as an adult person. No abortion shall be performed on any minor against her will, except that an abortion may be performed against the will of a minor pursuant to a court order described in subdivision (4) of subsection 1 of this section that the abortion is necessary to preserve the life of the minor."

[5] The District Court also awarded attorney's fees for all hours claimed by the plaintiffs' attorneys. The Court of Appeals affirmed this allocation of fees. See 655 F. 2d 848, 872 (CA8 1981). The petition for certiorari raises the issue whether an award of attorney's fees, made pursuant to 42 U. S. C. § 1988, should be proportioned to reflect the extent to which plaintiffs prevailed.

[6] Missouri does not define the term "hospital" in its statutory provisions regulating abortions. We therefore must assume, as did the courts below, see 483 F. Supp., at 686, n. 10; 664 F. 2d, at 689–690, and nn. 3, 5 and 6, that the term has its common meaning of a general, acute-care facility. Cf. Mo. Rev. Stat. § 188.015(2) (Supp. 1982) (defining "abortion facility" as "a clinic, physician's office, or any other place or facility in which abortions are performed other than a hospital"). Section 197.020.2 (1978), part of Missouri's hospital licensing laws, reads:

"'Hospital' means a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of three or more nonrelated individuals suffering from illness, disease, injury, deformity or other abnormal physical conditions; or a place devoted primarily to provide for not less than twenty-four hours in any week medical . . . care for three or more nonrelated individuals. . . ."

Cf. Mo. Rev. Stat. § 197.200(1) (1978) (defining "ambulatory surgical center" to include facilities "with an organized medical staff of physicians" and "with continuous physician services and registered professional nursing services whenever a patient is in the facility"); 13 Mo. Admin. Code 50–30.010(1)(A) (1977) (same). The regulations for the Department of Social Services establish standards for the construction, physical facilities, and administration of hospitals. *Id.*, 50–20.010 to 50–20.030 (1977). These are not unlike those set by JCAH. See *City of Akron*, *ante*, at 13, and n. 16.

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fringes upon a woman's constitutional right to obtain an abortion." *Ante*, at 20–21. For the same reasons, we affirm the Court of Appeals' judgment that § 188.025 is unconstitutional.

III

We turn now to the State's second-physician requirement. In *Roe* v. *Wade*, 410 U. S. 113 (1973), the Court recognized that the State has a compelling interest in the life of a viable fetus: "[T]he State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id.*, at 164–165. See *Colautti* v. *Franklin*, 439 U. S. 379, 386–387 (1979); *Beal* v. *Doe*, 432 U. S. 438, 445–446 (1977). Several of the Missouri statutes undertake such regulation. Post-viability abortions are proscribed except when necessary to preserve the life or the health of the woman. Mo. Rev. Stat. § 188.030.1 (Supp. 1982). The State also forbids the use of abortion procedures fatal to the viable fetus unless alternative procedures pose a greater risk to the health of the woman. § 188.030.2.

The statutory provision at issue in this case requires the attendance of a second physician at the abortion of a viable fetus. § 188.030.3. This section requires that the second physician "take all reasonable steps in keeping with good medical practice . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman." See n. 3, *supra*. It also provides that the second physician "shall take control of and provide immediate medical care for a child born as a result of the abortion."

The lower courts invalidated § 188.030.3.[7] The plaintiffs, respondents here on this issue, urge affirmance on the grounds that the second-physician requirement distorts the traditional doctor-patient relationship, and is both impractical and costly. They note that Missouri does not require two physicians in attendance for any other medical or surgical procedure, including childbirth or delivery of a premature infant.

The first physician's primary concern will be the life and health of the woman. Many third-trimester abortions in Missouri will be emergency operations,[8] as the State permits these late abortions only when they are necessary to preserve the life or the health of the woman. It is not unreasonable for the State to assume that during the operation the first physician's attention and skills will be directed to preserving the woman's health, and not to protecting the actual life of those fetuses who survive the abortion procedure. Viable fetuses will be in immediate and grave danger because of their premature birth. A second physician, in situations where Missouri permits third-trimester abortions, may be of assistance to the woman's physician in preserving the health and life of the child.

By giving immediate medical attention to a fetus that is delivered alive, the second physician will assure that the State's interests are protected more fully than the first physician alone would be able to do. And given the compelling interest that the State has in preserving life, we cannot say that the Missouri requirement of a second physician in those unusual circumstances where Missouri permits a third-trimester abortion is unconstitutional. Preserving the life of a viable fetus that is aborted may not often be possible,[9] but the

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[7] The courts below found, and JUSTICE BLACKMUN's dissenting opinion agrees, *post*, at 6–7, that there is no possible justification for a second-physician requirement whenever D&E is used because no viable fetus can survive a D&E procedure. 483 F. Supp., at 694; 655 F. 2d, at 865. Accordingly, for them, § 188.030.3 is overbroad. This reasoning rests on two assumptions. First, a fetus cannot survive a D&E abortion, and second, D&E is the method of choice in the third trimester. There is general agreement as to the first proposition, but not as to the second. Indeed, almost all of the authorities disagree with JUSTICE BLACKMUN's critical assumption, and as the Court of Appeals noted, the choice of this procedure after viability is subject to the requirements of § 188.030.2. See *id.*, at 865, and n. 28. Nevertheless, the courts below, in conclusory language, found that D&E is the "method of choice even after viability is possible." 655 F. 2d, at 865. No scholarly writing supporting this view is cited by those courts or by the dissent. Reliance apparently is placed solely on the testimony of Dr. Robert Crist, a physician from Kansas, to whom the District Court referred in a footnote. 483 F. Supp., at 694, n. 25. This testimony provides slim support for this holding. Dr. Crist's testimony, if nothing else, is remarkable in its candor. He is a member of the National Abortion Federation, "an organization of abortion providers and people interested in the pro-choice movement." 2 Record 415–416. He supported the use of D&E on 28-week pregnancies, well into the third trimester. In some circumstances, he considered it a better procedure than other methods. See 2 Record 427–428. His disinterest in protecting fetal life is evidenced by his agreement "that the abortion patient has a right not only to be rid of the growth, called a fetus in her body, but also has a right to a dead fetus." *Id.*, at 431. He also agreed that he "[n]ever ha[s] any intention of trying to protect the fetus, if it can be saved," *id.*, and finally that "as a general principle" "[t]here should not be a live fetus," *id.*, at 435. Moreover, contrary to every other view, he thought a fetus could survive a D&E abortion. *Id.*, at 433–434. None of the other physicians who testified at the trial, those called both by the plaintiffs and defendants, considered that *any* use of D&E after viability was indicated. See 1 Record 21 (limiting use of D&E to under 18 weeks); 2 Record 381, 410–413 (Dr. Robert Kretzschmar) (D&E up to 17 weeks; would never perform D&E after 26 weeks); 4 Record 787 (almost "inconceivable" to use D&E after viability); 7 Record 52 (D&E safest up to 18 weeks); *id.*, at 110 (doctor not performing D&E past 20 weeks); *id.*, at 111 (risks of doing outpatient D&E equivalent to childbirth at 24 weeks). See also 8 Record 33, 78–81 (deposition of Dr. Willard Cates) (16 weeks latest D&E performed). Apparently Dr. Crist performed abortions only in Kansas, 2 Record 334, 368, 428, a state having no statutes comparable to § 188.030.1 and § 188.030.2. It is not clear whether he was operating under or familiar with the limitations imposed by Missouri law. Nor did he explain the circumstances when there were "contraindications" against the use of any of the procedures that could preserve viability, or whether his conclusory opinion was limited to emergency situations. Indeed, there is no record evidence that D&E ever will be the method that poses the least risk to the woman in those rare situations where there are compelling medical reasons for performing an abortion after viability. If there were such instances, they hardly would justify invalidating § 188.030.3.

In addition to citing Dr. Crist in its footnote, the District Court cited—with no elaboration—Dr. Schmidt. His testimony, reflecting no agreement with Dr. Crist, is enlightening. Although he conceded that the attendance of a second physician for a D&E abortion on a viable fetus was not necessary, he considered the point mostly theoretical, because he "simply [did] not believe that the question of viability comes up when D&E is an elected method of abortion." 4 Record 836. When reminded of Dr. Crist's earlier testimony, he conceded the remote possibility of third-trimester D&E abortions, but stated: "I personally cannot conceive that as a significant practical point. It may be important legally, but [not] from a medical standpoint. . . ." *Ibid.* Given that Dr. Crist's discordant testimony is wholly unsupported, the State's compelling interest in protecting a viable fetus justifies the second-physician requirement even though there may be the rare case when a physician may think honestly that D&E is required for the mother's health. Legislation need not accommodate every conceivable contingency.

[8] There is no clearly expressed exception on the face of the statute for the performance of an abortion of a viable fetus without the second physician in attendance. There may be emergency situations where, for example, the woman's health may be endangered by delay. Section § 188.030.3 is qualified, at least in part, by the phrase "provided that it does not pose an increased risk to the life or health of the woman." This clause reasonably could be construed to apply to such a situation. Cf. *H. L.* v. *Matheson*, 450 U. S. 398, 407, n. 14 (1981) (rejecting argument that Utah statute might apply to individuals with emergency health care needs).

[9] See ACOG Technical Bulletin No. 56, *supra* n. 7, at 4 (as high as 7% live-birth rate for intrauterine instillation of uterotonic agents); Stroh & Hinman, Reported Live Births Following Induced Abortion: Two and One-Half Years' Experience in Upstate New York, 126 Am. J. Obstet. Gynecol. 83, 83–84 (1976) (26 live births following saline induced-abortions; 9 following hysterotomy; 1 following oxtyocin-induced abortion) (one survival out of 38 live births); 4 Record 728 (50–62% mortality rate for fetuses 26 and 27 weeks); *id.*, at 729 (25–92% mortality rate for fetuses 28 and 29 weeks); *id.*, at 837 (50% mortality rate at 34 weeks).

State legitimately may choose to provide safeguards for the comparatively few instances of live birth that occur. We believe the second-physician requirement reasonably furthers the State's compelling interest in protecting the lives of viable fetuses, and we reverse the judgment of the Court of Appeals holding that § 188.030.3 is unconstitutional.

IV

In regulating hospital services within the State, Missouri requires that "[a]ll tissue surgically removed with the exception of such tissue as tonsils, adenoids, hernial sacs and prepuces, shall be examined by a pathologist, either on the premises or by arrangement outside of the hospital." 13 Mo. Admin. Code 50-20.030(3)(A)7 (1977). With respect to abortions, whether performed in hospitals or in some other facility, § 188.047 requires the pathologist to "file a copy of the tissue report with the State Division of Health. . . ." See n. 2, *supra*. The pathologist also is required to "provide a copy of the report to the abortion facility or hospital in which the abortion was performed or induced." Thus, Missouri appears to require that tissue following abortions, as well as from almost all other surgery performed in hospitals, must be submitted to a pathologist, not merely examined by the performing doctor. The narrow question before us is whether the State lawfully also may require the tissue removed following abortions performed in clinics as well as in hospitals to be submitted to a pathologist.

On its face and in effect, § 188.047 is reasonably related to generally accepted medical standards and "further[s] important health-related State concerns." *City of Akron*, *ante*, at 12. As the Court of Appeals recognized, pathology examinations are clearly "useful and even necessary in some cases," because "abnormalities in the tissue may warn of serious, possibly fatal disorders." 655 F. 2d, at 870.[10] As a rule, it is accepted medical practice to submit *all* tissue to the examination of a pathologist.[11] This is particularly important following abortion, because questions remain as to the long-range complications and their effect on subsequent pregnancies. See App. 72-73 (testimony of Dr. Willard Cates, Jr.); Levin, et al., Association of Induced Abortion with Subsequent Pregnancy Loss, 243 J. A.M.A. 2495, 2499 (1980). Recorded pathology reports, in concert with abortion complication reports, provide a statistical basis for studying those complications. Cf. *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 81 (1976).

Plaintiffs argue that the physician performing the abortion is as qualified as a pathologist to make the examination. This argument disregards the fact that Missouri requires a pathologist—not the performing physician—to examine tissue after almost every type of surgery. Although this requirement is in a provision relating to surgical procedures in hospitals, many of the same procedures included within the Missouri statute customarily are performed also in outpatient clinics. No reason has been suggested why the prudence required in a hospital should not be equally appropriate in such a clinic. Indeed, there may be good reason to impose stricter standards in this respect on clinics performing abortions than on hospitals.[12] As the testimony in the District Court indicates, medical opinion differs widely on this question. See 3 Record 623; 4 Record 749-750, 798-800, 845-847; n. 2, *supra*. There is substantial support for Missouri's requirement. In this case, for example, Dr. Bernard Nathanson, a widely experienced abortion practitioner, testified that he requires a pathologist examination after each of the 60,000 abortions performed under his direction at the New York Center for Reproductive and Sexual Health. He considers it "absolutely necessary to obtain a pathologist's report on each and every specimen of tissue removed for abortion or for that matter from any other surgical procedure which involved the removal of tissue from the human body." App. 143-144. See also App. 146-147 (testimony of Dr. Keitges); 5 Record 798-799 (testimony of Dr. Schmidt).[13]

In weighing the balance between protection of a woman's health and the comparatively small additional cost of a pathologist's examination, we cannot say that the Constitution requires that a State subordinate its interest in health to minimize to this extent the cost of abortions. Even in the early weeks of pregnancy, "[c]ertain regulations that have no significant impact on the woman's exercise of her right to decide to have an abortion may be permissible where justified by im-

---

[10] A pathological examination is designed to assist in the detection of fatal ectopic pregnancies, hydatritaforme moles or other precancerous growths, and a variety of other problems that can be discovered only through a pathological examination. The general medical utility of pathological examinations is clear. See, *e. g.*, American College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 52 (5th ed. 1982); National Abortion Federation (NAF), National Abortion Federation Standards 6 (1981) (compliance with standards obligatory for NAF member facilities to remain in good standing); Brief of the American Public Health Association as *Amicus Curiae* in Nos. 81-185, 81-746, 81-1172, at 29, n. 6 (supporting the NAF standards for non-hospital abortion facilities as constituting "minimum standards").

[11] ACOG's standards at the time of the District Court's trial recommended that a "tissue or operative review committee" should examine "all tissue removed at obstetric-gynecologic operations." ACOG, Standards for Obstetric-Gynecologic Services 13 (4th ed. 1974). The current ACOG standards also state as a general rule that, for all surgical services performed on an ambulatory basis, "[t]issue removed should be submitted to a pathologist for an examination." ACOG, *supra*, at 52 (5th ed. 1982). The dissent, however, relies on the recent modification of these standards as they apply to abortions. ACOG now provides an "exception to the practice" of mandatory examination by a pathologist and makes such examination for abortion tissue permissive. *Ibid.* Not surprisingly, this change in policy was controversial within the College. See 4 Record 799-800. ACOG found that "[n]o consensus exists regarding routine microscopic examination of aspirated tissue in every case," though it recognized—on the basis of inquiries made in 29 institutions—that in a majority of them a microscopic examination is performed in all cases. ACOG, Report of Committee on Gynecologic Practice, Item #6.2.1 (June 27-28, 1980).

[12] The professional views that the plaintiffs find to support their position do not disclose whether consideration was given to the fact that not all abortion clinics, particularly inadequately regulated clinics, conform to ethical or generally accepted medical standards. See *Bellotti* v. *Baird*, 443 U. S. 622, 641, n. 21 (1979) (*Bellotti II*) (minors may resort to "incompetent or unethical" abortion clinics); *Planned Parenthood of Central Mo.* v. *Danforth*, 428 U. S. 52, 91, n. 2 (1976) (Stewart, J., concurring). The Sun-Times of Chicago, in a series of special reports, disclosed widespread questionable practices in abortion clinics in Chicago, including the failure to obtain proper pathology reports. See "The Abortion Profiteers," Chicago Sun-Times 25-26 (Special Reprint 1978). It is clear, therefore, that a State reasonably could conclude that a pathology requirement is necessary in abortion clinics as well as in general hospitals.

In suggesting that we make from a "comfortable perspective" the judgment that a State constitutionally can require the additional cost of a pathology examination, the dissent suggests that we disregard the interests of the "woman on welfare or the unemployed teenager." *Post*, at 4. But these women may be those most likely to seek the least expensive clinic available. As the standards of medical practice in such clinics may not be the highest, a State may conclude reasonably that a pathologist's examination of tissue is particularly important for their protection.

[13] The dissent appears to suggest that § 188.047 is constitutionally infirm because it does not require microscopic examination, *post*, at 4, but that misses the point of the regulation. The need is for someone other than the performing clinic to make an independent medical judgment on the tissue. See n. 12, *supra*; 4 Record 750 (Dr. Pierre Keitges, a pathologist). It is reasonable for the State to assume that an independent pathologist is more likely to perform a microscopic examination than the performing doctor. See H. Cove, Surgical Pathology of the Endometrium 28 (1981) ("To the pathologist, abortions of any sort are evaluated grossly *and* microscopically for the primary purpose of establishing a diagnosis of intrauterine pregnancy.") (emphasis added).

Memorandum: Present Constitutional Law Provides for "Elective" Abortion Throughout the Full Nine Months of Pregnancy

The United States Supreme Court abortion decisions, Roe v. Wade, 410 U.S. 113 (1973), and Doe v. Bolton, 410 U.S. 179 (1973), assuredly mandated the legalization of abortion on demand throughout the entire length of pregnancy. The Court said in those deicisons that a State may not proscribe abortion prior to viability and, even after viability, the State may not proscribe abortion necessary, in the medical judgment of the physician, for the preservation of the life or health of the mother. The following exemplifies the Court's holdings in the Roe and Doe decisions:

Roe states

> For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
>
> ...For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.

Roe, 410 U.S. at 164.

Thus, the state legislatures must allow a woman and her doctor to decide that she is to have an abortion and execute that decision. After the end of the first trimester (first three months) of pregnancy, the State may regulate abortion to safeguard the woman's health (an example the Court gives is a requirement that the abortion be performed in a hospital, Id. at 163 but it may not proscribe any such abortion.

It is true that the Supreme Court did say:

> For the stage subsequent to viability, the State in promoting its interests in the potentiality of human life, may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.

Id. at 164-65 (emphasis added).

SOURCE: A.U.L.

On its face, this seems to allow abortion prohibition except for medical reasons after "viability" (when the "fetus develops the capability of meaningful life outside the mother's womb," Id. at 163), or as a later Supreme Court decision put it, "when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support," Colautti v. Franklin, 439 U.S. 379, 388 [1979], which the Court in 1973 said "is usually placed at about seven months [28 weeks] but may occur earlier, even at 24 weeks," Roe, 410 U.S. at 163).

The key words, however, are "health of the mother." In Roe's campanion case, Doe v. Bolton, 410 U.S. 179, 191-92 (1973), the Court construed "preservation of the mother's life or health" to include "all factors--physical, emotional, psychological, familial, and the woman's age--relevant to the well-being of the patient." The Court emphasized this "allows the attending physician the room he needs...[a]nd it is room that operates for the benefit, not the disadvantage, of the pregnant woman." Id. at 192. In Roe itself, the Court further explicated factors which could be regarded as relating to the "well-being" of the patient

> Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by childcare. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties in continuing stigma of unwed motherhood may be involved. All these are factors the woman and her responsible physician necessarily will consider in consultation.

Roe, 410 U.S. at 153.

It should be unmistakeable that the Supreme Court abortion decisions of 1973--which in this respect have not been subsequently modified by the Court --require as a matter of constitutional law that a woman be allowed a legal abortion at any time during the course of pregnancy, provided only that she can find a physician willing to conclude that, without an abortion, her child will be unwanted or her family too numerous.

Judge Eli Chernow
Dept. M. Courthouse
6230 Sylmar Avenue
Van Nuys, CA 91401

Document #5

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B. Wendel
COUNTY CLERK

SUPERIOR COURT OF THE STATE OF CALIFORNIA

FOR THE COUNTY OF LOS ANGELES

FEMINIST WOMEN'S HEALTH CENTER, INC., a California nonprofit corporation, and DUNCAN DONOVAN,

Plaintiffs,

vs.

JOHN K. VAN DE KAMP, in his official capacity as District Attorney for the County of Los Angeles, BOARD OF SUPERVISORS OF THE COUNTY OF LOS ANGELES, AND THE INDIVIDUAL MEMBERS THEREOF, and the COUNTY OF LOS ANGELES,

Defendants,

THE CATHOLIC LEAGUE, SOUTHERN CALIFORNIA CHAPTER, a California corporation, and PAUL L. FREESE, an Individual,

Intervenors.

CASE No. C 413,606

JUDGMENT PURSUANT TO CODE OF CIVIL PROCEDURE § 437c

On December 22, 1982, this court heard cross motions by plaintiffs and defendants for summary judgment or, in the alternative, cross motions for summary adjudication of issues. Plaintiff ahve appeared by their counsel Dorothy Triffo Lang and Fred Okrand, defendants by their counsel, Robert C. Lynch,

Assistant Chief Deputy County Counsel, and intervenors by their counsel, Paul L. Freese and Donna P. Arlow, and this court having read and considered the papers and documents on file in this case, plaintiffs' motion for summary adjudication of issues is granted as follows:

1. IT IS HEREBY ORDERED that the following declaratory relief be granted:

a. The portion of Health and Safety Code Section 25953 which reads, "[i]n no event shall the termination be approved after the 20th week of pregnancy" is unconstitutional under the privacy guarantees of the Ninth and Fourteenth Amendments to the United States Constitution, and article I, section 1 of the California Constitution.

b. If said statute were construed in accordance with the opinion of the Attorney General at 65 Ops. Cal. Atty. Gen. 261 (1982),it would fail to give fair notice consistent with the due process guarantees of the United States and California Constitutions to physicians and women as to what conduct with respect to abortion would be punishable in a criminal proceeding. Because only the California Legislature can amend a statute to produce an enforceable restriction on abortion, the opinion of the Attorney General cannot form a legal basis to criminally prosecute any person under Penal Code Sections 186a, 274, 275, 276 or any other statute on the basis of the length of gestation of a pregnancy.

2. IT IS HEREBY FURTHER ORDERED that defendant Van De Kamp, his successors in interest, agents, assigns and employees and all persons acting in concert with them, are permanently enjoined from criminally prosecuting any person under Penal Code sections

Legality of State Abortion Law Doubted

Discovery of 2,000 Fetuses Raises Issue of Validity of Prohibitions

Document #

By PAUL JACOBS, *Times Medical Writer*

State health and law-enforcement officials are reluctantly coming to the conclusion that California's abortion law is unconstitutional and they have no way to prevent abortions up to the time of a normal delivery.

The state Department of Health Services has determined that a series of federal and state court decisions has gutted the 1967 state statute that limits abortions to the first 20 weeks of pregnancy.

An analysis of the legal issues, prepared last year for the department's chief legal counsel, Richard Koppes, concluded that "neither California nor federal law prohibits abortion at any point during pregnancy."

County officials have suddenly become aware of that state health department analysis as a result of the discovery earlier this month of an estimated 2,000 fetuses that were stored at a Woodland Hills residence. Some of the fetuses may have been aborted more than 20 weeks after conception.

The state health services legal opinion has no force of law, but it has been used as a guide to state and county officials who inspect clinics and hospitals that perform abortions.

And it agrees with a legal analysis done privately for the California Medical Assn., whose 29,000 members represent two-thirds of the doctors practicing in the state.

The Los Angeles County district attorney's office is researching the same question.

The district attorney has joined an investigation of the 2,000 fetuses that until this month were stored at the home of Malvin R. Weisberg. Until a year ago, Weisberg operated Medical Analytic Laboratories in Santa Monica, a lab that performed medical tests on fetuses from facilities in several states.

At least some of the fetuses were large enough to cause health officials to ask the coroner whether they might be older than 20 weeks.

However, one county official, who asked not to be identified, doubted that there will be criminal charges brought for late abortions in the case unless the coroner shows that "a fetus was viable and born alive and drowned in formaldehyde."

The state health department legal analysis points out that a separate California statute makes it a crime for a physician to withhold medical care from an infant who survives an abortion.

But no one has yet been prosecuted under that law, according to a spokesman for county Supervisor Mike Antonovich, who authored the legislation as a state senator.

In any case, after 20 weeks of pregnancy, abortions typically are performed in a way that kills the fetus before it leaves the womb, health officials say.

In a saline abortion, a strong salt solution is injected in the amniotic sac, in effect poisoning the fetus. In another method, the fetus is cut up before it is mechanically removed from the uterus.

Reagan Signed Law

California's statute permitting therapeutic abortions—for the physical and mental well-being of the mother—was signed into law by then-Gov. Ronald Reagan 15 years ago.

But key U.S. Supreme Court decisions in 1973 and 1976, while not directly striking down the California law, created doubt about its constitutionality.

In its landmark decision, the court ruled that early abortions—in the first third, or trimester, of pregnancy—are a private matter between a woman and her physician and not subject to state regulation.

And states cannot prevent a medical decision to terminate pregnancy at any time when necessary for the health of the woman.

The combined effect of the decisions was to knock out entire sections of the California statute and allow virtually unrestricted abortions, according to the state health department analysis.

The Supreme Court also ruled that only when a fetus becomes "viable" can the state intervene to protect the fetus, but left the definition of "viability" up to physicians, not to courts or legislatures.

Some state and county health officials say that, because of the absence of abortion regulations in California, the state has become a mecca for women wanting abortions late in pregnancy. These officials, however, have no hard evidence to support that contention.

State statistics on abortion are at best incomplete because a California court tossed out a statute requiring that physicians file death certificates for all fetuses more than 20 weeks old from the time of conception. The court ruled that the statute would violate a woman's constitutional right of privacy.

Dr. Jimmie Westberg, an obstetrician who heads the state medical association's study of maternal and infant deaths, estimates that less than 1% of all abortions are conducted after 20 weeks. That number is consistent with national statistics.

In a two-month sampling of 18,598 abortions performed in California in 1980, the state Center for Health Statistics found that about 3,000 abortions were performed after 12 weeks—41 of them after 24 weeks.

But the state abortion reporting system is voluntary, and the 1980 figures are further complicated by confusion over whether fetal ages reported represent age from conception or age from the mother's last menstrual period.

Physicians who specialize in gynecology and obstetrics point out that there are medical justifications for aborting a fetus after 20 weeks.

Genetic testing for serious fetal abnormalities generally must wait until at least 16 weeks of pregnancy and sometimes longer. The results of those tests, which are often crucial in deciding whether to abort a fetus, take a minimum of four weeks to complete.

Because of difficulties in determining the age of a fetus precisely, it is possible that some of the pregnancies terminated because of the possibility of birth defects could be beyond 20 weeks, according to Dr. Charles A. Ballard, head of the therapeutic abortion program at Los Angeles County-USC Medical Center.

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February 26, 1982

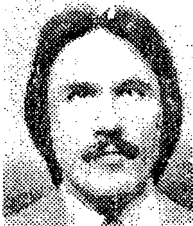
Document #7

Abortion-Law Charges Dismissed

By Robert Dorr
World-Herald Staff Writer

Charges of violating Nebraska's abortion law filed in 1979 against Omaha obstetrician C.J. LaBenz were dismissed Friday.

The charges resulted from an incident at the University of Nebraska Medical Center in which a 2-pound, 9-ounce baby boy born alive during an abortion died 2½ hours later.


Dr. LaBenz

The Douglas County Attorney's Office asked that the charges be dropped because the parts of Nebraska's abortion law under which Dr. LaBenz was charged have been ruled unconstitutional.

"You can't prosecute a guy on a statute the 8th Circuit Court has declared unconstitutional," said Robert Sigler, deputy Douglas County attorney.

Douglas County District Judge John T. Grant dismissed the charges.

In a statement released through his attorney, Dr. LaBenz said he is grateful for the charges being dropped.

He said: "Despite all the litigation and publicity surrounding an unfortunate incident, I thank God for the support of my family, friends and the overwhelming public support from the medical and lay community."

Dr. LaBenz, now 35, was charged with violating two parts of Nebraska's abortion law.

One charge alleged that the abortion was performed even though sound medical judgment should have made it clear the fetus was viable. The second alleged that Dr. LaBenz failed to take all reasonable steps to treat a child born alive with a chance of surviving.

U.S. District Court Judge Warren Urbom of Lincoln declared the two sections of the law unconstitutional, and the 8th U.S. Circuit Court of Appeals upheld Urbom's decision.

The Nebraska Attorney General's Office has decided that further appeal of Urbom's decision would be hopeless, said attorney Jerry Fennell, who has handled the defense of Nebraska's abortion law.

"We decided it would be best to seek new legislation protecting unborn children in the second and third trimesters (of pregnancy)," Fennell said.

A new law will be sought in next year's Legislature, he said.

In his statement, Dr. LaBenz added:

Please turn to Page 6, Col. 1

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THE WORLD HERALD (Omaha)
July 23, 1983

Abortion Charge Dropped; Obstetrician Is 'Grateful'

●Continued from Page 1

"It is unfortunate that we have to use the federal court system to eliminate the state's interference in the practice of medicine.

"It has been very trying and unfair for my family, friends and myself to have had to endure the 'unjust-'guilty until proven innocent' attitude of the County Attorney's Office and The World-Herald simply because of their attitude toward the controversial issue of abortion."

Deputy Douglas County Attorney Henry Wendt, co-counsel in prosecuting Dr. LaBenz, said he has no response to Dr. LaBenz's statement.

Dr. LaBenz's attorney, Lawrence Batt, said the physician was upset with news articles that appeared in The World-Herald, especially one that quoted several residents of Humphrey, Neb., Dr. LaBenz's hometown, as saying they were saddened by the case. Humphrey is a heavily Catholic community.

'Unjustly Treated'

If the case had come to trial, Dr. LaBenz would have been found innocent, Batt said. "It's unfortunate that we were not able to show the facts surrounding the incident which would show that he was unfairly and unjustly treated (in being charged)," the attorney said.

The physician never was tried because of the questions about the constitutionality of the two abortion statute sections.

Dr. LaBenz, affiliated with the Womens Services medical clinic, has continued to perform abortions as part of his obstetric and gynecological practice, Batt said.

The University of Nebraska Medical Center, which suspended Dr. LaBenz's privilege to perform abortions at the center, has restored that privilege, Batt said.

In private medical practice only six months at the time he was charged, Dr. LaBenz since has become board-certified in obstetrics and gynecology and has been accepted for membership in the American College of Obstetrics and Gynecology, Batt said.

First Account

The first news account of the incident that led to the charges against Dr. LaBenz appeared in The World-Herald, after an interview with Dr. LaBenz in Batt's presence.

In that interview, Dr. LaBenz said: "I feel very badly. That is the last thing I would ever want to happen to any patient or the medical personnel involved."

The name of the abortion patient — a divorced woman in her late 20s from an outstate Nebraska community — never has been made public. When she came to Dr. LaBenz, the doctor estimated she was 19 to 20 weeks pregnant.

A saline solution (sterile salt water) was used to induce labor. The woman aborted about 1 a.m. Sept 6, 1979.

Testimony at a preliminary hearing in the case against Dr. LaBenz differed on the physical condition of the aborted infant.

A nurse who was present said the infant's arms and legs were moving, its color was pink, its eyes were open and it had a gasping form of breathing.

A doctor who checked the infant 15 to 30 minutes after its birth said it had no chance of survival.

Dr. LaBenz, who was called at home by a nurse, said he didn't order the use of extraordinary life-saving measures because he believed they would be futile.

Between 7 and 20 minutes elapsed between the birth and the notification of Dr. LaBenz, nurses testified.

A doctor who examined the infant after its birth said the pregnancy was 27 to 29 weeks along. A normal-term pregnancy is 40 weeks.

THE WORLD HERALD (Omaha)
July 23, 1983

THE HUMAN LIFE REVIEW
Fall 1981

Late Abortion Statistics

It comes as no surprise that more people oppose late abortions than early ones. Indeed, many people believe that late abortions are still illegal, or, where they are permitted, it is due to indifference on the part of the state legislature. Even when they are informed that late abortions are legal everywhere in the U.S. and are beyond the reach of any legislature, skeptics will still reply that abortions are rarely, if ever, performed after viability. While it is certainly true that a very small proportion of all abortions occur after 20 weeks gestation, it is also true that a very small proportion of the postnatal deaths in the U.S. are homicides, yet we properly give these considerable attention.

The word "late" needs a precise definition, but there is no common agreement on its meaning in this context. Since babies have been born at 20 weeks and have subsequently developed normally, it is not unreasonable to begin a table at 21 weeks and to let the reader decide from there.

The following table was constructed using data supplied by the U.S. Dept. of Health, Center for Disease Control, in Atlanta. However, only eight states (Illinois, Kansas, Nebraska, New York (*excluding* New York City), Oregon, South Carolina, Tennessee, Vermont) report abortions by single week of gestation. Since Chicago is the only large city included in this group of states, the simple extrapolation methods which I used to estimate the totals for the entire U.S. probably underestimate the actual figures. After all, a late abortion is a dangerous operation which is not socially acceptable in most circles. Big cities offer better facilities and greater anonymity. Further, the reported figures show unmistakable signs of underreporting of the gestational age. For example, the eight states reported hundreds of abortions after one week, i.e. prior to conception itself. (Gestation is measured from the last day of the last menstrual period.) The figures are for 1978, the latest available.

Gestational age in weeks from last day of menstrual period.	Actual abortions reported in the eight state group beyond this age.	Estimate of the total U.S. abortions beyond this age.
21	1144	9702
22	792	6717
23	479	4063
24	318	2697
25	223	1891
26	154	1306
27	118	1001
28	91	772
29	66	560
30	44	373
31	26	221
32	10	85
	3,465	29,388

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September, 1983

Clinic advertises late abortion services, prices

While MCCL and other pro-life organizations continue to battle the public misconception, promoted through the media, that the 1973 Supreme Court decisions legalized abortion only during the first trimester, abortionists around the country continue to advertise openly their second trimester abortion services.

Recently Women's Health Care Services, a Kansas abortion facility, sent promotional material to doctors in that state. According to a cover letter signed by George R. Tiller, the clinic's medical director, over 1,600 second trimester "outpatient terminations" have been performed there.

"We routinely accept patients up to 26 weeks last menstrual period or approximately 6.0 BPD," the letter said. The latter figure refers to the biparietal diameter of the fetal skull, measured by ultrasonography. A measurement of 6.0 BPD equals 2.4 inches and indicates a fetus of 24½ weeks.

"If you were to refer a patient to our organization for advanced second trimester termination," Dr. Tiller told physicians, "you could expect a telephone call from me personally at the conclusion of the surgery, and have a follow up letter on your desk within a week after the procedure."

The clinic performs second trimester abortions by the dilatation and evacuation (D&E) method, which involves opening the cervix with laminaria, described as "match stick like pieces of sterilized seaweed which will absorb fluid and gradually swell in a sponge-like fashion." After dilatation, "the pregnancy can be removed quickly, comfortably and safely."

(The comfort and safety apply only to the woman, since the baby is dismembered and his or her skull is crushed so the "pregnancy" can be removed.)

The brochure explains to potential patients that the "procedure" takes several days. "The first day of your abortion process will be a busy one," it cautions, filled with such things as paper work, lab testing and sonography. The abortion is completed on the second day for pregnancies 16 weeks or less, or the third day for those over 16 weeks.

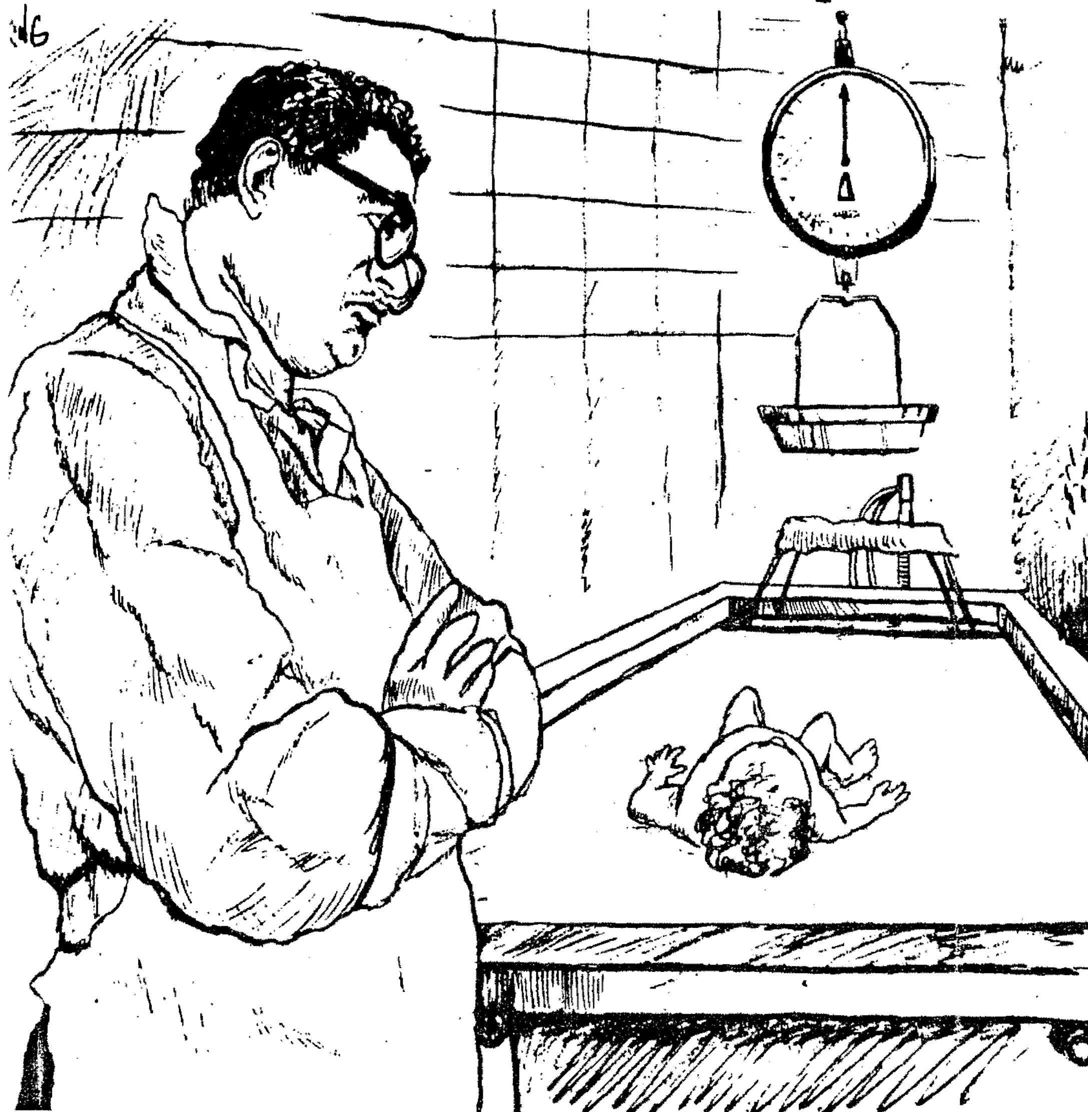
The information also included the clinic's price list: 13-14 weeks, $300; 15-16 weeks, $500; over 16 weeks to 22 weeks, $700; 22 weeks and above, $950. A sonogram is included in the price, but the anesthetic "twilight sleep" costs $50 extra, and the administration of RhoGam to Rh negative women is $45 extra.

"Payment must be made on the day that the procedure is started and only by travelers check, cashiers check or cash," the literature says. "We are unable to accept personal checks, payroll checks or credit cards. We do accept qualified Kansas Blue Shield, otherwise we do not accept insurance in lieu of payment."

The brochure adds that spousal consent or parental consent for mature minors is not required.

MINNESOTA CITIZENS CONCERNED FOR LIFE NEWSLETTER
September 1983

Life's cruelty leads to postmortem for Infant Doe



MALAK: *holding her heart in his hand*

By MIKE MASTERSON
Special to
The Sentinel-Record

The doctor pressed his scalpel against the soft skin of the upper chest. With a precise stroke, like thousands of others made over the years, he began the postmortem.

But this autopsy was more difficult. Before him on the stainless steel table lay the form of a slightly premature yet well-developed baby girl.

Found in a drainage ditch on April 28, the fetus had been aborted after nearly seven months in the womb. Because she had no identity, the pathologist and his staff called her Infant Doe.

Dr. Fahmy Malak, the state's chief medical examiner, had become calloused to the fact of death in his 30 years as a physician and pathologist. Besides the daily autopsies, he had been born and raised in Egypt where suffering and death were commonplace.

This case, however, was painful to him. The brown-eyed baby with velvet, ivory skin was just too new and fresh to be lifeless. There was no logic. And she reminded him of his own two children who had hugged him goodbye that morning.

"This was a beautiful little flower that will never hug anyone," he said. "She was a healthy, perfect little bud that was clipped before she could blossom."

Malak, whose once black hair is now flecked with strands of silver, also talked about how difficult it is for him whenever he finds any child on his autopsy table.

This infant had been brought to the State Crime Laboratory morgue late on the previous afternoon. An eight-year-old boy playing near his yard had discovered her wedged between two large rocks in a ditch that drains Cantrell Road.

Beer cans, paper sacks and other garbage were scattered around the baby. Little Rock policeman Jim McDaniel, the first officer on the scene, said it was among the worst sights he had seen in 13 years on the force. "It really tore me up," he said. "I have two kids of my own."

McDaniel speculated she had been tossed into the ditch somewhere upstream and had washed down with the other castoffs

A 20-inch-long umbilical cord trailed away from her stomach into the murky water. Her full head of auburn hair was drenched. Malak said her little body was still warm when he received it, indicating she had been dead only a few hours.

"Our society calls this baby a fetus instead of a person," said Malak. "But this child was alive and healthy inside the womb and was developed well enough to have survived outside the womb with a Caesarean section."

Three morgue technicians wearing white lab coats stood beside the autopsy table, watching and assisting as the pathologist performed his task. Malak's

See BABY on Page 10

THE SENTINEL-RECORD (Arkansas)
May 7, 1983

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BABY

From Page One

gloved hands swept back and forth in almost mechanical fashion across the opened body.

"She is 16 inches long and weighs five pounds," his distinctive voice was subdued.

"The arms are six and-a-half inches long.

"Her eyes are well developed with eyelashes fully formed.

"The gastrointestinal tract is well developed also."

It was the fifth and final autopsy of the day. But instead of hurrying to finish, Malak lingered over the fetus, almost as if to search for a way to make her whole again.

"This child could have been placed for adoption," he thought aloud. "She might have become a fine, productive person."

Finally, after examining and weighing each vital organ, Malak determined the infant died from asphyxiation in the womb due to an abortion.

She drowned from inhaling fluids after the embryonic sac was punctured.

Her death, Malak said, was acute as reflected by the massive congestion in most of her internal organs. "At first," he said, "the child jerked and fought desperately to fill her lungs with oxygen. She struggled tremendously to save her life.

"Then, as her lungs filled with fluids, the movements slowed and she suffocated. It was just like the asphyxiation of any baby."

Shortly afterwards, the fetus was expelled naturally from her mother. And the baby was called a "still birth."

"Some people might think it was the murder of a child," said Malak. "However, this infant was not considered to be a person in the legal sense. It does not matter, that she could have survived and that her heart had been beating for six months.

"It also does not matter that premature infants weighing only half as much as this little girl have survived in hospital incubators. This baby had not yet taken her first breath. And that's all that matters."

Since last year, Malak said he has autopsied at least 10 well-developed fetuses that were aborted in the final weeks before birth. "They were 10 coming lives that were snuffed out for someone else's convenience. Ten lives for which no one is assigned responsibility.

"Just for the record," he continued, "I am a Christian but not a Catholic and I'm not advocating anything except common sense.

"The question we need to answer for this little child is one of accountability for her life that was snuffed out. If we are to accept free love and sex, then we must begin to accept the responsibility that goes with it."

The U.S. Supreme Court has determined that a fetus is not considered a person and consequently no crime can be committed against a person who doesn't exist.

Up until 1969, when Arkansas' abortion statutes were enacted, the state did consider it a homicide to take the life of an unborn child that was moving inside the womb – a so-called "quick child."

But that law was repealed with the passage of the state's abortion laws.

In the sterile setting of Malak's domain, it is easy to see how a medical scientist can detach his feelings from the thousands of bodies he examines each year.

However, the pathologist said he has never felt closer to any victim than when he held the tiny heart of Infant Doe in his hand for a long moment before beginning to analyze it scientifically.

When the autopsy was over, a black bag was zipped tightly around her and she was placed in the morgue freezer.

She will remain frozen for up to six months while police search for the mother. Sources say busy authorities have never looked very long or hard for these people because, legally, there was no victim in a "still birth."

The mother could be prosecuted under the state's abortion laws, which make it a felony punishable by a $1,000 fine and a year in jail for aborting a child that is alive and moving inside the womb.

But Pulaski County's Chief Deputy Prosecutor Lloyd Haynes said his office has never prosecuted anyone under the abortion statute.

"Most of these mothers are terrified and destitute," he said. "They incite sympathy when you see them and there would be little to be gained by putting them in prison."

If police are unsuccessful, the taxpayers will pay to bury Infant Doe sometime next November.

Document #11

Bizarre cases of abortions gone awry

One case involves discovery of 17,000 aborted fetuses in a lab operator's back yard

This story contains graphic, possibly objectionable, descriptions. It reveals examples of abortions gone awry, doctors leaving viable fetuses to die, fetuses being used in medical experiments and fetal remains being used for commercial purposes. The story, by syndicated columnist Nick Thimmesch, raises questions of concern to people on both sides of the abortion issue and it cannot be told without citing certain specific incidents. Although some of these incidents are grotesque, the subject matter is too important to ignore.

By Nick Thimmesch

Since the Supreme Court decision of 1973 virtually permitting abortion on demand, American women have undergone this operation 10 million times. While most abortions are performed without discernible incident, thousands wind up traumatically. Some lead to shocking stories.

One such story involving the outcome of abortion surfaced recently in Los Angeles. The Los Angeles County Attorney's office deals with many unusual situations, but none more extraordinary than its current investigation of the 17,000 fetuses found at the home of a former medical laboratory operator.

District Attorney John Van de Kamp, under fire from anti-abortion groups, ordered a one-by-one visual examination of the fetuses to determine whether criminal abortion charges should be filed.

The case has become an issue in at least one state political campaign, and the controversy is expected to intensify since President Reagan wrote an anti-abortion official, saluting him for plans to hold memorial services "for these children." Reagan also wrote: "The terrible irony about this sudden discovery is not that so many lives were legally aborted, but that they are only a tiny proportion of the 1.5 million unborn children quietly destroyed in our nation each year. This is a truth many would rather not face."

The story was startling enough when officials reported in February that an estimated 1,000 fetuses had been found in an 8-by-20-foot steel container in the back yard of Malvin R. Weisberg, operator of a pathology laboratory in Santa Monica that had closed because of financial difficulties.

According to Nick Martin, who sold the container to Weisberg in October 1980, Weisberg was $1,700 behind in his payments. So on Feb. 4, 1982, Martin sent workmen to repossess it. According to one employee, Hank Stolk, the container weighed at least 11,000 pounds and was difficult to lift by winch onto a truck trailer. Empty, the container weighed 4,000 pounds. When Stolk and fellow workmen got the container to the company lot, they began unloading the cartons and boxes inside. One box was dropped, Stolk said, and parts of a small body spilled out.

Ron Gillett, forklift operator, said in a newspaper interview: "I saw one fetus with legs 2½ and 3 inches long, and the body and head were demolished. I was scared and had tears in my eyes. What else can you say?" Stolk told reporters the workmen couldn't continue because of the stench. Medical investigators who came to the scene wore respirators, but only opened a small number of the boxes.

According to Al Albergate, spokesman for Van de Kamp's office, "The original estimate was low because not enough boxes were opened. It was a very unpleasant job." Two weeks after the initial find, another 400 fetuses were discovered inside Weisberg's house. By now, Van de Kamp's office was trying to determine which laws, if any, had been violated in this case.

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An assistant coroner was quoted as saying, "There is no evidence of foul play, but there could be violations of the health code covering the disposal of medical waste."

The collection of fetuses found in Weisberg's container was interspersed with other "medical waste" — cancerous growths from operations, material from Pap smears and other lab specimens. They had been sent to Weisberg's laboratory by doctors, clinics and hospitals from half a dozen states. Some had been in storage three years. Some of the fetuses were egg-size. At least 42, according to the coroner's office, were 4 to 5 pounds in size, and at least 20 weeks old when aborted. Five to seven, officials said, were considerably more developed, possibly to the point they could have lived.

Albergate said autopsies on five to seven fetuses indicated that they could have been viable outside the womb, thus raising the possibility of charges being filed for criminal abortion.

Many perplexing questions remain unanswered about the Weisberg find. What is clear, however, is that the sheer volume of abortions in the United States (1.5 million in 1981) can create consequent problems. There are even cases of the commercial use of fetal materials. Moreover, since the National Center for Health Statistics lists abortion as the most common surgical procedure in the United States, it is inevitable that some go wrong and the unborn child that the mother assumed would be aborted, is born live.

Late one September night in 1979, according to The Philadelphia Inquirer, a woman's scream caused nurses to rush to Room 4456 at the University of Nebraska Medical Center in Omaha. There, a patient, instead of delivering a mass of dead tissue from a saline abortion, had given birth to a 2½-pound baby boy who was crying and moving his arms and legs. One nurse put the infant in bed covers and ran with it — not to the intensive-care nursery — but to the maternity unit's Dirty Utility Room where bed pans were emptied and dirty linen stored. She put the baby on the steel drain board of the sink.

Other nurses and a resident doctor stood by. Finally, the head nurse phoned the patient's physician, Dr. C.J. LaBenz, at home. The nurse testified later: "He told me to leave it where it was. Just to watch it for a few minutes, and that it would probably die in a few minutes."

The baby boy did die. Two counts of criminal bortion were filed against LaBenz, but the case as been delayed in the courts and has not been ecided.

Just as abortion has become "routine," so have uch cases as the Omaha baby. Recently, a story roke in the Torrance (Calif.) Daily Breeze that an Vicente Hospital was being investigated for llegedly allowing a live fetus from a late-term bortion to be immersed in a jar of formaldehyde.

A hospital technician stated in an affidavit filed rith the Los Angeles County Department of Health Services that she saw another technician take a noving, live fetus, and put it in the jar.

Health Department records state that the first echnician "could not believe the doctor would not ttempt to resuscitate the fetus." He didn't. The nale fetus was estimated to be from six to seven nonths developed. The fetus died. The case is still being investigated.

In July 1974, at West Penn Hospital in Pennsylvania, a doctor performed an abortion on a woman who contended that she had been raped — a claim later disputed. Another hospital had turned down her request for abortion after her pregnancy was estimated at 26 to 31 weeks along. But at West Penn, she was aborted with an injection of prostaglandin, a drug that stimulates muscle contraction.

The delivery of her fetus was filmed for instructional use, but the film was never used for those purposes. It was destroyed, on orders of hospital authorities, after being shown once in a coroner's inquest. The film showed a 3-pound infant moving and gasping. Later, a nurse and a medical student testified that they had noticed signs of life. The baby died. No charges were filed.

In February 1975, Dr. Kenneth Edelin was convicted in Boston of manslaughter. Witnesses stated that he held down a 24-week fetus he was trying to abort in a fashion constricting the flow of oxygen through the umbilical cord, thus smothering the baby. The Massachusetts Supreme Court overturned his conviction on a technicality.

An even more gruesome case involved Dr. William Waddill and a baby girl born in Westminster, Calif., Community Hospital in March 1977. The baby was born live after a late-term saline abortion, and Waddill was called back to the hospital.

According to testimony given in Santa Ana Superior Court in January 1978, Waddill stopped a nurse trying to help the baby breathe. Waddill had been charged with murder by the Orange County District Attorney's office after a Westminster police investigation of the baby girl's death. A fellow doctor also testified that he saw Waddill choke the infant while complaining: "I can't find the . . . trachea. This baby won't stop breathing." After two deadlocked jury trials, charges against Waddill were dismissed.

There are many people alive today who were once thought to be aborted. A nursing supervisor in Florida told Rick Edmund of The Philadelphia Inquirer that in the mid-'70s an aborted fetus was dumped into a bed pan — a standard practice. "It did not die," she said. "It was there one hour before signs of life were noticed." This infant weighed slightly more than 1 pound, was given excellent care, and was adopted. At last report, the child was 6 years old, "riding a bicycle and playing a little piano."

In the spring of 1979, according to The Philadelphia Inquirer investigation, two babies were born alive within five weeks at the Wilmington, Del., Medical Center after saline abortions. A nurse discovered one was struggling to breathe and had a faint heartbeat after being put in a specimen jar. The other was breathing when delivered and was immediately helped. Both were given special care and were adopted.

The line between life and death can be rather fine at times in abortions. Nurses and doctors, time after time, have described the anguish they felt when an abortion went wrong, and the baby lived. If the baby survives, and leaves the hospital healthy, there is a great feeling of relief among medical people.

When abortions are carried out as planned, however, the procedure is usually regarded as routine. Hospitals generally regard aborted fetuses as "medical waste" and incinerate them with hospital garbage about three weeks after the abortions.

There was an exception to this practice that made news in 1976. Dr. Sophie Perry, director of the Department of Pathology at the District of Columbia General Hospital, revealed to the press that employees of that department had collected more than $68,000 from commercial firms for organs of stillborn and dead premature babies, some from "late-term elective abortions." A hospital official later admitted that the earnings were used to buy a television set for the lounge, to cover expenses for physicians attending conventions, and for soft drinks and cookies for visiting professors.

Fetal materials have value. Last April, guards at the Swiss-French border intercepted a truck loaded with frozen human fetuses destined for French cosmetic laboratories. This was reported in Gazette du Palais, a reputable legal journal, which explained that there was a busy trade in fetal remains for "beauty products used in rejuvenating the skin, sold in France at high prices." Officials of several leading U.S. cosmetic firms and a spokesman for that industry make assurances that fetal materials are not used in American cosmetic products.

According to a Food and Drug Administration announcement in 1980, fetal lung tissues have been approved as the key ingredient in a new vaccine against human rabies. The vaccine is distributed by the Merieux Institute in Miami, which gets its fetal material from Britain. And, in 1977, the Environmental Protection Agency acknowledged that an Ohio medical research company tested the brains, hearts and other organs of nearly 100 fetuses as part of a $300,000 pesticide research project for the EPA.

There has been a hushed debate for years in medical circles about non-therapeutic research on human fetuses in the second and third trimesters of pregnancy — fetuses destined for abortion. Finally, in June 1979, Joseph Califano, then-secretary of the Department of Health, Education and Welfare, approved such research with clear-cut restrictions. The Califano directive emphasized the research benefits from prenatal diagnosis through fetoscopy and fetal blood sampling.

Earlier reports of experimentation were grotesque. According to testimony by an anesthetist at the Magee-Women's Hospital in Pittsburgh, taken by the Pennsylvania Abortion Commission in 1972: "It was repulsive to watch live fetuses being packed in ice while still moving and trying to breathe, then being rushed to a laboratory."

In 1972, there was also testimony that a doctor at Stanford University included "slicing open the rib cage of a still-living human fetus in order to observe the heart action," as part of an experiment.

Science magazine reported in 1965 that a medical team kept human fetus brains alive for five months. Medical World News reported on June 8, 1973, that Dr. Peter Adam, a professor at Case Western Reserve University, had performed an experiment at the University of Helsinki, Finland, where he cut off the heads of live babies delivered by Caesarean section. He attached the heads to a machine that pumped chemicals through the brains of the severed heads. The American Journal of Obstetrics and Gynecology reported in January 1974 that live, beating hearts of embryos and fetuses up to 15 weeks old were removed for experimentation at the University of Szeged in Hungary.

There is a possibility of personal exploitation of fetuses. In 1978, the Hastings Center report issued by the Institute of Society, Ethics and Life in New York told of a 28-year-old engineer who considered getting his wife pregnant so she could have an abortion — to improve his deteriorating health. The engineer had lost the use of his kidneys and he desperately needed a kidney transplant. But since he was an orphan, he had no known close relatives who could have been compatible donors. So his wife volunteered to become pregnant, and abort the baby after five or six months. Though their surgeon said the operation was technically feasible, the surgeon decided not to go ahead with it for moral reasons.

This kind of question will be raised with increasing frequency as medical technolgoy advances. Physicians can do far more testing with the unborn today than even five years ago. Indeed, fetal surgery is already a fact, and fetal experimentation seems to have unlimited possiblities.

Moreover, since the Food and Drug Administration has no specific regulations forbidding commercial use of fetal materials, some entrepreneurs may find applications for these materials, just as the French cosmetics industry has.

Whatever a person's view on abortion, more and more questions concerning fetal life and death are going to be raised. There will likely be considerable controversy and anguished decisions.

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ABORTION

Although abortions remain one of the major ethical controversies of our time, the fact is that an abortion has become the most common medical procedure performed on adults in the United States. More than a million and a half fetuses are aborted annually, and the number has increased about 50 percent from five years ago. At present, approximately one out of every four pregnancies is terminated by an abortion. American doctors remove more fetuses than tonsils.

But despite the intense attention the subject has received and the frequency with which the procedure is performed, something happens in a very small number of abortions, performed relatively late in the pregnancy, that no one wants to talk about. It horrifies many of the medical personnel who have encountered it.

What happens is that about once a day, somewhere in the U.S., something goes wrong and an abortion results in a *live baby*.

THE PHILADELPHIA INQUIRER
August 2, 1981

Document #12

The Dreaded Complication

Reprinted by permission of
The Philadelphia Inquirer, August 2, 1981,
and co-author, Liz Jeffries

By LIZ JEFFRIES and RICK EDMONDS

A woman's scream broke the late-night quiet and brought two young obstetrical nurses rushing to Room 4456 of the University of Nebraska Medical Center. The patient, admitted for an abortion, had been injected 30 hours earlier with a salt solution, which normally kills the fetus and causes the patient to deliver a mass of lifeless tissue, in a process similar to a miscarriage.

This time, though, something had gone wrong. When nurse Marilyn Wilson flicked on the lights and pulled back the covers, she found, instead of the stillborn fetus she'd expected, a live 2½-pound baby boy, crying and moving his arms and legs there on the bed.

Dismayed, the second nurse, Joanie Fuchs, gathered the squirming infant in loose bedcovers, dashed down the corridor and called to the other nurses for help. She did not take the baby to an intensive care nursery, but deposited it instead on the stainless steel drainboard of a sink in the maternity unit's Dirty Utility Room — a large closet where bedpans are emptied and dirty linens stored. Other nurses and a resident doctor gathered and gaped.

Finally, a head nurse telephoned the patient's physician, Dr. C.J. LaBenz, at home, apparently waking him.

"He told me to leave it where it was," the head nurse testified later, "just to watch it for a few minutes, that it would probably die in a few minutes."

This was in Omaha, in September 1979. It was nothing new. Hundreds of times a year in the United States, an aborted fetus emerges from the womb kicking and alive. Some survive. A baby girl in Florida, rescued by nurses who found her lying in a bedpan, is 5 years old now and doing well. Most die. The Omaha baby lasted barely 2½ hours after he was put in the closet with the dirty linen.

Always, their arrival is met with shock, dismay and confusion.

When such a baby is allowed to die and the incident becomes known, the authorities often try to prosecute the doctor. This has happened several dozen times in the past eight years, most recently in the case of Dr. LaBenz, who is to go on trial in Omaha this fall on two counts of criminal abortion. But interviews with nurses, some of them visibly anguished, uncovered dozens of similar cases that never reached public attention.

In fact, for every case that does become known, a hundred probably go unreported. Dr. Willard Cates, an expert on medical statistics who is chief of abortion surveillance for the Center for Disease Control in Atlanta, estimates that 400 to 500 abortion live births occur every year in the United States. That is only a tiny fraction of the nation's 1.5 million annual abortions. Still, it means that these unintended live births are literally an everyday occurrence.

They are little known because organized medicine, from fear of public clamor and legal action, treats them more as an embarrassment to be hushed up than a problem to be solved. "It's like turning yourself in to the IRS for an audit," Cates said. "What is there to gain? The tendency is not to report because there are only negative incentives."

One result of the medical community's failure to openly acknowledge the problem is that many hospitals and clinics give their staffs no guidelines for dealing with abortion live births. Even where guidelines exist, they may not be followed. The doctor is seldom present when a live birth occurs, because most late abortions — those done later than the midpoint of pregnancy — are performed by the injection of a solution (the method used in the Omaha case) that slowly induces delivery of the fetus many hours later. Crucial decisions therefore fall to nurses and physician residents with secondary authority over the case.

Signs of life in the baby may or may not be recognized. At some hospitals a live-born abortion baby is presumed dead unless it conspicuously demonstrates otherwise, by crying or waving its arms and legs. Even then, the medical personnel on the scene may let the baby die rather than try to save it.

Because they are premature, these infants need immediate care, including machine support, in order to live. Given such care, many can survive in good health, as did a pair of abortion babies born in separate incidents in Wilmington, Del., in the spring of 1979 and since adopted. Others are too premature to be saved even with the best care.

Whether they live or die, these abortion live births — and even successful, routine abortions of late-term, highly developed fetuses — are taking a heavy emotional toll on medical staffs across the country. Some physicians say they have "burned out" and have stopped doing abortions altogether. Nursing staffs at hospitals in Cleveland, Grand Rapids, Fort Lauderdale and elsewhere have rebelled at late abortions and have stopped their hospitals from performing any abortions later than the midpoint of pregnancy. Some staff members who regularly perform late abortions report having nightmares about fetuses, including recurring dreams in which they frantically seek to hide fetuses from others.

In legalizing abortion in 1973, the Supreme Court said it was reserving the right to protect the life of a viable fetus — that is, one with the potential to survive outside the womb. But the court never directly acknowledged the chance of an aborted fetus' being born alive. And it therefore never gave a clear guideline for dealing with what Dr. Thomas Kerenyi, a leading New York expert on abortions, has called "the dreaded complication."

Twenty states (including Pennsylvania, New Jersey and Delaware) have no laws limiting late abortions or mandating care for live-born abortion babies. Even where such state laws exist, they have usually been found unenforceable in practice or unconstitutional.

"Everyone — doctors, attorneys, state legislators — is looking for some clear guidelines concerning disposition of these infants," said Newman Flanagan, district attorney for the City of Boston. "If a baby has rejected an abortion and lives, then it is a person under the Constitution. As such, it has a basic right to life. Unfortunately, it is difficult to protect that right, because there are no guidelines addressed to this specific issue."

Medical trends indicate that abortion live births will continue. They may even become more frequent. For one thing, demand for late-term abortions is undiminished, and with the growing popularity of genetic testing to screen for fetal defects midway through pregnancy, educated and affluent women are now joining the young, the poor and the uninformed who have been, until now, the main groups seeking late abortions.

Furthermore, estimating the gestational age of a fetus in the womb — a crucial aspect of a successful abortion — remains an inexact art. In March, doctors at the Valley Abortion Clinic in Phoenix estimated that one woman was 19 to 20 weeks pregnant; days later she delivered not an aborted fetus but a 2½-pound, 32-week baby. It survived after two months of intensive care at a Phoenix hospital.

Finally, medical science in the past 10 years has greatly improved its ability to care for premature babies. Infants are becoming viable earlier and earlier. Those with a gestational age of 24 weeks and weighing as little as 1½ pounds can now survive if given the best of care.

So long as doctors perform abortions up to the 24th week of pregnancy (as is legal everywhere in the United States under the 1973 Supreme Court ruling), it is statistically certain that some of these borderline cases will turn out to be viable babies, born alive. It happened again last May in Chicago — a 19-to-20-week estimate, a live-born 2-pound baby boy.

LIZ JEFFRIES is a free-lance writer based in Southern California.

RICK EDMONDS is a staff writer for The Inquirer.

When a crying baby emerges instead of a lifeless fetus, doctors have a problem with no easy answer.

Lennart Nilsson's remarkable photo of a human baby in its mother's womb just 18 weeks after conception.

By ignoring the problem of abortion live births, the courts and the medical establishment are choosing to overlook a long, well-documented history of cases: *January 1969*, Stobhill Hospital, Glasgow, Scotland: A custodian heard a cry from a paper bag in the snow beside an incinerator. He found a live baby. It was taken inside and cared for in the hospital's operating theater but died nine hours later. The infant's gestational age had been estimated at 26 weeks by the physician performing the abortion. It was actually closer to 32 weeks. No efforts were made to check for signs of life before the aborted baby was discarded. No charges were filed. Because the case had been written about in British medical journals, it was a matter of record — before abortion was legalized in this country — that such things could happen.

April 1973, Greater Bakersfield Hospital, Bakersfield, Calif.: A 4½-pound infant was born live following a saline abortion (induced by an injection of salt solution) performed by Dr. Xavier Hall Ramirez. Informed by phone, Dr. Ramirez ordered two nurses to discontinue administering oxygen to the baby. His instructions were countermanded by another doctor; the baby survived and later was placed for adoption. Ramirez was indicted for solicitation to commit murder. His attorney argued that a medical order based on medical opinion, no matter how mistaken, is privileged. Dr. Irvin M. Cushner of the University of California at Los Angeles, later to become a top health policy official in the Carter administration, testified that it was normal for Ramirez to expect the delivery of a dead or certain-to-die infant as the result of a saline abortion.

July 1974, West Penn Hospital, Pittsburgh: Dr. Leonard Laufe performed an abortion on a woman who contended she had been raped — though that and her account of when she became pregnant were later disputed. She had been turned down for an abortion at another hospital, where the term of her pregnancy was estimated at 26 to 31 weeks. Laufe put it at 20 to 22. The abortion, induced by an injection of prostaglandin, a substance that stimulates muscle contraction and delivery of the fetus, was filmed for use as an instructional film. The film showed the three-pound infant moving and gasping. Also, a nurse and a medical student testified that they had noticed signs of life. No charges were filed, however, after a coroner's inquest at which Laufe testified that the infant sustained fatal damage during delivery.

February 1975, Boston: Dr. Kenneth Edelin was convicted of manslaughter for neglecting to give care to a 24-week infant after a 1973 abortion at Boston City Hospital. Witnesses said Edelin held the infant down, constricting the flow of oxygen through the umbilical cord and smothering it. He was the first and only American doctor ever convicted on charges of failing to care for an infant born during an abortion. The conviction was overturned by the Massachusetts Supreme Court on the ground that improper instructions had been given to the jury. Edelin and his lawyer argued that he had taken no steps to care for the infant because it was never alive outside the womb.

March 1977, Westminster Community Hospital, Westminster, Calif.: A seven-month baby girl was born live after a saline abortion performed by Dr. William Waddill. A nurse testified that Waddill, when he got to the hospital, interrupted her efforts to help the baby's breathing. A fellow physician testified that he had seen Waddill choke the infant. "I saw him put his hand on this baby's neck and push down," said Dr. Ronald Cornelson. "He said, 'I can't find the goddam trachea,' and 'This baby won't stop breathing.' " Two juries, finding Cornelson an emotional and unconvincing witness, deadlocked in two separate trials. Charges against Waddill were then dismissed. He had contended the infant was dying of natural causes by the time he got to the hospital.

July 1979, Cedars-Sinai Medical Center, Los Angeles: Dr. Boyd Cooper delivered an apparently stillborn infant, after having ended a problem pregnancy of 23 weeks. Half an hour later the baby made gasping attempts to breathe, but no efforts were made to resuscitate it because of its size (1 pound 2 ounces) and the wishes of the parents. The baby was taken to a small utility room that was used, among other things, as an infant morgue. Told of the continued gasping, Cooper instructed a nurse, "Leave the baby there — it will die." Twelve hours later, according to testimony of the nurse, Laura VanArsdale, she returned to work and found the infant still in the closet, still gasping.

Cooper then agreed to have the baby boy transferred to an intensive care unit, where he died four days later. A coroner's jury ruled the death "accidental" rather than natural but found nothing in Cooper's conduct to warrant criminal action.

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A common thread in all these incidents is that life was recognized and the episode brought to light by someone other than the doctor. Indeed, there is evidence that doctors tend to ignore all but the most obvious signs of life in an abortion baby.

In the November 1974 newsletter of the International Correspondence Society of Obstetricians and Gynecologists, several doctors addressed a question from a practitioner who had written in an earlier issue that he was troubled by what to do when an aborted infant showed signs of life.

One was Dr. Ronald Bolognese, an ob-

stetrician at Pennsylvania Hospital in Philadelphia, who replied:

"At the time of delivery, it has been our policy to wrap the fetus in a towel. The fetus is then moved to another room while our attention is turned to the care of [the woman]. She is examined to determine whether complete placental expulsion has occurred and the extent of vaginal bleeding. Once we are sure that her condition is stable, the fetus is evaluated. Almost invariably all signs of life have ceased."

(Bolognese recanted that statement in a 1979 interview. "That's not what we do now," he said. "We would transport it to the intensive care nursery.")

In addition, Dr. William Brenner of the University of North Carolina Medical School suggested that if breathing and movement persist for several minutes, "the patient's physician, if he is not in attendance, should probably be contacted and informed of the situation. The pediatrician on call should probably be apprised of the situation if signs of life continue."

Dr. Warren Pearse, executive director of the American College of Obstetrics and Gynecology, was asked in a 1979 interview what doctors do, as standard practice, to check whether an aborted fetus is alive.

"What you would do next [after expulsion] is nothing," Pearse said. "You assume the infant is dead unless it shows signs of life. You're dealing with a dead fetus unless there is sustained cardiac action or sustained respiration — it's not enough if there's a single heartbeat or an occasional gasp."

These seemingly callous policies are based on the assumption that abortion babies are too small or too damaged by the abortion process to survive and live meaningful lives. That is not necessarily the case, though, even for babies set aside and neglected in the minutes after delivery.

A nursing supervisor who asked not to be identified told of an abortion live birth in the mid-'70s in a Florida hospital. The infant was dumped in a bedpan without examination, as was standard practice. "It did not die," the nurse said. "It was left in the bedpan for an hour before signs of life were noticed. It weighed slightly over a pound."

The baby remained in critical condition for several months, but excellent care in a unit for premature infants enabled it to survive. The child, now 5 years old, was put up for adoption. The nursing supervisor, who has followed its progress, said she has pictures of the youngster "riding a bicycle and playing a little piano."

In the spring of 1979 two babies were born live, five weeks apart, after saline abortions at the Wilmington Medical Center. They were given vigorous care, survived and were later adopted. One had been discovered by a nurse, struggling for breath and with a faint heartbeat, after having been placed in a plastic specimen jar. The second was judged to be a live delivery and was given immediate help breathing.

A baby girl, weighing 1 pound 11 ounces, was born in February 1979 after a saline abortion at Inglewood (Calif.) Hospital. Harbor General Hospital, which is associated with UCLA and is fully equipped to care for premature babies, was called for help, but the neonatal rescue team did not respond. The infant died after three hours.

The Los Angeles Department of Health Services investigated and was told that there had been confusion over the baby's weight and that it reportedly showed poor vital signs. It was "very unusual for them not to pick up [an infant] of this size," Dr. Rosemary Leake of Harbor General told investigators.

The administrator of a New York abortion unit, asked what would be done for a live-born abortion baby, said, "The nurses have been trained in how to handle this. I'd like to think we would do everything to save it. But honestly I'm not sure."

These incidents together suggest that life in an aborted infant may or may not be recognized. If it is, supportive treatment may or may not be ordered.

Such incidents, when discovered, often provoke prosecutions. A few may seem something like murder at first blush. But on closer inspection the doctors' actions have been judged, time and again, not quite to fit the definition of a crime.

Nowhere was this more vividly shown than in the case of Dr. Jesse J. Floyd, who was indicted on charges of murder and criminal abortion by a grand jury in Columbia, S.C., in August 1975. The charges were the result of an abortion a year earlier of a baby that appeared to have a gestational age of 27 to 28 weeks. It weighed 2 pounds 5 ounces and lived for 20 days.

In October 1979 the state dropped its

Dr. Willard Cates, chief of abortion surveillance for the Center for Disease Control.

Reporting abortion live births is "like turning yourself in to the IRS for an audit. What is there to gain?"

case against Floyd County prosecutor James C. Anders later conceded in an interview that South Carolina's abortion law was of dubious constitutionality. "In the second place," he said, "I had a reluctant witness [the infant's mother]. That and the passage of time worked against me."

A detailed record was developed in the case, as part of a federal suit that Floyd brought against Anders in which he sought to block the state prosecution. The 20-year-old mother, Louise A., lived in the small town of Hopkins, worked at a military-base commissary and had plans to enroll in a technical college. Those plans made her unwilling to have the baby she was carrying, so she presented herself for an abortion at Floyd's office in July 1974. Court records indicate that she had been told erroneously by her hometown doctor's nurse that she was not pregnant, and that she only slowly realized that she was.

Floyd found her to be past the first trimester of pregnancy, and under South Carolina law that meant an in-hospital abortion would be required. There were delays in her raising $450 for the abortion and more delays in admitting her to Richland Memorial Hospital. She was injected with prostaglandin on Sept. 4 and expelled the live baby early on the morning of Sept. 6.

"I started having real bad labor pains again," Louise recalled in her deposition, "and finally my baby was born. I called the nurse. Then about four or five of them came in the room at the time. The head nurse came in the same time the other nurses came in and she told me did I know that the baby was a seven-month baby. I told her no.

"One of the nurses said that the baby was alive. They took the baby out of the room. He never did cry, he just made some kind of a noise."

The first doctor on the scene, paged from the cafeteria, was a young resident. She did not hesitate. On detecting a heartbeat of 100, she clamped and severed the umbilical cord and had the baby sent to the hospital's intensive care unit.

"It was a shock, a totally unique emergency situation, very upsetting to all of us," the doctor, who now practices in California, said in an interview. "Some people have disagreed with me [about ordering intensive care for an abortion live birth] but that seems to me the only way you can go.

"It's like watching a drowning. You act. You don't have the luxury of calling around and consulting. You institute life-preserving measures first and decide about viability later on."

Ten days after birth, the baby had improved markedly and was given a 50-50 chance of survival. Then he developed a tear in the small intestine and died of that and other complications on Sept. 26.

Louise A. never saw the child. She checked out of the hospital two days after the abortion and did not return. But she did show a passing interest in the baby's progress.

"I kept calling this nurse," Louise said in her deposition. "I would call . . . and get information from them about the baby, and they told me he was doing fine. They told me he had picked up two or three pounds. I started going to school, and one afternoon I called home and they told me the baby had died, but no one told me the cause of his death."

Floyd never saw the infant either. On the day of the abortion, his hospital privileges at Richland were withdrawn, and they have never been restored.

These circumstances presented prosecutor Anders with a difficult case. Floyd had had no physical contact with the live-born

Dr. Thomas F. Kerenyi, a New York expert on abortions.

"You have to have a feticidal dose" of saline solution. "It's almost a breach of contract not to. Otherwise, what are you going to do — hand her back a baby having done it questionable damage?"

infant, nor was he issuing orders concerning its care. Nonetheless, Anders thought the doctor could be held responsible for the infant's death.

Anders pressed his murder charge using an old English common-law theory. Under this theory, willfully doing damage to a "vital" infant in the womb could be considered a crime against the fetus as a person. The abortion itself, Anders alleged, was an assault.

This line of argument is not entirely far-fetched. For instance, a Camden, N.J., [illegible] convicted of murder in 1975 after he shot a woman in the abdomen late in her pregnancy, causing the death of the twins she was carrying. But application of the theory to abortion had never been tested — in South Carolina or anywhere else.

South Carolina law in the mid-1970s prohibited third-trimester abortion unless two other doctors certified that the abortion was essential to protect the life or health of the mother. No such certifications were made for Louise. However, various Supreme Court rulings suggested that both the requirement of consultation with other doctors and the explicit definition of viability (as beginning in the third trimester) would make that law unconstitutional.

Floyd's lawyers, George Kosko of Columbia, S.C., and Roy Lucas of Washington, also filed voluminous expert affidavits on the difficulty of estimating gestational age accurately. At worst, they argued, Floyd had made a mistaken diagnosis. What proof was there that he had intentionally aborted a viable baby?

District Court Judge Robert Chapman and the Fourth Circuit Court of Appeals agreed that the prosecution was based on flimsy evidence and should be blocked. However, the Supreme Court disagreed, in a ruling in March 1979, and suggested that judgment should be withheld on constitutional matters until the state prosecution had run its course. The way was thus cleared for Anders to proceed, but with witnesses dispersed, memories fading and the legal basis for prosecution still doubtful, Anders chose to drop the case.

Floyd, 49, continues performing first-trimester abortions at his Ladies Clinic, but the loss of hospital privileges and the damage to his reputation caused his surgical practice to collapse, he said.

The long legal proceeding also seems to have had a chilling effect on abortion practice throughout South Carolina, which Anders concedes was one of his intentions.

"The main thing is the dilemma it puts the other physicians in," Floyd said in an interview. "It's just about dried up second-trimester abortions in this state. I have to send mine to Atlanta, Washington or New York."

Asked about late abortions and the risk of live births, Floyd said he thought abortions performed through the sixth month of pregnancy create "a problem to which there isn't an answer. We probably need to move back to 20 weeks. I would be reluctant to do one now after 20 weeks."

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A similar case occurred about the same

time in South Carolina, when Anders obtained a criminal indictment charging Dr. Herbert Schreiber of Camden, S.C., with first-degree murder and illegal abortion.

On July 18, 1976, a month after the charges had been filed, the 60-year-old doctor was found dead in a motel room in Asheville, N.C. A motel maid discovered the body slumped in a chair. Several bottles of prescription drugs were recovered from the room. Two days later the Buncombe County medical examiner ruled the death a suicide from a drug overdose.

Schreiber, who left no note, had pleaded not guilty to the charge of having killed a live baby girl after an abortion by choking or smothering her to death.

Comparing the Floyd and Schreiber cases, Anders found an irony: Schreiber "just reached in and strangled the baby," the prosecutor said his evidence showed. "I charged him with murder, and he committed suicide. If he had been willing to wait, he probably would have been OK too."

Not every doctor who performs a late abortion has to confront an aggressive prosecutor like Anders. But even those abortion live births that escape public notice raise deeply troubling emotions for the medical personnel involved. "Our training disciplines you to follow the doctor's orders," explained a California maternity nurse. "If you do something on your own for the baby that the doctor has not ordered and that may not meet with his commitment to his patient, the mother can sue you. A nurse runs a grave risk if she acts on her own. Not only her immediate job but her license may be threatened."

Nonetheless, nursing staffs have led a number of quiet revolts against late abortions. Two major hospitals in the Fort Lauderdale area, for instance, stopped offering abortions in the late 1970s after protests from nurses who felt uncomfortable handling the lifelike fetuses.

A Grand Rapids, Mich., hospital stopped late-term abortions in 1977 after nurses made good on their threat not to handle the fetuses. One night they left a stillborn fetus lying in its mother's bed for an hour and a half, despite angry calls from the attending physician, who finally went in and removed it himself.

In addition, a number of hospital administrators have reported problems in mixing maternity and abortion patients — the latter must listen to the cries of newborn infants while waiting for the abortion to work. And it has proved difficult in general hospitals to provide round-the-clock staffing of obstetrical nurses willing to assist with the procedure.

Newman Flanagan, district attorney for the City of Boston.

"If a baby has rejected an abortion and lives, then it is a person under the Constitution. . . ."

One young nurse in the Midwest, who quit to go into teaching, remembers "a happy group of nurses" turning nasty to each other and the physicians because of conflicts over abortion. One day, she recalled, a woman physician "walked out of the operating room after doing six abortions. She smeared her hand [which was covered with blood] on mine and said, 'Go wash it off. That's the hand that did it.' "

Several studies have documented the distress that late abortion causes many nurses. Dr. Warren M. Hern, chief physician, and Billie Corrigan, head nurse, of the Boulder (Colo.) Abortion Clinic, presented a paper to a 1978 Planned Parenthood convention entitled "What About Us? Staff Reactions. . . ."

The clinic, one of the largest in the Rocky Mountain states, specializes in the D&E (dilatation and evacuation) method of second-trimester abortion, a procedure

in which the fetus is cut from the womb in pieces. Hern and Corrigan reported that eight of the 15 staff members surveyed reported emotional problems. Two said they worried about the physician's psychological well-being. Two reported horrifying dreams about fetuses, one of which involved the hiding of fetal parts so that other people would not see them.

"We have produced an unusual dilemma," Hern and Corrigan concluded. "A procedure is rapidly becoming recognized as the procedure of choice in late abortion, but those capable of performing or assisting with the procedure are having strong personal reservations about participating in an operation which they view as destructive and violent."

Dr. Julius Butler, a professor of obstetrics and gynecology at the University of Minnesota Medical School, is concerned about studies suggesting that D&E is the safest method and should be used more widely. "Remember," he said, "there is a human being at the other end of the table taking that kid apart.

"We've had guys drinking too much, taking drugs, even a suicide or two. There have been no studies I know of of the problem, but the unwritten kind of statistics we see are alarming."

"You are doing a destructive process," said Dr. William Benbow Thompson of the University of California at Irvine. "Arms, legs, chests come out in the forceps. It's not a sight for everybody."

Not all doctors think the stressfulness is overwhelming. The procedure "is a little bit unpleasant for the physician," concedes Dr. Mildred Hanson, a petite woman in her early 50s who does eight to 10 abortions a day in a clinic in Minneapolis, just a few miles across town from where Butler works. "It's easier to ... leave someone else — namely a nurse — to be with the patient and do the dirty work.

"There is a lot in medicine that is unpleasant" but necessary — like amputating a leg — she argues, and doctors shouldn't let their own squeamishness deprive patients of a procedure that's cheaper and less traumatic.

However, Dr. Nancy Kaltreider, an academic psychiatrist at the University of San Francisco, has found in several studies "an unexpectedly strong reaction" by the assisting staff to late-abortion procedures. For nurses, she hypothesizes, handling tissues that resemble a fully formed baby "runs directly against the medical emphasis on preserving life."

The psychological wear-and-tear from doing late abortions is obvious. Philadelphia's Dr. Bolognese, who seven years ago was recommending wrapping abortion live-borns in a towel, has stopped doing late abortions.

"You get burned out," he said. Noting that his main research interest is in the management of complicated obstetrical cases, he observed: "It seemed kind of schizophrenic, to be doing that on the one hand [helping women with problem pregnancies to have babies] and do abortions."

Dr. John Franklin, medical director of Planned Parenthood of Southeastern Pennsylvania, was the plaintiff in a 1979 Supreme Court case liberalizing the limits on late abortions. He does not do such procedures himself. "I find them pretty heavy weather both for myself and for my patients," he said in an interview.

Dr. Kerenyi, the New York abortion expert, who is at Mt. Sinai Hospital, has similar feelings but reaches a different conclusion. "I first of all take pride in my deliveries. But I've seen a lot of bad outcomes in women who did not want their babies — so I think we should help women who want to get rid of them. I find I can live with this dual role."

The legal jeopardy, the emotional strain, the winking neglect with which "signs of life" must be met — all these things nurture secrecy. Late abortions take place "behind a white curtain," as one prosecutor put it, well sheltered from public view.

Only one large-scale study has been done of live births after abortions — by George Stroh and Dr. Alan Hinman in upstate New York from July 1970 through December 1972 (a period during which abortion was legal in New York alone). It turned up 38 cases of live births in a sample of 150,000 abortions.

Other studies, including one that found signs of life in about 10 percent of the prostaglandin abortions at a Hartford, Conn., hospital, date from the mid-1970s. No one is so naive as to think there is reliable voluntary reporting of live births in the present climate, according to Dr. Cates of the Center for Disease Control.

Evidence gathered during research for this story suggests, without proving definitively, that much of the traffic in late abortions now flows to the New York and Los Angeles metropolitan areas, where loose practice more easily escapes notice.

"The word has spread," the Daily Breeze, a small Los Angeles suburban paper, said in July 1980, "that facilities in greater Los Angeles will do late abortions. How late only the woman and the doctor who performs them know."

This kind of thing is disturbing even to some people with a strong orientation in favor of legal abortion. For instance, the Philadelphia office of CHOICE, which describes itself as "a reproductive health advocacy agency," will recommend only Dr. Kerenyi's service at Mt. Sinai among the half-dozen in New York offering abortion up to 24 weeks. The others have shortcomings in safety, sanitation or professional standards, in the agency's view.

An internal investigation of the abortion unit at Jewish Memorial Hospital in Manhattan showed that six fetuses aborted there in the summer of 1979 weighed more than 1⅓ pounds. The babies were not alive, but were large enough to be potentially viable. A state health inspector found in June 1979 that the unit had successfully aborted a fetus that was well over a foot long and appeared to be of 32 weeks gestation. Hospital officials confirmed in an interview that later in 1979 a fetus weighing more than four pounds had been aborted.

"It's disconcerting," Iona Siegel, administrator of the Women's Health Center at Kingsbrook Jewish Medical Center in Brooklyn, said of abortions performed so late that the infant is viable. When Ms. Siegel hears, as she says she often does, that a patient turned away by Kingsbrook because she was past 24 weeks of pregnancy had an abortion somewhere else, "that makes me angry. Number one, it's against the law. Number two, it's dangerous to the health of the mother."

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Though one might expect organized medicine to take a hand in bringing some order to the practice of late abortions, that is not happening.

"We're not really very pro-abortion," said Dr. Ervin Nichols, director of practice activities for the American College of Obstetrics and Gynecology. "As a matter of fact, anything beyond 20 weeks, we're kind of upset about it."

If abortions after 20 weeks are a dubious practice, how does that square with abortion up to 24 weeks being offered openly in Los Angeles and New York and advertised in newspapers and the Yellow Pages there and elsewhere?

"That's not medicine." Nichols replied. "That's hucksterism."

Cates, of the Center for Disease Control, concedes that he has ambivalent feelings about those who do the very late procedures. There is obviously some profiteering and some bending of state laws forbidding abortions in the third trimester. But since late abortions are hard to get legally in many places, Cates puts a low priority on trying to police such practices. Medical authorities leave the late-abortion practitioners to do what they will. And so, too, by necessity, do the legal authorities.

The Supreme Court framed its January 1973 opinion legalizing abortion around the slippery concept of viability. As defined by Justice Harry Blackmun in the landmark *Roe vs. Wade* case, viability occurs when the fetus is "potentially able to live outside the mother's womb albeit with artificial aid."

The court granted women an unrestricted right to abortions, as an extension to their right of privacy, in the first trimester of pregnancy. From that point to viability, the state can regulate abortions only to make sure they are safe. And only after a fetus reaches viability can state law limit abortion and protect the "rights" of the fetus.

Dr. John Franklin, medical director of Planned Parenthood of Southeastern Pennsylvania.

"I find [late abortions] pretty heavy weather both for myself and for my patients."

"Viability," Blackmun wrote, after a summer spent researching the matter in the library of the Mayo Clinic, "is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks."

The standard was meant to be elastic, changing in time with medical advances. Blackmun took no particular account, though, of the possibility of abortion live births, or of errors in estimating gestational age.

In subsequent cases, the high court ruled that:

- A Missouri law was too specific in forbidding abortion after 24 weeks. "It is not the proper function of the legislature or the court," Blackmun wrote, "to place viability, which essentially is a medical concept, at a specific point in the gestational period."
- A Pennsylvania law was too vague. The law banned abortions "if there is sufficient reason to believe that the fetus may be viable." The court said it was wrong to put doctors in jeopardy without giving them clearer notice of what they must do.
- State laws could not interfere with a doctor's professional judgment by dictating the choice of procedure for late abortions, or by requiring aggressive care of abortion live births.

According to a 1979 survey by Jeanie Rosoff of Planned Parenthood's Alan Guttmacher Institute, 30 states have laws regulating third-trimester abortions. Some of these laws prohibit or strictly limit abortions after the fetus has reached viability. Some require doctors to try to save abortion live-born babies. Only a few states have both types of laws.

In addition, a number of these laws have been found unconstitutional. Others obviously would be, in light of Supreme Court rulings. Virtually all the state laws would be subject to constitutional challenge if used as the basis of prosecution against an individual doctor.

New York and California, ironically, have among the strongest, most detailed laws mandating care for survivors of abortions. But these laws have proved only a negligible check on the abortion of viable babies.

"We've had a number of claims come up that a baby was born live and full effort was not given to saving it," said Dr. Michael Baden, former chief medical examiner of New York City. "We've not had cases of alleged strangulation [as with Dr. Waddill in California] and that surely must be rare. All [the doctor] has to do is nothing and the result is the same."

Alan Marrus, a Bronx County assistant district attorney, has investigated several

Dr. Sissela Bok, Harvard Medical School.

Dr. Bok and others have proposed two possible solutions: Prohibit late abortions or define the woman's abortion right as being only a right to terminate the pregnancy, not to have the fetus dead.

live-birth cases and the applicable New York law. He has yet to find "a case that presented us with facts that warranted prosecution. You need an expert opinion that in fact there was life and that the fetus would have survived. Often the fetus has been destroyed — so there is nothing for your expert witness to examine."

The incidents only come to light at all, Baden and Marrus noted, if some whistle-blower inside the hospital or clinic brings them to the attention of the legal authorities. The credibility of that sort of witness may be subject to attack. And even if the facts do weigh against a doctor, he has some resources left. Almost always he can claim to have made no more than a good-faith error in medical judgment.

"This is happening all over the place," said a California prosecutor. "Babies that should live are dying because callous physicians let them die." But he despairs of winning any convictions. "Nobody's as dumb as Waddill. They're smarter today. They know how to cover themselves."

Unfortunately, advances in medical technique may only aggravate the overall problem. Fetuses are becoming viable earlier and earlier, while the demand for later abortions shows no sign of abating. Some argue that Justice Blackmun's definition of viability as "usually seven months" was obsolete the day it was published. It clearly is now.

A decade ago, survival of an infant less than 3 pounds or 30 weeks gestation was indeed rare, principally because the lungs of smaller infants, unaided, are too undeveloped and fragile to sustain life. Now, infants with birth weights of about 1⅔ pounds routinely survive with the best of care, according to Dr. Richard Behrman, chief of neonatology at Rainbow Babies and Childrens Hospital in Cleveland and chairman of a national commission that studied viability in the mid-1970s.

Sometimes even smaller babies make it, and the idea that most of them will be retarded or disabled is out-of-date, Behrman said. "Most... survive intact."

Even with the medical advances, though, some live-born infants are simply too small and undeveloped to have a realistic chance to survive. A survey last year of specialists in neonatal care found that 90 percent would not order life-support by machine for babies smaller than 1 pound 2 ounces or less than 24 weeks gestation. And on occasion, a newborn may manifest muscular twitches or gasping movements without ever "being alive" according to the usual legal test of drawing a breath that fills the lungs.

Still, it is no longer a miracle for an infant of 24 weeks development (which can be legally aborted) to be saved if born prematurely.

"It is frightening," said Dr. Roger K. Freeman, medical director of Women's Hospital at the Long Beach Memorial Medical Center in Long Beach, Calif. "Medical advances in the treatment of premature babies enable us to save younger fetuses than ever before. When a fetus survives an abortion, however, there may be a collision of tragic proportions between medicine and maternity. Medicine is now able to give the premature a chance that may be rejected by the mother."

In 1970, Freeman developed the fetal stress test, a widely used technique for monitoring the heart rate of unborn fetuses. Also, he and a colleague at Long Beach, Dr. Houchang D. Mondalou, have developed a drug, betamethzene, that matures premature lungs within days instead of weeks. The hospital claims a 90 percent success rate with infants weighing as little as 1 pound 11 ounces.

At the University of California at Irvine, work is under way on an "artificial placenta" that doctors there say could, within five years, push the threshold of viability back even further.

The life-saving techniques are not exclusive to top academic hospitals, either. Good neonatal care is now broadly available across the United States. In fact, the lively issue in medical circles these days is not whether tiny premature babies can be saved, but whether it is affordable. Bills for the full course of treatment of a two-pound infant typically run between $25,000 and $100,000. To some, that seems a lot to pay, especially in the case of an abortion baby that was not wanted in the first place.

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The only way out of the dilemma, it would seem, would be for fewer women to seek late abortions. Though some optimists argue that this is happening, there is evidence that it is not.

Studies show that women seeking abortions late in the second trimester are often young, poor and sexually ignorant. Many either fail to realize they are pregnant or delay telling their families out of fear at the reaction. The patients also include those who have had a change of circumstance or a change of heart after deciding initially to carry through a pregnancy; some of these women are disturbed.

As first-trimester abortion and sex education become more widely available, the optimists' argument goes, nearly all women who choose abortion will get an early abortion. But in fact a new class of older, well-educated, affluent women has now joined the hardship cases in seeking late abortions.

This is because a recently developed technique, amniocentesis, allows genetic screening of the unborn fetus for various

ABORTION

hereditary diseases. Through this screening, a woman can learn whether the child she is carrying is free of such dreaded conditions as Downs syndrome (mongolism) or Tay-Sachs disease, a genetic disorder that is always fatal, early in childhood.

The test involves drawing off a sample of amniotic fluid, in which the fetus is immersed in the womb. This cannot be done until the 15th or 16th week. Test cultures for the various potential problems take several weeks to grow. Sometimes the result is inconclusive and the test must be repeated. The testing also reveals the unborn child's sex and can be used to detect minor genetic imperfections.

To many women, particularly those over 35, amniocentesis seems a rational approach to minimizing the chances of bearing a defective child. A few, according to published reports, go a step further and make sure the baby is the sex they want before deciding to bear the child.

In any case, it is late in the second trimester — within weeks of the current threshold of viability — before the information becomes available on which a decision is made to abort or not abort. The squeeze will intensify as amniocentesis becomes more widely available and as smaller and smaller infants are able to survive.

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The abortion live-birth dilemma has caught the attention of several experts on medical ethics, and they have proposed two possible solutions.

The simplest, advocated by Dr. Sissela Bok of the Harvard Medical School among others, is just to prohibit late abortions. Taking into account the possible errors in estimating gestational age, she argues, the cutoff should be set well before the earliest gestational age at which infants are surviving.

Using exactly this reasoning, several European countries — France and Sweden, for example — have made abortions readily available in the first three months of pregnancy but very difficult to get thereafter. The British, at the urging of Sir John Peel, an influential physician-statesman, have considered in each of the last three years moving the cutoff date from 28 weeks to 20 weeks, but so far have not done so.

But in this country, the Supreme Court has applied a different logic in defining the abortion right, and the groups that won that right would not cheerfully accept a retreat now.

A second approach, advocated by Mrs. Bok and others, is to define the woman's abortion right as being only a right to terminate the pregnancy, not to have the fetus dead. Then if the fetus is born live, it is viewed as a person in its own right, entitled to care appropriate to its condition.

This "progressive" principle is encoded in the policies of many hospitals and the laws of some states, including New York and California. As the record shows, though, in the alarming event of an actual live birth, doctors on the scene may either observe the principle or ignore it.

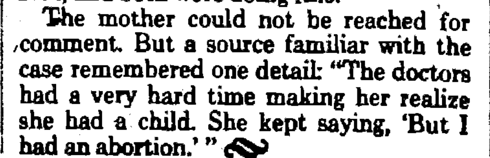
And the concept even strikes some who do abortions as misguided idealism.

"You have to have a feticidal dose" of saline solution, said Dr. Kerenyi of Mt. Sinai in New York. "It's almost a breach of contract not to. Otherwise, what are you going to do — hand her back a baby having done it questionable damage? I say, if you can't do it, don't do it."

The scenario Kerenyi decribes did in fact happen, in March 1978 in Cleveland. A young woman entered Mt. Sinai Hospital there for an abortion. The baby was born live and, after several weeks of intensive care at Rainbow Babies and Childrens Hospital, the child went home — with its mother.

The circumstances were so extraordinary that medical personnel broke the code of confidentiality and discussed the case with friends. Spokeswomen for the two hospitals confirmed the sequence of events. Mother and child returned to Rainbow for checkup when the child was 14 months old, the spokeswoman there said, and both were doing fine.

The mother could not be reached for comment. But a source familiar with the case remembered one detail: "The doctors had a very hard time making her realize she had a child. She kept saying, 'But I had an abortion.'"



"I Stood By And Watched That Baby Die"

Nurses are the ones who bear the burden of handling the human-looking products of late abortions. And when an unintentional live birth occurs, they are the first to confront the waving of limbs and the gasping.

Reluctant to talk about their experiences, most of those interviewed for this article did not want their names to be published, and out of professional loyalty, they did not even want their hospitals to be named.

They spoke of being deeply troubled by what they have seen of late abortions in American hospitals.

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Linda is a nurse in her late 50s in Southern California. Hurrying out of a patient's room one day to dispose of the aborted "tissue," as nurses were taught to think of it, she felt movement. Startled, she looked down, straight into the staring eyes of a live baby.

"It looked right at me," she recalled. "This baby had real big eyes. It looked at you like it was saying, 'Do something — do something.' Those haunting eyes. Oh God, I still remember them."

She rushed the 1½-pound infant to the nursing station. She took the heart rate — 80 to 100 beats a minute. She timed the respirations — three to four breaths a minute. She called the doctor.

"I called him because the baby was breathing," Linda said. "It was pink. It had a heartbeat. The doctor told me the baby was not viable and to send it to the lab. I said, 'But it's breathing' and he said, 'It's non-viable, it won't be breathing long — send it to the lab.' "

She did not follow the order. Nor did she have resources at her command to provide any life-saving care. Two hours later the infant died, still at the nursing station, still without medical treatment. It died in a makeshift crib with one hot-water bottle for warmth and an open tube of oxygen blowing near its head.

The nursing supervisor, Linda said, had refused to let her put the baby in the nursery, where there was equipment to assist premature babies in distress. "She said to follow the doctor's orders and take it to the lab. I kept it with me at the station. We couldn't do an awful lot for it."

This happened eight years ago, in 1973, but Linda is still upset. "I stood by and watched that baby die without doing a thing," she said. "I have guilt feelings to this day. I feel the baby might have lived had it been properly cared for."

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Jane, about 50, is the head floor nurse in an Ohio hospital. She and her fellow nurses successfully petitioned their hospital in 1978 to stop doing late abortions. Twice before that, she witnessed live births after abortions.

She recalls vividly the 16-year-old patient who phoned her mother after her abortion and said in an agonized voice, "Ma, it's out — but Ma, it's alive."

That happened in 1975. Jane still speaks of it bitterly, her eyes flashing anger.

A year earlier Jane saw the second abortion live birth in her experience. "I was called by the patient's roommate," she recalled. "When I got there the baby's head was sticking out and its little tongue was wiggling. Everybody felt they couldn't do anything until they called the doctor. It was a little thing — it only lasted about 15 minutes. But it was alive, and we did nothing. And that was wrong."

It rankles, too, that she was routinely forced to handle dead fetuses, the size and shape of well-formed premature babies.

"Because of my position," she said, "I had to pick them up off the bed and put them in a bottle of formalin [a preservative fluid]. Sometimes you had to have a very large container. Our gynecologists seemed to have a very poor ability to estimate gestational age. Time and again they would say with a straight face, 'This woman is 20 weeks pregnant' when she was actually 26 weeks."

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Norma Rojo, about 35, is an obstetrical nurse at Indio Community Hospital in Indio, Calif. She was present the night of May 3, 1980, when a 15-year-old patient delivered a live baby girl after a saline abortion.

"Get rid of it," the patient cried hysterically. "I'm sorry, Mama — get rid of it," she said, the baby alive, kicking and crying, between her legs.

Two weeks earlier the girl had been in a traffic accident that killed four others and had sought the abortion out of fear that her baby might be damaged.

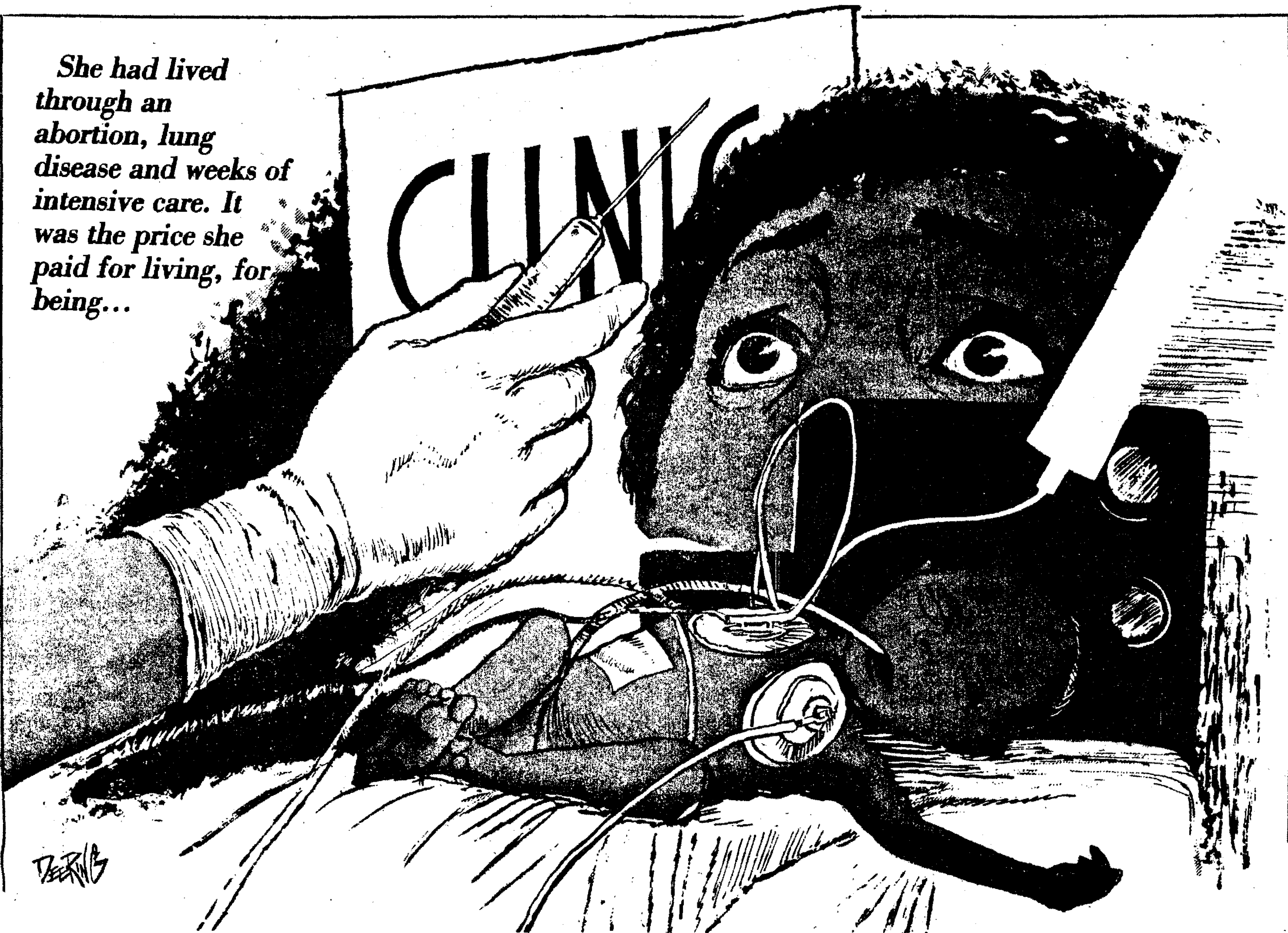
The fetus, which in tests had shown a normal heartbeat of 132 to 136 in the womb, appeared healthy at birth. "She was beautiful," said Mrs. Rojo. "She was pink. There were no physical deformities. She let out a little lusty cry. She lay in a basin put there to catch all the stuff. She was waving her arms and legs. You could tell she was making a big effort to live."

The nurses cut the umbilical cord, wrapped the infant in a blanket and took her to the intensive care nursery. She was put in an isolette (a life-support system) within minutes and was given oxygen.

Acting on their own, the nurses had the 1 pound 14 ounce baby transferred six hours later to Loma Linda University Medical Center, one of several hospitals in the Los Angeles area specializing in the care of very small premature infants. Four days later the baby was reported stable but had developed a complication causing hemorrhaging of the brain. Dr. David Deming of Loma Linda said then that its chances were only 50-50. He added, though, that the abortion had done little damage. "I would say there is probably no effect on her from the saline."

Eleven days after birth, the baby died. Family members indicated they were upset by the nurses' effort to save it.

"After this experience," Rojo said, "my friend [another nurse] and I are changed. We realize doctors aren't perfect. . . . I hope this is the last [abortion live birth] I ever see, but if there are any more, we will do the same thing."



ARKANSAS MAGAZINE
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Document #13

Born too soon

BY MIKE MASTERSON
Special Writer

Three frightened women paced the living room floor waiting for the baby girl in the grocery sack to die. But after almost two hours, they could still hear the faint stirrings and gasps.

When their anguish finally became unbearable, the women roused Marie from a deep sleep. They had decided to take the mother and her newly aborted infant to the hospital.

On May 3, about 4 p.m., three neatly-dressed women came through the emergency room door of the Jefferson County Regional Medical Center in Pine Bluff.

Inside the sack they were carrying, a nurse discovered a black-haired female infant wrapped in a towel.

The ailing baby, her temperature below 94 degrees, had lapsed into shock from the loss of body heat.

Dr. Ronald Tanner, the obstetrician on call that afternoon, was summoned to the hospital. He, in turn, asked for a consulting pediatrician.

THE EMERGENCY room staff had already started working to save the infant who weighed just one pound and 13 ounces. She was 12.9 inches long.

It had not occurred to Marie that the baby growing for 28 weeks inside of her would survive the abortion.

The procedure – as the doctor had described it – seemed simple enough: a series of chemical injections in her arm to induce the premature delivery of some meaningless disposable tissues.

But something had gone terribly wrong in the Pine Bluff doctor's office earlier that day. Instead of a lifeless fetus, a perfectly-shaped child with hands smaller than an adult's thumbnail came kicking and screaming onto the delivery table.

Shy, with soft features that made her seem even younger than 19, Marie had squeezed her eyes shut when the baby first began to cry. The muffled wails were terrifying, the sudden guilt unbearable.

Later, she expressed her feelings.

"THE ABORTION WAS SUPPOSED to be easy. I never imagined there would be a live baby. I guess I wanted to believe a fetus was something very, very small and not alive. I was so frightened and I felt so bad."

In the examining room after the abortion, the doctor had wrapped the baby in a towel and laid it aside while he finished caring for Marie. The infant continued to squirm and cry.

Soon afterward, Marie left the doctor's office for a friend's house nearby. The physician then placed the child in a sack and gave it to one of the two friends who had accompanied Marie to the hospital.

In a few minutes, the woman with the sack arrived at the house where Marie was waiting. She said the doctor had told her to "take it along with you and pretty soon, it would stop moving."

AFTER MARIE FELL ASLEEP, the friends kept their death watch over the aborted infant until they decided to seek help.

Back at the hospital it was 4:30 p.m. The metal end of Dr. Tanner's stethescope covered practically all of the baby's frail chest. Her heartbeat remained strong.

Blood cultures were drawn to determine her condition. Antibiotics were injected intravenously. And her head was placed beneath an oxygen hood to ease her labored breathing.

The instant warmth generated by an umbrella of powerful heat lamps over the infant's isolette soon caused her body temperature to rise.

An umbilical catheter was tediously threaded into the child's own umbilical artery. This slender, pliable tube fed directly into the aorta where it could provide nutrients and continuously monitor critical blood gases.

LATER THAT EVENING, AFTER her condition had stabilized, the emergency van from Arkansas Children's Hospital was racing along the 50 miles of freeway that separated the two cities.

The aborted baby had already beaten overwhelming odds by living for 11 hours.

The survival of aborted infants, in itself, is not a unique phenomenon. Three years ago, the Center for Disease Control in Atlanta estimated that as many as 500 babies a year survive abortions in the United States, but most of them don't live more than a few hours.

Dr. David Grimes of the Atlanta center believes fewer babies are surviving abortions now because doctors have changed techniques to ensure that fetuses are born dead.

The chances of aborted babies surviving for more than a few hours have always been slim. For example, of 607 abortions performed at Mount Sinai Hospital in Hartford, Conn., one year, 45 resulted in live births. None of those infants survived more than 13 hours despite attempts to save them, according to Dr. C. Everett Koop, author and surgeon-in-chief at the Philadelphia Children's Hospital.

TWO YEARS AGO, THERE WERE 5,722 reported abortions in Arkansas, about 300 of which involved fetuses in their final 15 weeks of development. No one knows for certain how many of the older fetuses showed signs of life after being aborted.

Once inside the Arkansas Children's Hospital emergency van in Pine Bluff, Darlene Howard, a nurse and Eddy Peters, a respiratory therapist, wrapped the aborted baby in Saran Wrap to preserve her restored body heat.

During the 45-minute return trip to Little Rock, they also gently inserted a plastic endotrachial tube into the infant's throat to a point just above her lungs.

This enabled a mechanical ventila-

Continued

tor to begin regularly breathing for her – a process called "intubation."

Meanwhile, Marie, her mind and body exhausted from the ordeal, had been examined and admitted to the Pine Bluff hospital for observation.

LYING IN THE HOSPITAL BED, she closed her eyes and began to remember. She could still see the cramped examining room where it happened. There was the aroma of antiseptic and the muffled crying of the baby in the towel.

When she opened her eyes, tears had welled up in the corners and were spilling onto her cheeks.

She had decided to abort the baby when her pregnancy began to show. Her boyfriend for four years, who was also the baby's father, had agreed with the decision.

A friend who had undergone her own successful abortion by the same doctor also encouraged Marie to rid herself of the unwanted baby and return to college in the fall.

Marie had been raised with five brothers and sisters in a close, rural family where such things as obedience, education and religion were woven tightly into the fabric of everyday life.

But even her mother had left the final decision up to Marie. For the first time in her life, she felt truly alone amid all the familiar people and places.

On the morning of the abortion, Marie was still ambivalent. She had wanted to get it over with, yet, she didn't want it to happen.

BY HER ESTIMATION, SHE HAD been five months pregnant. "The doctor examined me beforehand," she said, "and he didn't find any reason not to do it. I trusted his judgment."

If Marie had known that the baby could already recognize her mother's voice and could even perceive shadowy outlines in the watery environment of the womb, she would have backed out of the abortion.

It was just after 1 a.m. on May 4 when the transport van containing the aborted infant arrived at the Arkansas Children's Hospital Neonatal Intensive Care Unit.

Inside the unit, Dr. Clarke McIntosh, a 26-year-old pediatric resident, had been working since 8 a.m. the previous day. He and an intensive care nurse were anticipating the baby's arrival.

AN OPEN BASSINET – CALLED an infant warmer – lay prepared and waiting on the first row. This row was where the most critical premature babies were kept to save precious moments in an emergency.

In the bright, sterile room filled with the latest in life support technology, the Pine Bluff baby would join 11 other miniature infants who lay quietly clinging to life by sophisticated electronic threads.

If she survived, this would be her home for at least three months. The cost of that care would be staggering: about $150,000, which the hospital and the state would absorb.

As one physician later put it, "an ironic medical battle was under way to save a baby that only hours earlier, another doctor was asked to destroy."

The conflicting values entwined in the Pine Bluff abortion had not gone unnoticed by others. Dr. Betty Lowe, medical director at Children's, said her facility just happened to find an unwanted baby on its doorstep who needed help to survive.

"The fact that the mother didn't want the child at the time didn't affect our responsibility at all."

WHAT DISTURBED DR. LOWE more than anything, she said, was the deeper significance of the incident. "Abortion and its peculiar slant on the value of human life is only the tip of an ungodly problem that stretches across the ranks of society today.

"For the last decade or so, society had increasingly equated the value of human life with money, whether it be the very young or the very old. We are educating young people today who will consider an abortion with no more deep-seated feelings than a tonsilectomy.

"It's going to turn out to be a much more difficult issue than simply unwanted pregnancy. We gear our whole society to sexual pleasure. At the same time, we are not teaching our young people the moral values they should be getting."

At Children's Hospital, additional blood tests showed the baby was very anemic. A transfusion was started to replenish her depleted red blood cells.

A SMALL VEIN ALSO HAD HEmorrhaged inside her brain. The bleeding was carefully watched with ultra-sound equipment that beamed an image of the damaged area onto a small screen.

While intra-cranial bleeding was not uncommon in premature babies, it could lead to brain damage and even death.

"It's remarkable that this baby survived for even two hours without anyone to help her," said Dr. McIntosh, gathering up her finger-sized leg in the palm of his hand. "She's not out of the woods yet, but she has a strong will to live."

By sunrise on May 4, the baby's vital signs looked better. Dr. McIntosh went home to sleep.

With the routine change of nursing shifts at 7 a.m. came a fresh group of guardian angels in plum-colored jump suits mingling noisily into the room.

A monitor above the baby's bed showed her heart was beating normally, about 130 times each minute. She was now almost 17 hours old.

SUDDENLY, HER HEART RATE plummeted to 90 beats per minute, then to 70, then 60, 50, 40. The monitor's alarm was pinging wildly. In a moment, two nurses, another pediatric resident and Dr. Donald Hill, the unit's chief physician, were working beside each other to resusitate her.

To hurriedly evaluate the infant, they placed a high-intensity light in her arm pit. Using the light, the doctor could literally see through the baby's chest to the right lung which had collapsed.

The condition – called pneumothorax – had resulted from the rythmical forces of the ventilator. Most of the air had escaped from her lung and formed a pocket around the deflated organ.

Dr. Hill skillfully guided a needle into the baby's chest cavity until it penetrated the air pocket. As the air was withdrawn, the lung reinflated and her heart rate began climbing upward.

A CHEST TUBE WAS THEN SURgically implanted just outside the lung to continuously remove any other leaks that might occur.

In the days that followed, the infant was never left unattended. Alarms constantly sounded in the unit as doctors and nurses resolved dozens of crises each day.

On her third day, the baby developed another pneumothorax, this time in her left lung. Again, her heart rate fell drastically. The delicate procedure with the needle was repeated on the left side and another tube was inserted to continually relieve the pressures on that side.

The tiny girl, in her struggle to survive, now had four tubes attached to her body, along with several chest monitors and a myriad of wires feeding into machines that constantly clicked and hissed.

IN SPITE OF THE PAINFUL APpearance, there was consolation in realizing that this expensive, man-made gadgetry could be translated into the saving of a human life.

But as Dr. Bernard Nathanson, an obstetrician-gynecologist and a reformed New York abortionist has suggested, the same technology within five years will be able to save babies of much younger gestation than the little aborted girl.

"And that will mean that instead of abortions as we know them, unwanted babies will be removed from their mothers and transplanted into women who do want them."

Dr. Nathanson, a professed aetheist, also anticipates the development of artifical placentas in laboratories. Unwanted fetuses will be raised to full term in such places and given to people who want to adopt them.

ABORTION HAS NOW BECOME the most common medical procedure performed on adults in the United States. About 4,000 abortions are performed each day, or more than 1.5 million each year.

by Mike Masterson

"We call these babies fetuses to dehumanize them," said Dr. Nathanson. "But if we're truthful, we're really talking about killing living human beings in the womb. The little girl from Pine Bluff could have been legally killed before taking her first breath."

Between 1972 and 1974, Dr. Nathanson, who has authored several anti-abortion books, operated the largest abortion clinic in the world in downtown New York City. He said he gave it up after "finally understanding that I was making my living by destroying human lives."

On May 9, a pediatric heart surgeon was paged to the prenatal unit after the aborted baby developed an acute cardiovascular disorder.

KNOWN AS "PATENT DUCTUS Arteriosus," the problem stemmed from a fetal vessel near the heart that had not closed after birth. Now her lungs were slowly filling with fluid. She was in danger of congestive heart failure.

The surgeon moved quickly, entering the left side of her chest with a precise incision. He was able to tie off the vessel in a matter of minutes and stitch the opening shut.

Once again, the baby fought back to regain her strength.

One afternoon, in the second week of life, the infant opened her eyes for a long, curious moment. She turned her head slightly and looked through the tubes encircling her head to a person standing by the bassinet.

As he slowly moved around the little bed, her eyes followed him until the lids became too heavy. Then she slowly closed them and drifted back to sleep.

"She knows we're here," said nurse Rosemary Moore. "She just can't tell us about it yet."

ALSO IN THE SECOND WEEK, Marie and her boyfriend visited the baby. Standing beside the bed, she felt an inseparable link with the child.

"We shared an experience together that no one else could understand," she said.

After a long talk, Marie and her boyfriend had decided to keep the baby. In fact, she now wanted her more than ever. Both of their parents had agreed to help.

"If she is like me," said Marie, "she will make it through this. I pray she does. She's been a tough little fighter. I do want her to live so bad."

Through the intravenous feedings of vitamin-enriched fluids, the baby grew to more than two pounds in seven weeks and began successfuly digesting infant formula through a feeding tube.

Dr. Byron Hawks, an obstetrician-gynecologist who directs maternity services and family planning for the Arkansas State Health Department, said the child's growth and development in the years ahead should become more predictable within six months.

"Increasing numbers of premature children are surviving intact with the technology available today," he said.

"You always hope for the best. But it's no great way to start a life."

While this story is true, the mother's name was changed to "Marie" in order to protect her identity and privacy. The doctor who performed the abortion, while confirming the incident, would not discuss the matter on advice from his attorney.

ARKANSAS MAGAZINE
June 26, 1983

Life after abortion: A moral dilemma in Del.

By Rick Edmonds
Inquirer Staff Writer

WILMINGTON — The two tiny infants, a boy and a girl, each weighing three pounds if that, were doing well, breathing on their own power last week at the Wilmington Medical Center's intensive care nursery. And that was the problem.

Both babies were supposed to have suffered cardiac arrest and been expelled stillborn after injection of a saline solution into their mothers' wombs.

The unwanted babies have both been signed over for adoption by their mothers, and so they have no real names as yet. They are called Sal and Salina by interns and nurses — a flip reference to the saline solution that failed to kill them.

But the consequences of these abortions that didn't work are no joke.

The Delaware Attorney General's office has subpoenaed hospital records and is interviewing staff in an investigation of allegations that the infants' development was grossly underestimated and that one of them, upon delivery, was not checked promptly for signs of life.

Already, according to sources in the medical community, the medical center has begun new ultrasound screening of women requesting abortions in the second trimester of pregnancy, and it has turned away those beyond the 20th week. (A full-term pregnancy lasts about 36 weeks.)

In Wilmington and beyond, the coincidence of two such live births in the space of a month has posed for public discussion an ethical problem that long has troubled professionals.

Voluntary abortions late in the second trimester (up to 24 weeks) are clearly legal under a 1973 U.S. Supreme Court decision. But are such abortions morally acceptable if the result is sometimes a live — and likely damaged — infant?

Births like the two at the medical center are rare but by no means unprecedented. According to Dr. Willard Cates, chief of abortion surveillance at the Center for Disease Control in Atlanta, about 2 out of 1,000 saline abortions result in a live birth.

The chances of such an infant surviving for any length of time are considerably less though, Cates said. In 1974, the latest year studied, there were 200 such unintended births nationally. Of that group, six survived early infancy and have a good chance of growing to maturity. It is safe to assume that at least six infants a year have been surviving abortions since then, he said.

Ironically, the saline procedure's supposed advantage over two other methods used late in the second trimester is that it alone kills the fetus before expulsion.

The saline solution is injected so as to replace some of the nurturing amniotic fluid of the mother's womb.

(See ABORTION on 6-B)

THE INQUIRER (Philadelphia)
June 10, 1979

Failed abortions: A moral dilemma

ABORTION, From 1-B

As the fetus swallows the fluid, its heart stops beating. At the same time, the salt solution induces contractions and eventually causes delivery of a stillborn child.

Exactly why some fetuses are born live instead "really is impossible to say," according to Dr. Joel Polin, an associate professor of obstetrics and gynecology at the University of Pennsylvania Medical School. "It may be that the fetus is larger — larger physically or more developed or both. And some are simply stronger."

A live birth from a saline abortion often involves a mistake in estimating the development of the fetus, Polin said. "If a patient is obese, that makes her harder to examine ... Generally we assume patients are telling the truth (about when they missed a menstrual period and likely were impregnated) ... But errors can be made. Patients can deceive us."

Being a few weeks off in estimating the development of a fetus in the late second trimester can have profound consequences, since 24 to 26 weeks is the borderline of "viability" — that is, the ability to survive and develop under the best of circumstances outside the womb. Once such a fetus with that ability presents itself live, Polin said, the physician's obligation is clear: "Every effort must be made to save it."

Unfortunately, the prospects for full development of an early seven-month baby are not good, he said. So the abortions that do not work yield infants who — by their prematurity alone — may need expensive, even heroic treatment to survive and who run a vastly higher risk than full-term infants of being brain damaged.

The saline solution may do additional damage to babies like the two born in Wilmington, according to Dr. Cates, but not enough of them have survived and been studied to say for sure.

The legal context into which such abortion mishaps fall was set by the Supreme Court in 1973. Essentially, the ruling allows voluntary abortions in the first and second trimesters on the theory that such fetuses are not yet viable; in the third trimester, the fetus is deemed to have limited rights as a human being and abortion is permissible only under extreme threats to the mother's health.

Delaware's 1971 abortion law set a more conservative standard, allowing voluntary abortions only through the 20th week of pregnancy. But when a women's health group challenged the law in federal court, the state agreed by stipulation that it was unconstitutional. That was in 1977, and no replacement law has been drafted.

But the absence of a valid state law on abortion is no obstacle to an investigation like the one that Chief Deputy Attorney General Joseph J. Farnan Jr. launched last week. Prosecutors in other states have taken the direct route of bringing criminal charges against physicians who have performed abortions that involved (even fleetingly) live births.

Edelin case

In the best known of these cases, Dr. Kenneth Edelin was convicted of manslaughter by a Boston jury in 1975, although the conviction was later set aside by the Massachusetts Supreme Judicial Court. Edelin, having failed to abort a fetus by the saline method, had performed a hysterotomy on a patient — opening her abdomen and lifting the fetus out. He was alleged by witnesses to have held the infant down in the woman's abdominal area, thereby preventing its breathing.

In a case now on trial in California, Dr. Wiliam Waddill is charged with murder in the death of an infant born live during a saline abortion. Waddill, who examined the infant 30 minutes after birth and has testified that it was dying, has been accused by another physician of having strangled the baby and then of having tried to get witnesses to agree on a cover story.

A jury finished its seventh day of deliberation without reaching a verdict Friday. This is Waddill's second trial on the charges; a jury failed after 11 days last year to agree on a verdict.

State authorities in South Carolina are pressing murder and criminal abortion charges there against a doctor who administered saline at

(Continued on next page)

An increasingly complex problem

Continued from preceding page

the 25th week and delivered an infant who lived 18 days.

In such a charged legal atmosphere as this, details of what happened at the Wilmington Medical Center have been hard to come by. The hospital, which serves all of northern Delaware and was the site of 2,000 abortions last year, acknowledged the two live births in a sketchy statement last Monday. The infants (both in good condition) were described only as a girl now about five weeks old and a boy about 10 days old.

By week's end, with Farnan's investigation in full gear, the medical center was unwilling even to reconfirm its earlier report of the babies' weights and developmental age at birth. Drs. John M. Levinson and Mohammed Imran, identified by sources as the physicians involved, refused comment.

From unofficial sources, some details of the births and the investigation were available. The births were brought to light by local anti-abortion groups, which had been alerted by a person with strong anti-abortion views who works at the center.

The source inside the center alleges that the infants were 31 weeks and 28 weeks developed. This puts them well into the third trimester. (The center first said the infants were in the fifth or sixth month, but it declined to confirm that estimate when challenged.)

Data and charges

The size and developmental age of the infants will be pivotal to any charges that may result.

Fetal development can be dated to within a week by ultrasound examination (a procedure in which sound waves are used to measure the size of the fetus). However, sources allege that ultrasound examinations (which are considered an unnecessary expense under routine circumstances) were not done before the two abortions that resulted in live births.

Last week, although no formal announcement was made, the medical center began to require ultrasound examinations before late second trimester abortions and to turn away women more than 20 weeks pregnant, according to two sources. Steps have been taken, in other words, to prevent any further accidental live deliveries during abortions.

One of the charges that Farnan is investigating is that proper care was not given to one of the infants. One of them, by the center's own account, was believed dead and set aside in a plastic specimen jar briefly before a pulsating in its umbilical chord was observed.

For Delaware Right-to-Life members, the incidents were a vehicle for renewing their protests of all abortions. Right-to-Life president Walter Janocha said his teaching colleagues at a private school for the retarded were taking him and his cause a good deal more seriously before the events than they had before.

One speaks out

Last week, most Wilmington doctors were ducking even general questions about the significance of the two live births. An exception was Dr. John Gehret, a plain-spoken obstetrician who did much of the drafting of Delaware's abortion law.

"There's a lot of logic to making 20 weeks the cutoff," Gehret said in an interview Thursday night. "For one thing, that's when the woman begins to feel the baby ... Also there's no conceivable way a 20-week infant can be kept alive outside the womb ...

"I'm personally not interested in doing later abortions. They're kind of revolting to me. But I understand the guy who says, 'They're legal someone's going to do 'em — why not offer them here close to the woman's home?' "

Dr. Louise B. Tyrer, vice president for medical affairs of the Planned Parenthood Federation of America, said Friday that she and her organization, like Dr. Gehret, view the dangers of late second-trimester abortions with some alarm.

Planned Parenthood's own clinics do not encourage abortions except for medical reasons after 18 weeks, Dr. Tyrer said. Early on in the liberalization of abortion policies, some doctors advocated providing no life support assistance to the rare live-born infant. "Now we think that's very inappropriate and does not show proper respect for human life," she said.

A rollback

Many medical centers around the country are rolling the limit for voluntary abortions back to 20 weeks, said Dr. Cates of the Center for Disease Control, and some states now require by law that a pediatrician be present in case of live birth for any abortion later in term.

But this approach also has its critics. Patrick A. Trueman, general counsel for the Chicago-based Americans United for Life, an anti-abortion group, said it makes little sense to move the limit back to 20 weeks, or any such arbitrary number.

"That would be only minimal progress in my view," he said Friday.

"It wasn't so many years ago that no baby born at less than 32 weeks was given a chance to survive. Now we're down to 24 weeks. What do we do when the technology is such that we can keep them alive at 19 or 16 weeks, or in vitro?"

LIVE BIRTHS - MIDTOWN HOSPITAL, ATLANTA, GA. (All abortion hospital)

1980	DATE	DOCTOR	CAUSE	APPROX. INTERVAL BETWEEN ONSET & DEATH	LIVED	RACE
1)	4/24	Jonathan Erlich, M.D.	induced prior to viability	2 hrs 48 min	23 min	bl/f
2)	4/30	Steve Goldman, M.D.	premature birth	5 hrs 5 min	5 hrs	bl/m
3)	10/17	James L. Waters, M.D.	saline induction to term. pregnancy, extreme immaturity, 22 weeks	12 hrs 20 min	20 min	w/m
4)	8/16	James L. Waters, M.D.	pulmonary insufficiency extreme immaturity, 19 weeks ges	14 hrs 5 min	5 hrs 55 min	bl/m
5)	9/12	James L. Waters, M.D.	respiratory insufficiency	3 hrs 10 min	3 hrs 10 min	oriental/f
6)	8/21	Steve Goldman, M.D.	neonatal demise post induced preg.	12 hrs 55 min	6 hrs 20 min	bl/m
7)	6/19	Jonathan Erlich, M.D.	immaturity, induced delivery	3 hrs 35 min	25 min	bl/f
8)	12/30	James L. Waters, M.D.	extreme immaturity induced abor.	n/a	4 hrs 10 min	w/m
9)	11/6	Stephen Goldman, M.D.	extreme immaturity	n/a	2 hrs 10 min	w/f
10)	12/8	Stephen Goldman, M.D.	extreme immaturity induced abortion	n/a	1 hr 45 min	bl/m

Document #15

LIVE BIRTHS - MIDTOWN HOSPITAL

<u>1981</u>

11)	2/24	James L. Waters, M.D.	pulmonary insufficiency n/a	30 min	w/m
12)	4/3	James L. Waters, M.D.	pulmonary insufficiency, n/a thera. abor.	13 hrs 5 min	w/m
13)	8/28	James L. Waters, M.D.	pulmonary insufficiency, n/a thera. abor.	50 min	w/m

<u>1982</u>
INCOMPLETE

14)	10/15	Tyrone Cecil Malloy,M.D.	asphixiation due to abortion	35 min	w/f

BODY COUNT:

Waters	7
Erlich	2
Goldman	4
Malloy	1
	14

Nancy Creger 4/5/83

SOURCE: GEORGIA DEPARTMENT OF HUMAN RESOURCES
DEPARTMENT OF VITAL RECORDS
Computer run by death certificate number,
Midtown Hospital, Atlanta, Ga.

MEDICAL TRIBUNE Wednesday. April 2, 1975

Fetal Viability Floor Placed at 22 Weeks

Medical Tribune World Service

GENEVA—An infant born before 22 weeks of gestation (under 500 G.) has no possibility of survival in the present state of medical knowledge, a World Health Organization scientific group has decided.

The W.H.O. experts, including Dr. Helen M. Wallace, Professor and chairman, Maternal and Child Health, School of Public Health, University of California, Berkeley, and Swiss gynecologist Prof. Hubert de Watteville of Geneva, Cantonal Hospital and University Clinic, came to the conclusion that infants delivered between 22 and 28 weeks (500 to 999 G.) have a "survival potential," but noted that such potential is extremely limited.

Less than 10 % Survival

Available statistics show that fewer than 10 per cent of such infants survive, even in the most advanced centers.

"After 28 weeks' gestation (1000 G.) the fetus can be considered to have reached a stage of development where, if delivered alive, it has a reasonable expectation of survival," the group said in a WHO report.

The experts, who also included scientists, physicians, and public health specialists from Britain, France, U.S.S.R. Israel, and Jamaica, have thus moved the limits for viability of the fetus further into the period of gestation than a British group who studied the question in 1972 and recommended that a period of 20 weeks or a weight of 400-500 G. should be considered as the criterion.

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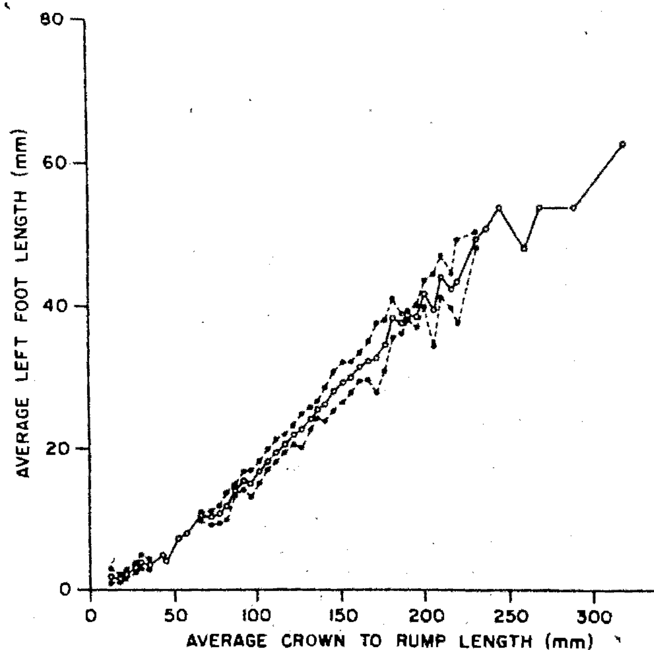

Figure 13. Correlation between crown-rump length and left-foot length of fetus during first half of gestation. Solid line shows mean growth rate with interrupted line on either side representing ±1 standard deviation. (Adapted from Iffy et al: see legend of Fig. 11.)

those conceived during the summer and the lowest averages in those conceived in the fall (51). Menstrual age (MA) can be estimated from the CRL measurement (47). For the 20- to 50-mm range the equation is: MA = 46 + 0.71(CRL). For the 50- to 200-mm range the equation is: MA = 64 + 0.41(CRL). Table 2 correlates menstrual age with foot length, fetal weight, and CRL. If one desires to predict these fetal dimensions for a given menstrual age, linear interpolation of this table should be satisfactory. Studies have also been made that permit extrapolation of these data to other measurements such as head diameter, arm, palm, and leg lengths, and the weight and functional status of various internal organs (50,52–56).

Second Half of Gestation (Immature, Premature, and Mature Groups)

The direct relationship between menstrual age of the fetus and certain body measurements continues throughout the second half of gestation. An accurate means of determining age and level of maturity of the fetus during this period is necessary not only for medicolegal requirements but also, especially, for an adequate prediction of fetal wastage and prevention of fetal accidents and neonatal complications. Prior to the relatively recent application of ultrasound, in utero fetal growth could only be estimated since it was not possible to take such measurements directly. There is abundant information on fetal growth in the literature. Most of it is based on measurements obtained postnatally from live, prematurely born infants. Premature birth itself is unnatural and presents an indeterminable bias in the data. One should therefore be aware that the dimensions contained herein on intrauterine growth (i.e., weight, length, and head circumference) are only approximations of group fetal growth patterns determined from the onset of the mother's last menstrual period.

Because the definitions of viability, immaturity, prematurity, and maturity of the newborn differ from clinic to clinic and from country to country, several different methods of classifying the conceptus by age have been used. In most studies fetuses with menstrual ages of 20 thru 42 weeks exhibit a weight growth pattern that approximates a sigmoid curve (Fig. 14). Traditionally, they have been classified into three groups: immature, premature, and mature. Each group has approximate weight and crown-heel length limits (immature, 500–1,000 gm and 23–35 cm; premature, 1,000–2,500 gm and 35–47 cm; mature, above 2,500 gm and 47–50 cm). Immature fetuses are often included in the nonviable group along with

Table 2. Correlation of Menstrual Age to Foot Length, Fetal Weight, and Crown-Rump Length

Menstrual Age (Days)	*Foot Length (mm)*	*Fetal Weight (gm)*	*Crown-Rump Length (mm)*
52.4	1.78	0.20	14.80
60.1	2.45	0.82	22.64
66.3	2.83	0.95	25.33
73.8	4.91	3.49	44.09
81.2	9.30	16.13	63.19
88.0	12.15	35.50	82.85
95.5	12.27	36.06	83.11
102.2	16.47	55.64	100.90
109.6	20.66	110.50	116.00
116.5	21.29	117.92	118.81
123.3	24.78	162.14	133.81
129.9	27.23	198.27	144.06
137.5	29.72	246.13	154.20

SOURCE: Iffy L, Jakobovits A, Westlake W, et al: Early intrauterine development: I. The rate of growth of Caucasian embryos and fetuses between the 6th and 20th weeks of gestation. *Pediatrics* 56:173, 1975.

Raymond Gasser, "Embryology and Fetology," in Leslie Iffy and Harold A. Kaminetzky, eds., Principles and Practice of Obstetrics and Perinatology. Copyright 1981, Principles and Practice of Obstetrics and Perinatology. Reprinted by permission of John Wiley & Sons, Inc.

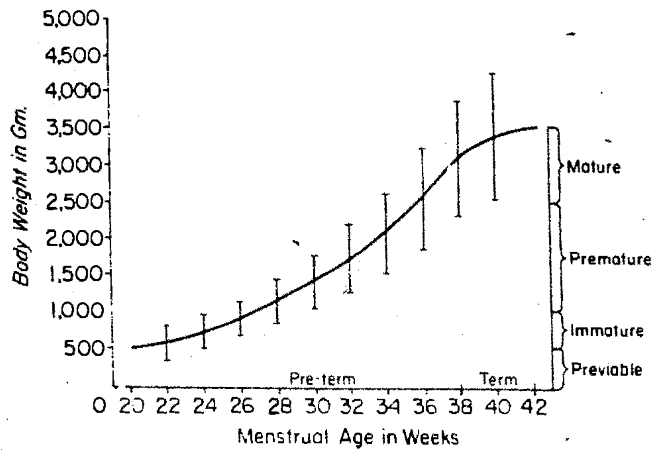

Figure 14. Increase in body weight of fetus during second half of gestation according to menstrual age. Based on 11,000 single births. Center line represents mean birth weight with ±2 standard deviations indicated (95% of a given group lies within ±2 standard deviations). Note that body weight at 20 weeks is higher than indicated in Fig. 12. (Adapted with modification from Hendricks CH: Patterns of fetal and placental growth: The second half of normal pregnancy. *Obstet Gynecol* 24:357, 1964.)

those having a gestational age of less than 20 weeks. It seems desirable, however, to place fetuses between 500 and 1,000 gm in a separate category since survival of as many as 25% of them have been reported by some clinics. In addition, the survival of a fetus weighing less then 400 gm has been recorded (57). With continued efforts and a deeper understanding of fetal requirements, methods will be devised that will allow progressively more such fetuses to survive. Liveborn infants weighing less than 2,500 gm have a survival rate between 80% and 90%, but two-thirds of those not surviving weigh less than 1,500 gm (58).

concerned. Assuming that legislative bodies are able to engage in this exacting task,[4] it is difficult to believe that our Constitution *requires* that they do it as a prelude to protecting the health of their citizens. It is even more difficult to believe that this Court, without the resources available to those bodies entrusted with making legislative choices, believes itself competent to make these inquiries and to revise these standards every time the American College of Obstetricians and Gynecologists (ACOG) or similar group revises its views about what is and what is not appropriate medical procedure in this area. Indeed, the ACOG standards on which the Court relies were changed in 1982 after trial in the present cases. Before ACOG changed its standards in 1982, it recommended that all mid-trimester abortions be performed in a hospital. See *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 651 F. 2d 1198, 1209 (CA6 1981). As today's decision indicates, medical technology is changing, and this change will necessitate our continued functioning as the nation's "*ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States." *Planned Parenthood* v. *Danforth*, 428 U. S. 52, 99 (1976) (WHITE, J., concurring in part and dissenting in part).

Just as improvements in medical technology inevitably will move *forward* the point at which the State may regulate for reasons of maternal health, different technological improvements will move *backward* the point of viability at which the State may proscribe abortions except when necessary to preserve the life and health of the mother.

In 1973, viability before 28 weeks was considered unusual. The fourteenth edition of L. Hellman & J. Pritchard, Williams Obstetrics, on which the Court relied in *Roe* for its understanding of viability, stated that "[a]ttainment of a [fetal] weight of 1,000 g [or a fetal age of approximately 28 weeks gestation] is . . . widely used as the criterion of viability." *Id.*, at 493. However, recent studies have demonstrated increasingly earlier fetal viability.[5] It is certainly reasonable to believe that fetal viability in the first trimester of pregnancy may be possible in the not too distant future. Indeed, the Court has explicitly acknowledged that *Roe* left the point of viability "flexible for anticipated advancements in medical skill." *Colautti* v. *Franklin*, 439 U. S. 379, 387 (1979). "[W]e recognized in *Roe* that viability was a matter of medical judgment, skill, and technical ability, and we preserved the flexibility of the term." *Danforth*, *supra*, 428 U. S., at 64.

The *Roe* framework, then, is clearly on a collision course with itself. As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health is moved further forward to actual childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception. Moreover, it is clear that the trimester approach violates the fundamental aspiration of judicial decision making through the application of neutral principles "sufficiently absolute to give them roots throughout the community and continuity over significant periods of time . . . ." A. Cox, The Role of the Supreme Court in American Government 114 (1976). The *Roe* framework is inherently tied to the state of medical technology that exists whenever particular litigation ensues. Although legislatures are better suited to make the necessary factual judgments in this area, the Court's framework forces legislatures, as a matter of constitutional law, to speculate about what constitutes "accepted medical practice" at any given time. Without the necessary expertise or ability, courts must then pretend to act as science review boards and examine those legislative judgments.

The Court adheres to the *Roe* framework because the doctrine of *stare decisis* "demands respect in a society governed by the rule of law." *Ante*, at 2. Although respect for *stare decisis* cannot be challenged, "this Court's considered practice [is] not to apply *stare decisis* as rigidly in constitutional as in nonconstitutional cases." *Glidden Company* v. *Zdanok*, 370 U. S. 530, 543 (1962). Although we must be mindful of the "desirability of continuity of decision in constitutional questions. . . . when convinced of former error, this Court has never felt constrained to follow precedent. In constitutional questions, when correction depends on amendment and not upon legislative action this Court throughout its history has freely exercised its power to reexamine the basis of its constitutional decisions." *Smith* v. *Allwright*, 321 U. S. 649, 665 (1944) (footnote omitted).

Even assuming that there is a fundamental right to terminate pregnancy in some situations, there is no justification in law or logic for the trimester framework adopted in *Roe* and employed by the Court today on the basis of *stare decisis*. For the reasons stated above, that framework is clearly an unworkable means of balancing the fundamental right and the compelling state interests that are indisputably implicated.

II

The Court in *Roe* correctly realized that the State has important interests "in the areas of health and medical standards" and that "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." 410 U. S., at 149, 150. The Court also recognized that the State has "*another* important and legitimate interest in protecting the potentiality of human life." *Id.*, at 162 (emphasis in original). I agree completely that the State has these interests, but in my view, the point at which these interests become compelling does not depend on the trimester of pregnancy. Rather, these interests are present *throughout* pregnancy.

This Court has never failed to recognize that "a State may properly assert important interests in safeguarding health [and] in maintaining medical standards." 410 U. S., at 154. It cannot be doubted that as long as a state statute is within "the bounds of reason and [does not] assume[] the character of a merely arbitrary fiat. . . . [then] [t]he State . . . must de-

[4] Irrespective of the difficulty of the task, legislatures, with their superior fact-finding capabilities, are certainly better able to make the necessary judgments than are Courts.

[5] One study shows that infants born alive with a gestational age of less than 25 weeks and weight between 500 and 1,249 grams have a 20% chance of survival. See Phillip, et al., *Neonatal Mortality Risk for the Eighties: The Importance of Birth Weight/Gestational Age Groups*, 68 Pediatrics 122 (1981). Another recent comparative study shows that preterm infants with a weight of 1000 grams or less born in one hospital had a 42% rate of survival. Kopelman, *The Smallest Preterm Infants: Reasons for Optimism and New Dilemmas*, 132 Am. J. Diseases Children 461 (1978). An infant weighing 484 grams and having a gestational age of 22 weeks at birth is now thriving in a Los Angeles hospital, and the attending physician has stated that the infant has a "95% chance of survival." Washington Post, March 31, 1983, p. A2, col. 2. The aborted fetus in No. 81-185, *Simopoulos* v. *Virginia*, *post*, weighed 495 grams and was approximately 22 gestational weeks.

Recent developments promise even greater success in overcoming the various respiratory and immunological neonatal complications that stand in the way of increased fetal viability. See, *e. g.*, Beddis, et al., *New Technique for Servo-Control of Arterial Oxygen Tension in Preterm Infants*, 54 Archives of Disease Childhood 278 (1979). "There is absolutely no question that in the current era there has been a sustained and progressive improvement in the outlook for survival of small premature infants." Stern, *Intensive Care of the Pre-Term Infant*, 26 Danish Med. Bull. 144 (1979).

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21 PREMATURE BABIES

BIRTH WEIGHT:

range 845 grams (1 lb. 14 oz.) to 343 grams (12 oz.)
- 16 weighed less than 750 grams
- 11 " " " 650 grams
- 6 " " " 550 grams
- 2 " " " 450 grams

GESTATIONAL AGE AT BIRTH (calculated from L.M.P.)

- 19 were less than 30 weeks
- 14 " " " 28 "
- 10 " " " 26 "
- 6 " " " 24 "
- 4 " " " 22 "
- 1 was " " 20 "

SURVIVAL·

All but one have survived
- (one died of fulminating pneumonia, 5 weeks after birth)

NORMALITY:

All are apparently developing normally.

Data compiled by: J.C. Willke, M.D.
7634 Pineglen Drive
Cincinnati, Ohio 45224

21 PREMATURE BABIES

GESTATIONAL AGE AT BIRTH	NAME	BIRTH WEIGHT
1. 36 weeks	boy, Lee B.	600 gm., 1 lb. 5 oz.
2. 32 "	girl, D.R.	670 gm., 1 lb. 8 oz.
3. 29 "	girl, Shannon C.	595 gm., 1 lb. 5 oz.
4. 28 "	boy, Christopher C.	650 gm., 1 lb. 7 oz.
5. 28 "	girl, Cherrie Lee L.	680 gm., 1 lb. 8 oz.
6. 28 "	girl, Katina F.	650 gm., 1 lb. 7 oz.
7. 28 "	girl, Regina Lynn C.	845 gm., 1 lb. 14 oz.
8. 27 "	girl, Melkeya K.	510 gm., 1 lb. 2 oz.
9. 27 "	girl, Jacqueline B.	340 gm., ---- 12 oz.
10. 26 " , 2 days	girl, Pamela P.	800 gm., 1 lb. 12 oz.
11. 26 "	girl, Cheryl P.	735 gm., 1 lb. 10 oz.
12. 25 " , 3 days	girl, Sherrie Lynn S.	675 gm., 1 lb. 7 oz.
13. 25 "	boy, Richard C.	813 gm. 1 lb. 12 3/4 oz.
14. 24 "	girl, Martine M.	453 gm., 1 lb.
15. 24 "	girl, Alicia Maria P.	644 gm. 1 lb. 6 3/4 oz.
16. 23 "	girl Tascha H.	580 gm., 1 lb. 4½ oz.
17. 22 " , 1 day	girl Tracy L.	538 gm., 1 lb. 3 oz.
18. 21 " , 2 days	girl, Suzanna S.	794 gm., 1 lb. 12 oz.
19. 21 "	girl, Marie J.	652 gm., 1 lb. 7 oz.
20. 21 "	girl, Kelly T.	596 gm., 1 lb. 5 oz.
21. 19 " , 6 days	boy, Marcus R.	780 gm., 1 lb. 10 oz.

For purposes of comparison, it may be of interest that the baby boy killed by Dr. Edlin was 24 weeks gestational age and weighed 755 grams. Sixteen of these babies weighed less and six were born younger.

Data compiled by: J.C. Willke, M.D.
7634 Pineglen Drive
Cincinnati, Ohio 45224

Frankie Pulls Through at Bethesda

Born 3½ Months Prematurely, Infant Leaves Neo-Natal Unit

(Editor's Note: While Navy Times does not like to reveal its news sources, in this case an exception is being made. The letter above, which brought the fascinating story of Frankie Krutsky to our attention, is also a warm and touching Valentine's Day message worth sharing with all our readers.)

By NANCY GRIFFIN
Times Staff Writer

WASHINGTON — The story of Frankie Krutzky III begins on Oct. 18, 1978, when his mother Sandra went into labor 3½ months early and delivered a one-pound, one-ounce baby at Bethesda Naval Medical Center.

He was 13 inches long, his eyelids still were fused together and no one expected him to live. The tiny bundle was rushed to the infant intensive care unit at Bethesda and immediately hooked up to life-supporting machines.

Frankie was kept warm those first days of life by being put into a plastic box that was then wrapped in Saran Wrap. His skin was so thin it couldn't retain much water and this method also acted as a humidifier.

Lt. Cmdr. Stephen M. Golden, head of the Bethesda neo-natal intensive care unit, said that Frankie had less than a five percent chance of survival when he was born after 24 weeks in the womb and weighed only 600 grams. "He is definitely the youngest baby to survive at Bethesda," said the doctor. "Although our advanced equipment helped, the staff care from nurses and attendants and the baby's own strength pulled him through."

Nurses sat beside Frankie 24 hours a day watching monitors, giving medicine, drawing blood and anticipating problems. The care given the child would have cost between $80,000 and $120,000 at a civilian hospital, Golden estimated.

Premature babies in the intensive care unit are nursed along from hour to hour. Room for error is minimal. Every machine, every test given endangers the child's life because the baby's body is not developed enough to fight infection. The blood circulating in the small body weighs less than two ounces, so every time a blood test is given, a transfusion also must be given to replace what has been taken out.

Frankie had lived two months before his parents began having hope he would survive. On December 5, he was taken off the respirator and breathed by himself. His body continued to mature, the skin thickened, the organs began to work, enzymes were produced and he began sucking from a bottle so intravenous fluids could be stopped.

After living almost four months in the hospital, during which time his parents visited him every other day and called on the days they couldn't come from Quantico where they live, Frankie met the criteria for discharge. He could breathe room air without using a respirator, he had demonstrated constant growth and his parents were capable of caring for him.

Golden said there still may be complications such as neurological problems, but as of now, everything looks fine. Frankie will return to Bethesda for much testing in the coming months so doctors can monitor his development.

When his parents dressed him to take him home, his blue knitted pants, the smallest size made, came up to his arm pits and the matching top reached his ankles.

He was 18 inches long, weighed a robust five pounds, 3½ ounces and he was 113 days old. If he had been born on schedule, he would have been two days old.

(Staff photo by Joe Matera)

LAST CHECK before releasing Frankie to go home with his parents is made by Lt. Cmdr. Stephen M. Golden, who has been caring for the infant since he was born 3½ months prematurely on October 18.

NAVY TIMES
February 26, 1979

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Document #20

2 'miracle' babies beat odds

Girl most premature to survive

SAN DIEGO (UPI) — Doctors announced yesterday they are caring for an infant girl believed to be the most premature baby ever to survive birth.

Ernestine Hudgins was 18 weeks premature when she was born Feb. 8, weighed only 1 pound, 1 ounce and was 12 inches long, said Dr. Morton L. Cohen, medical director of Children's Hospital neonatal unit.

The baby, born to two housekeepers, Gloria Patterson, 27, and Ernest Hudgins, 24, was listed in good condition. Doctors have given the infant, who has gained more than 13 ounces, a "95 percent" chance to survive.

"Before Ernestine came along, the chance of a baby surviving at this stage of development was zero," said Cohen. "She certainly is special."

Her birth reportedly erases the record for prematurity held by another San Diego baby, Mignon (Mimi) Faulknor, born Nov. 7, 1978. She was born 17 weeks premature and also weighed about 1 pound, 1 ounce.

Cohen said female infants born prematurely have a better chance of survival than premature male babies, but doctors are not sure why.

He said Ernestine has developed chronic lung damage characteristic of premature babies, but the damage is considered minor. She is being kept on a respirator and is being fed high-calorie formula through a tube inserted in her stomach.

Patterson said a doctor who examined her before she delivered the baby told her it was doubtful the infant would survive.

"The first time I saw Ernestine, she seemed real, real little," she said.

AP Photo

Tiny Ernestine Hudgins, believed the most premature infant to survive, gets loving care from parents at San Diego, Calif. hospi-

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Document #21

Smallest human alive breathing on her own

VICTORIA (UPI) — A four-month premature infant — considered the smallest human being alive in the world — rested peacefully in a hospital incubator Wednesday breathing on her own, a doctor said.

"She is the youngest human alive in the world," said Dr. Wadieh El-Mahmoudi, the pediatrician for 14-ounce Melissa Maurer, born 4 months prematurely on June 1.

"They say in the Guinness Book (of World Records) that in England, they had one baby born at 10 ounces, 14 years ago. Now, she (Melissa) is the youngest and the smallest human being alive in the whole world," he said.

The mother, Sandy Maurer, is optimistic her daughter will survive.

"I think she's going to make it. She's my miracle baby," Maurer said.

The tiny blonde infant has breathed on her own since her birth. Nurses in the neonatal intensive care unit at the Citizens Memorial Hospital in Victoria, 50 miles south of Houston, said they keep a "watchful eye on her all the time."

Nurses have propped pillows around her to minimize any movements to prevent her from burning calories that could cause her to lose precious weight.

"The only thing near her is a bear that makes fetal noises like the womb," said one nurse.

"So far there are no complications that usually happen with prematurity," the doctor said.

Although El-Mahmoudi agrees the child is a miracle, he gives her only a 20 percent chance of surviving.

"As every day passes, I'm more hopeful. We go hour by hour. The more time passes, the better her chances are of survival," he said.

"So far she appears completely normal, just premature," the doctor said.

Maurer told doctors she was unaware she was pregnant until "several days prior to delivery," El-Mahmoudi said.

"She had two tests that were negative, and the third test was positive. When she knew she was pregnant . . . a couple of days later, she went into labor," the doctor said.

The tiny infant weighed one pound, two ounces at birth, but quickly dropped down to 12 ounces because she could not be fed.

Doctors inserted a tube through her navel to feed her a mixture of proteins, dextrose, and vitamins to keep her alive.

El-Mahmoudi holds Melissa as her mother watches

— AP photo

THE POST (Houston)
June 9, 1983

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News Release

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Contact: Doug Badger or
Norm Bendroth
(202) 544-1720

TWO A.C.O.G. PAST PRESIDENTS, 26 PHYSICIANS AFFIRM FETAL PAIN

Washington - A group of 26 physicians, including two Past Presidents of the American College of Obstetricians and Gynecologists (ACOG), today wrote President Reagan in support of his contention that fetuses "often feel pain" during abortions. The President made the statement during his January 30 speech to the National Religious Broadcasters convention.

"Over the last 18 years, real time ultrasonography, fetoscopy, study of the fetal E.K.G. (electrocardiogram) and fetal E.E.G. (electroencephalogram) have demonstrated the remarkable responsiveness of the human fetus to pain," the letter said.

The letter was prompted by a statement made by Ervin E. Nichols of ACOG in the New York Times. Nichols, purporting to speak for ACOG's 24,000 members, said that Reagan was wrong to contend that fetuses feel pain. "We are unaware of any evidence of any kind that would substantiate a claim that pain is perceived by a fetus," he said. Nichols subsequently admitted to the Washington Times that he lacked both "expertise" and "intimate knowledge" of fetology.

The letter, signed by physicians with expertise in the discipline, stated, "The ability to feel pain and respond to it is clearly not a phenomenon that develops de novo at birth. Indeed, much of enlightened modern obstetrical practice and procedure seeks to minimize sensory deprivation of, and sensory insult to, the fetus during, at, and after birth...

"Mr. President, in drawing attention to the capability of the human fetus to feel pain, you stand on firmly established ground."

Dr. Richard T. F. Schmidt and Dr. Fred Hofmeister, both Past Presidents of ACOG, were among the letter's signatories. Other signers included Dr. Vincent Collins, Professor of Anesthesiology at Northwestern University and the University of Illinois; Dr. Matthew Bulfin, a fellow of the American College of Obstetricians and Gynecologists; Dr. Bernie Pisani, President of the New York State Medical Society; Dr. Watson Bowes, Professor of Maternal and Fetal Medicine at the University of North Carolina; and Dr. Denis Cavanaugh, Professor of Obstetrics and Gynecology at the University of South Florida.

"When doctors first began invading the sanctuary of the womb, they did not know that the unborn baby would react to pain in the same fashion as a child would. But they soon learned that he would."

--Dr. H. M. I. Liley

"Lip tactile response may be evoked by the end of the 7th week. By 10.5 weeks, the palms of the hands are responsive to light stroking with a hair, and at 11 weeks, the face and all parts of the upper and lower extremities are sensitive to touch. By 13.5 to 14 weeks, the entire body surface, except for the back and the top of the head, are sensitive to pain."

--Stanislaw Reinis and Jerome Goldman
<u>The Development of the Brain</u>

"The fetus needs to be heavily sedated. The changes in heart rate and increase in movement suggest that these stimuli are painful for the fetus. Certainly it cannot be comfortable for the fetus to have a scalp electrode implanted on his skin, to have blood taken from the scalp or to suffer the skull compression that may occur even with spontaneous delivery. It is hardly surprising that infants delivered by difficult forceps extraction act as if they have a severe headache."

--"What the Fetus Feels"
<u>British Medical Journal</u>

"As early as eight to ten weeks gestation, and definitely by thirteen and a half weeks, the human fetus experiences organic pain."

--Vincent J. Collins, M.D.
Diplomate and Fellow,
American Board of Anesthesiologists

"Dilatation and evacuation, for example, where fetal tissue is progressively punctured, ripped and crushed, and which is done after 13-1/2 weeks when the fetus certainly responds to noxious stimuli, would cause organic pain in the fetus. Saline amnioinfusion, where a highly concentrated salt solution burns away the outer skin of the fetus, also qualifies as a noxious stimulus."

--Thomas D. Sullivan, M.D.
FAAP
American Academy of Neurosurgeons

"It can be clearly demonstrated that fetuses seek to evade certain stimuli in a manner which in an infant or an adult would be interpreted as reaction to pain."

--Richard T. F. Schmidt, M.D.
Past President, ACOG

"By 13-1/2 weeks, organic response to noxious stimuli occurs at all levels of the nervous system, from the pain receptors to the thalamus. Thus, at that point, the fetal organic response to pain is more than a reflexive response. It is an integrated physiological attempt to avert the noxious stimuli."

--William Matviuw, M.D.
Diplomate, ACOG

"Psychologist Thomas Verney notes in The Secret Life of the Unborn Child that some researchers now believe that the embryo, even in the first weeks of life, 'possess enough self-awareness to sense rejection and enough will to act on it.'"

--Landrum Shettles and David Rorvik
Rites of Life

"Fetuses (during the last four-and-a-half months of their development) do feel pain. They have the same response as a newborn baby. We treat fetal patients just like we treat newborns."

--Dr. Michael Harrison, Co-Director
Fetal Treatment Program
Univ. of Calif. at San Francisco
Quoted in Washington Times

"Whatever the method used, the unborn are experiencing the greatest of bodily evils, the ending of their lives. They are undergoing the death agony. However inarticulate, however slight their cognitive powers, however rudimentary their sensations, they are sentient creatures undergoing the disintegration of their being and the termination of their vital capabilities. That experience is painful in itself."

--Professor John T. Noonan
Univ. of Calif. at Berkeley

Period of Gestation

One of the most important factors in the evaluation of morbidity and mortality associated with abortion is the period of gestation at which the pregnancy is terminated. The traditional division has been between abortions in the first trimester and those in the second trimester, that is, between those performed at 12 weeks from the onset of the last menstrual period (LMP)[1] or earlier and those at 13 weeks or later. However, accumulating experience, primarily in Great Britain and the United States, has made it clear that this dichotomy is not sufficient, because morbidity and mortality increase with the progress of gestation even within each trimester. Unfortunately, period of gestation is not uniformly reported in available statistics. In some countries (e.g., Canada, England and Wales), the form used for the notification of legal abortions includes an entry for the date of onset of the last menstrual period, and gestation is tabulated in terms of completed weeks. In other countries (e.g., Czechoslovakia, Scotland), duration of pregnancy is reported by the physician in terms of weeks, which to him or her may mean ordinal week, nearest week, or completed week, corresponding for "12 weeks" to 77–83 days, 81–87 days, or 84–90 days, respectively. Hence, information on time trends and group differences within countries is more reliable than comparisons among countries.

Even when not prohibited by law, abortions are infrequently performed at more than 20 weeks of gestation, ranging from 0.2 percent of all legal abortions in Canada and 0.4 percent in Sweden to about one percent in the United States and the United Kingdom, according to the most recent available reports (1978–81).

Among the areas for which comparable statistics on legal abortions by period of gestation are available for recent years, the proportion of second-trimester abortions was highest in India, followed closely by Scotland, England and Wales, and, at some distance, Canada. India suffers from a general shortage of medical services, but it is certainly no mere coincidence that abortion services are less accessible in Britain and Canada than in most of the other western countries shown in Table 13. According to the Lane Report the average interval between a British woman's first contact with a physician and the performance of the operation was about four weeks *(United Kingdom, 1974a*, Vol. 3, pp. 4 and 6). In Canada, a few years later, it was eight weeks *(Canada, 1976*, p. 146). Second-trimester abortions occur less often in Sweden and Japan, where elective abortion is now permitted up to 18 and 24 weeks, respectively, and very rarely in Czechoslovakia, Hungary, and Yugoslavia, where, as elsewhere in eastern Europe, they are generally authorized only on medical indication.

A shift toward earlier abortion has occurred in almost all countries for which data are available, most dramatically in Sweden, where the mean duration of pregnancy dropped from 14.1 weeks in 1968 to 9.9 weeks in 1980. This trend probably reflects a growing awareness among women and physicians that abortion is less dangerous early in pregnancy than later on and, in some countries, the increasing availability of abortion services. Major exceptions are Hungary, where legal restrictions have resulted in some delays, and Denmark, where terminations following diagnostic amniocentesis increased from 0.04 percent of all abortions in 1974 to almost 3 percent in 1980 *(Philip, 1981)*. The higher proportions of second-trimester procedures among nonresident women obtaining abortions in New York State in 1973–80, contrasting with a downward trend for residents, suggest a selective migration from other areas where first-trimester abortions (performed in clinics) became more rapidly available than second-trimester abortions requiring hospitalization. By the same token, the rising proportions of late abortions among nonresident women aborted in England reflects the increasing availability of first-trimester abortions in the Netherlands, France, Germany, Italy, and other countries of western Europe.

By shifting some abortions from January to the preceding December, the trend to earlier abortion increases the number of abortions in a given calendar year. A reduction by one week in the average duration of pregnancy generates an increase of almost 2 percent in the number of abortions.

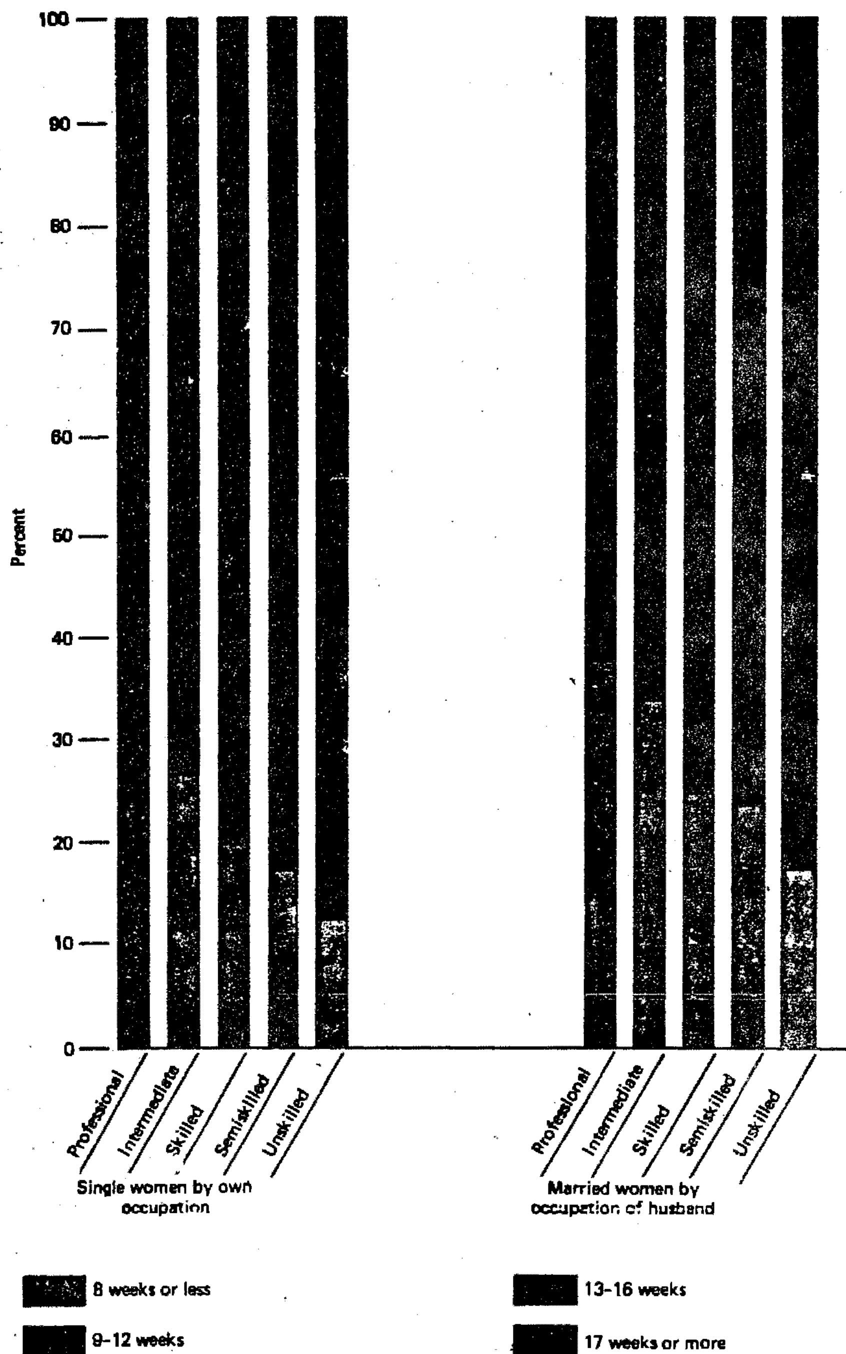
Late abortions occur most frequently among women of low socioeconomic status (Figure 9) and especially among the youngest women (Figure 10). The strong inverse association of period of gestation and woman's age probably reflects the inexperience of the very young in recognizing the symptoms of pregnancy, their unwillingness to accept the reality of their situation, their ignorance about where to seek advice and help, and their hesitation to confide in adults. Economic considerations and, in many places, regulations prohibiting surgery on minors without parental consent also contribute to delays.

The slight declines in the proportions of abortions performed at eight weeks or earlier, combined with increases in second-trimester proce-

[1] A distinction must be made between "menstrual weeks" (from LMP) and "gestational weeks" (from estimated date of conception, or two weeks less than menstrual weeks). In this fact book, the period of gestation is always stated in menstrual weeks from LMP.

Reprinted with the permission of the Population Council from Christopher Tietze, Induced Abortion: A World Review, 1981, 5th edition (New York: The Population Council, 1983), p. 65-67.

FIGURE 9 Percent distribution of legal abortions by weeks of gestation and occupation of woman or husband: England and Wales, 1973



dures, observed in most countries among older women, reflect primarily the association of high-order pregnancies with economic and cultural deprivation. Abortions on medical grounds are also more common among older women, and some women in their 40s may misinterpret the amenorrhea of pregnancy as the onset of menopause.

No information is available on the timing of illegal and self-induced abortions for any country. Survey data are not reliable sources of information, because a long time may have elapsed between the abortion and the interview; nor are hospital records to be depended on for such data, because the risk of complications requiring medical attention is higher after a late abortion than after an early one.

One category of second-trimester terminations deserves special mention: selective abortion to prevent the birth of infants with major physical or mental defects *(United States, 1979a)*. In many cases, the presence of such a condition can now be determined *in utero* with certainty or near-certainty, most often by amniocentesis and cell culture, but also by such other methods as biochemical analysis of the amniotic fluid, ultrasonography, and, in some cases, direct visual inspection of the fetus (fetoscopy) and fetal blood sampling. Conditions that can be detected *in utero* include Down's syndrome (mongoloid idiocy), Tay-Sachs disease (amaurotic familial idiocy), sickle cell anemia, neural tube defects (NTDs, primarily anencephaly and open spina bifida), and many others. In addition, it is possible to identify the sex of the fetus, permitting the selective abortion of male fetuses, one-half of which would be affected by sex-linked disorders, such as hemophilia, if the pregnant woman is known to be a carrier.

Because all procedures for the prenatal detection of fetal abnormalities require highly trained health personnel and some may result in injury to the pregnant woman or to a normal fetus *(Medical Research Council, 1978; NICHD, 1976)*, they are practically useful only if high-risk pregnancies can be identified. For many rare conditions, the only clues presently available are the prior birth of a defective child or such clinical signs as hydramnios, which is often associated with fetal malformation. However, pregnancies at risk for some conditions, such as NTDs and Tay-Sachs disease, can be identified by screening tests. Screening for NTDs can be achieved by a simple, inexpensive test of maternal blood serum. Tay-Sachs disease occurs most frequently among Jews of eastern European origin, one person in 30 being heterozygous for the condition and, therefore, a carrier of the disorder. Car-

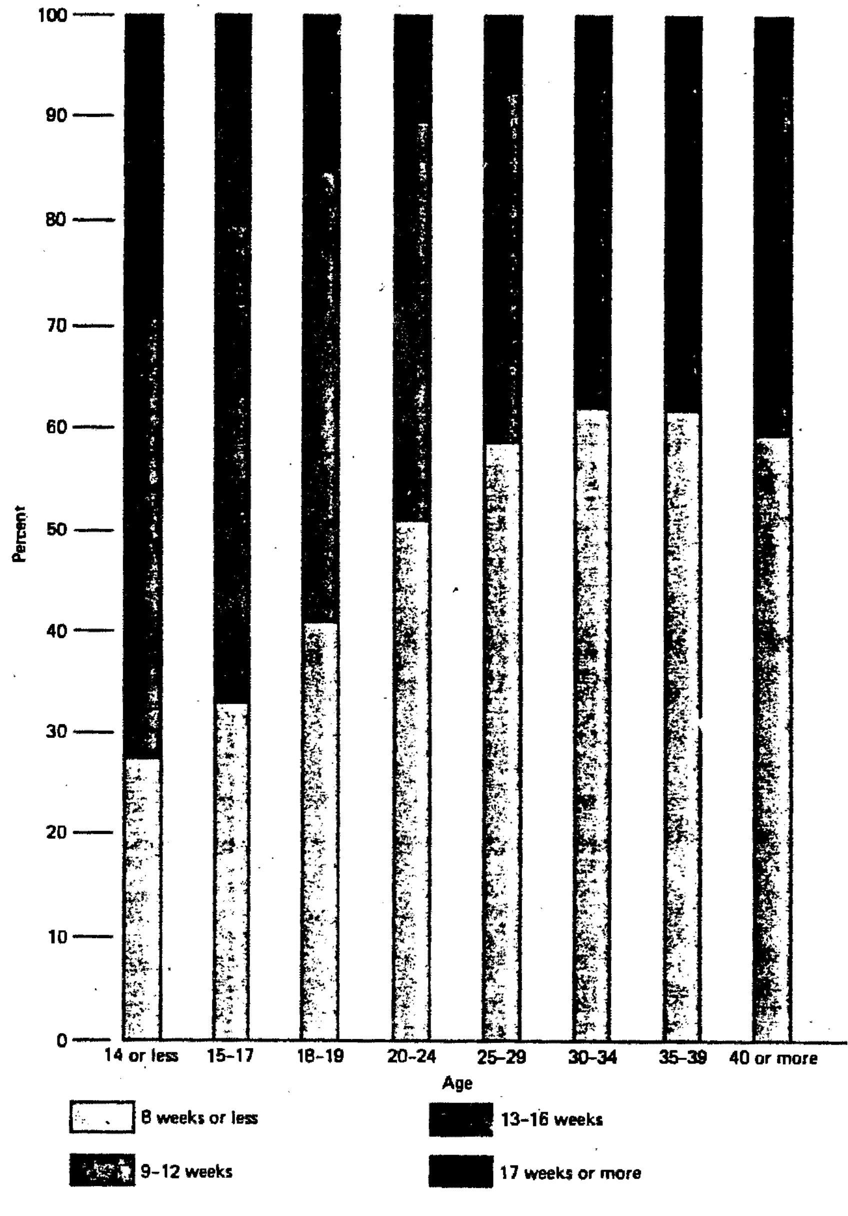


FIGURE 10 Percent distribution of legal abortions by weeks of gestation and woman's age: New York State, 1980

rier matings have been successfully identified by community-sponsored blood tests *(Kaback, 1977).* In the case of sickle cell anemia, about one-tenth of all black persons in the United States are carriers and readily identifiable, but the methods used for the diagnosis of homozygous and, therefore, affected fetuses are still experimental and not ready for routine use *(Chang, 1982; Orkin, 1982).* Because the incidence of Down's syndrome increases steeply with maternal age, it has been recommended that amniocentesis be offered to all pregnant women over age 35.

Prenatal diagnosis is rarely possible prior to 16 weeks of gestation, and in some cases a definitive determination may not be available before 22–24 weeks of gestation, at the borderline of fetal viability. The importance of such procedures lies in the fact that findings are negative in more than 95 percent of cases. Although it is never possible to guarantee a perfect baby, the prospective parents can at least be reassured that their child will not suffer from the disorder that had been suspected or feared. Prenatal diagnosis backed up by selective abortion thus makes procreation possible for couples who might otherwise avoid childbearing, perhaps by aborting all pregnancies.

At present, the number of abortions performed on the basis of prenatal diagnosis is quite small, even in developed countries. Because the procedures have been in use only since 1968, most prospective parents and even some physicians are not aware of them, and comparatively few centers exist where they can be carried out. In the United States, about 125 prenatal diagnosis programs were active in 1978, but only 10 to 15 laboratories were adequately staffed and equipped for the diagnosis of Tay-Sachs disease or NTDs. The number of diagnostic amniocenteses performed in 1978 was on the order of 15,000, compared with 150,000 to 200,000 pregnancies at risk under currently accepted criteria *(United States, 1979a).* By 1982, the number of programs had risen to at least 155 and the number of amniocenteses, to at least 30,000 *(Kaback, 1982).* The number of abortions then performed on the basis of prenatal diagnosis may have been on the order of 1,500, or one-tenth of one percent of all legal abortions in the United States. However, each of these abortions has averted a major catastrophe for a family.

Although damage to the fetus by exposure to rubella (German measles) during the early weeks of pregnancy cannot be determined by amniocentesis, the risk to the child to be born is great and is a significant ground for abortion, especially in times of epidemic. The numbers of abortions associated with rubella in the United States in 1964 is thought to have been around 3,500, dropping to about 1,000 in 1965 and to about 300 per year during 1966–68, by which time the epidemic had subsided *(Tietze, 1970).* Rubella was then not recognized by the laws of any state as a valid indication for abortion.

Right in the middle of one of those inevitable discussions of abortion practices and ethics, someone brought in the day's newspaper with the story from Mount Sinai. This would have provoked in any case an inconclusive argument, potentially emotional, and probably productive of no new light of moral reasoning. In the Bossey situation, however, the report on the doomed Down's baby carried a particular poignancy because of a remarkable film we had seen the previous evening.

When measured by every critical criterion, this film is superb. Titled *Stepping Out*, it was produced in Australia by Chris Noonan. At the film festival in Milan recently it won the grand prize for movies related to the International Year of Disabled Persons. It is a true story, filmed in *verité*; but it is not just a documentary. Let us say that it is the most persuasive affirmation imaginable of the humanness of persons afflicted by Down's syndrome.

In Sydney there is an institution for persons with this disability. They call it "intellectual disability," which is no euphemism. The community consists of adolescent and mature men and women as well as children. To this place came a man from Chile: an expert teacher of yoga, music, rhythm, drama and dance. With an extraordinary degree of patience, tact and persistence, this man showed the young women and men what they otherwise would never have known they could do. They could use color and costume with delightful aesthetic effect. By pantomime and dance they could convey emotions and tell stories of human distress, longing and hope.

After some weeks of his presence in the community, rehearsing the people with sober and respectful care, the man realized that they were capable of presenting something far better than an institutional fun-night show. Agreements were made with the glorious new Sydney Opera House. Professional costumes were purchased. Tickets were sold to fill the house. And all the while the cameramen achieved outstanding shots of the performers in make-up and dress rehearsal. The great night arrived. The film shows masterful close-ups of the faces of those awaiting their cues. Intellectually disabled, to be sure; but they acted as amateur actors always act before their performance. And when they appeared on stage, their presentation was not that of lovable-pitiable "Mongols" who had been taught, like walking dogs, to do entertaining tricks. They presented human art in musical motion and gesture, personal feelings and understanding in facial expression and rather squinting eyes.

The climax of the evening's program was a young man's portrayal through ballet of the anguish and suicide of Cho-cho-san, after Lieutenant Pinkerton of Puccini's *Madama Butterfly* abandoned her (his Japanese wife) and their child. The roaring ovation given by the standing audience was miles away from mere patronizing applause for well-meaning effort. It was an ovation of such spontaneity and sincerity as might have been accorded Australia's Joan Sutherland on the same stage.

II

There are times in the ongoing, intensifying debate over "Who shall live?" when the familiar arguments lose their sting. A woman's right? Unwanted pregnancy? Quality of life? Insupportable burden? Needless suffering? Sanctity of life? God's gift? By now we know them all: pro and con and in between. In our ecumenical group it was noted that Europeans, British and North Americans are more and more adopting the idea that genetically abnormal babies ought not be allowed to be born. Much of the guesswork has now been removed. Obstetrical technology with laboratory testing can deal with about 300 of the 3,000 known kinds of genetic disability. So why not, with good reason, save parents, families, institutions and society the trouble and expense? And why not, with a sense of mercy, spare these disabled boys and girls the unhappy and meaningless lives that must await them?

Unhappy? Meaningless? In many cases, so it seems. But we who have seen *Stepping Out* will not soon forget the expression of joyous fulfillment on the face of that male Cho-cho-san, robed in silken splendor, holding aloft the hara-kiri sword, and returning a look of triumph to the audience which clapped and cheered in approval.

J. Robert Nelson.

J. Robert Nelson, "Stepping Out of Down's Syndrome," The Christian Century, August 12-19, 1981, p. 790.

JAMA, October 5, 1979, Volume 242, Number 14,
p. 1455-1456. Copyright 1979, American
Medical Association.

Medical News

October 5, 1979

Abortion for 'wrong' fetal sex: an ethical-legal dilemma

"Please doctor, we have three girls and we want to know the sex of our new baby," says the couple seeking prenatal diagnosis. "Can you help us?"

The ethical dilemma facing the physician in such cases, although perhaps less pressing than some in applied human genetics, is certainly one of the most difficult to resolve in all of medicine.

Because abortion is a procedure that never elicits a noncommittal response, and because many genetics counselors are pediatricians who regard the fetus as the primary patient, it is extremely difficult for the counselor not to interfere in the decisions of parents seeking fetal sex determination for the purpose of choosing the sex of their next child.

In fact, the nature of the physician-patient relationship and way in which the physician presents the information learned from prenatal diagnosis (mainly amniocentesis) invariably influences the parents' decision.

There is some debate, however, about the right of parents to choose the sex of their child (and abort a fetus of the wrong gender), regardless of whether it is morally unpalatable to others.

Cases like this are infrequent, but physicians contacted at major medical centers that provide genetics services around the country all have had experience with them. It is the general consensus that such cases will become more common as population pressures increase and the public becomes better informed of the availability of procedures like amniocentesis.

"The idea of aborting a fetus for gender reasons alone is not acceptable to most genetics counselors," says John C. Fletcher, PhD, special assistant for bioethics to the director of the National Institutes of Health Clinical Center, Bethesda, Md. "But in taking this position, these people are overlooking a deep-set contradiction in their behavior. It is inconsistent for physicians to perform abortions for other reasons and then to refuse sex choice cases on the basis that this is a trivialization."

According to Fletcher, the moral issue surrounding sex choice as a reason for abortion should be approached only in terms of the legality of the procedure as defined by the US Supreme Court. The rules grant women the freedom to determine their own reproductive futures by prohibiting the creation of public tests of the reasons for which a woman might undergo an abortion.

Abortion for the purpose of sex choice is legal, argue the ethicists. There inevitably will be some disturbing reasons for abortion, but these should not deter physicians from protecting the right of women to make such decisions in the first place.

"If you accept the Supreme Court's decision on abortion, then you must accept sex choice as a valid reason for the procedure," says Fletcher.

The issue was discussed at the recent Symposium on Genetics and the Law in Boston sponsored by the National Foundation-March of Dimes. Most genetics clinics later contacted by *JAMA* MEDICAL NEWS said they refuse to handle these cases altogether. Some refer patients to other facilities where the information can be obtained. Some attempt to discourage parents from making such requests, but if couples insist, they will provide amniocentesis for gender determination of a presumably normal fetus.

"We exert a fair amount of pressure against using amniocentesis for this purpose. We're openly negative with patients about it," says Jerry Mahoney, MD, of the Department of Human Genetics at Yale University School of Medicine, New Haven, Conn. "The doctors here won't do an abortion simply because the parents aren't happy with the sex of their child.

"However," he adds, "once we've performed prenatal diagnosis, we never withhold information. We have no right to impose our ethical standards on anyone. The patients could go somewhere else for the abortion, and we would never know."

Noting that the sex of the fetus is incidentally revealed in every amniocentesis procedure, Mahoney estimates that three fourths of the couples he counsels, when told that the sex of their fetus will be identified, are eager to accept the information.

"Most of our chromosome study patients also want to know the sex of their fetus," says Sarah Finley, MD, of the Laboratory of Medical Genetics at the University of Alabama in Birmingham. "We don't perform amniocentesis just for that reason. However, we will refer patients to other facilities where they might be able to get this kind of service."

One such facility is Bioscience Enterprises in Van Nuys, Calif. Bioscience accepts samples of intrauterine fluid through the mail from licensed physicians, analyzes the sample, and provides a complete karyotype chart from which the physician can identify any genetic abnormalities, as well as the sex of the fetus.

Says Bill Jackson, an attorney for Bioscience, "Our service could conceivably be used as the basis for a

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decision to have an abortion. However, the physician decides what tests are appropriate for his patient. We take a morally neutral stand."

Almost every physician involved in genetics counseling contacted by *JAMA* MEDICAL NEWS stressed the importance of letting couples make their own decisions in cases of information obtained from prenatal diagnostic techniques.

"It is absolutely not the role or the right of the physician to reason with patients in these cases," says Aubrey Milunsky, MB, MRCP, director of the genetics division at Massachusetts General Hospital, Boston. "Once we have performed a test, it is the patient's right to have all the information derived from that test. You can't become involved in the final decision."

Despite assertions of objectivity, however, "doctors are routinely refusing to perform amniocentesis for nondiagnostic reasons," says Phil Riley, an attorney with experience in issues of human genetics and now a third-year student at the Yale Medical School. "And none of their reasons hold water. There is a much stronger case to be made in favor of amniocentesis for sex selection than against it."

Some of the reasons commonly given for refusing amniocentesis for fetal sex determination are these: (1) The technology is a scarce resource. (2) This is social engineering without full appreciation of possible consequences. (3) Sex is not a disease, and physicians cannot legally be forced to provide nonlifesaving procedures. (4) There is still some risk in amniocentesis.

"The scarce resources argument is rapidly becoming obsolete," says Riley, "and no one knows enough about the social engineering aspect of the situation to make a well-informed conclusion. As for the risk of amniocentesis, it is minimal. The real reason doctors are refusing to perform amniocentesis in these cases is personal opposition."

Says Fletcher, "Practitioners are erecting their own tests for abortion in these cases. They think that because they are prenatal diagnosticians they are somehow better than the rest. Doctors are going to have to realize that the public has caught up with knowledge of prenatal diagnosis. They are going to have to start exercising some humility."

There are other indications that some physicians involved in genetics counseling have set themselves up as gatekeepers.

In an attempt to discover how counselors regard the use of prenatal diagnosis specifically to determine gender, Clark Fraser, MD, of the Montreal Children's Hospital, sent separate letters to two groups of genetics counselors.

The first letter asked simply if the physician would perform amniocentesis in a case where the mother sought only knowledge of the sex of her fetus. The second letter presented a more complicated case in which a couple already had six girls and, after serious consultation and much agonizing, sought amniocentesis for sex determination with a possible abortion in mind. Would the physician perform the procedure?

Fraser found that a substantially greater number of the physicians queried answered yes to the second letter. Of physicians who received the first letter, 20% answered yes.

"These cases are infrequent," Fraser told *JAMA* MEDICAL NEWS. "I find them personally offensive. In this type of case we sit down with the family and talk about it.

"When the mother realizes that she will have to wait until the second trimester [amniocentesis is performed between the 14th and 16th week of pregnancy] when the baby is getting big and beginning to kick, she may well decide not to go through with it.

"Occasionally the couple is insistent," Fraser says. "Then we either refer them or do it ourselves."

The question arises as to whether the physician should remain involved at all in prenatal diagnosis and amniocentesis. Fletcher has his doubts. "The doctor complains about being treated as a technician in these cases, but the technology is rapidly becoming well known. Perhaps physicians should get out of this business altogether. I don't know."

Many physicians disagree. "British studies now suggest that the risk of fetal death from amniocentesis may be as high as 1%," notes Dorothy Warbuton, PhD, a genetics counselor at Columbia-Presbyterian Medical Center, New York. "It is entirely appropriate that physicians remain responsible for the use of this technology. If a patient came in and demanded a GI series or to have all her teeth pulled, would you comply? Experts use their judgment every day. Why should we provide amniocentesis on demand?"

"It is the responsibility and the moral obligation of the physician to safeguard the use of this technology and to see that it is not abused," adds Milunsky.

Whether these cases constitute abuse or proper use of amniocentesis is the crux of the matter. Only a test in the civil courts could decide such an ethical question, and to date no such case has been encountered.

"I suspect that if such a case ever occurred," says attorney Riley, "the patient seeking fetal sex information for whatever purpose would win. After all, much of this technology was developed with federal money, and the public has a right to direct access."

Adds Riley, "I think such a case would be particularly strong if it arose at a state-run institution, say, a state university hospital. If a woman is willing to pay for this service, I think the state would have a very difficult time trying to deny her access to it. The procedure is legal, the facilities are public. There should be no obstruction to free choice."

Until then, says Robert Gorlin, DDS, MS, chairman of the Department of Oral Pathology and a medical geneticist at the University of Minnesota Medical School, Minneapolis, "I'd tell a patient who came to me with such a request to go and get lost."

—by JOHN ELLIOTT

fringes upon a woman's constitutional right to obtain an abortion." *Ante*, at 20–21. For the same reasons, we affirm the Court of Appeals' judgment that § 188.025 is unconstitutional.

III

We turn now to the State's second-physician requirement. In *Roe* v. *Wade*, 410 U. S. 113 (1973), the Court recognized that the State has a compelling interest in the life of a viable fetus: "[T]he State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." *Id.*, at 164–165. See *Colautti* v. *Franklin*, 439 U. S. 379, 386–387 (1979); *Beal* v. *Doe*, 432 U. S. 438, 445–446 (1977). Several of the Missouri statutes undertake such regulation. Post-viability abortions are proscribed except when necessary to preserve the life or the health of the woman. Mo. Rev. Stat. § 188.030.1 (Supp. 1982). The State also forbids the use of abortion procedures fatal to the viable fetus unless alternative procedures pose a greater risk to the health of the woman. § 188.030.2.

The statutory provision at issue in this case requires the attendance of a second physician at the abortion of a viable fetus. § 188.030.3. This section requires that the second physician "take all reasonable steps in keeping with good medical practice . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman." See n. 3, *supra*. It also provides that the second physician "shall take control of and provide immediate medical care for a child born as a result of the abortion."

The lower courts invalidated § 188.030.3.[7] The plaintiffs, respondents here on this issue, urge affirmance on the grounds that the second-physician requirement distorts the traditional doctor-patient relationship, and is both impractical and costly. They note that Missouri does not require two physicians in attendance for any other medical or surgical procedure, including childbirth or delivery of a premature infant.

The first physician's primary concern will be the life and health of the woman. Many third-trimester abortions in Missouri will be emergency operations,[8] as the State permits these late abortions only when they are necessary to preserve the life or the health of the woman. It is not unreasonable for the State to assume that during the operation the first physician's attention and skills will be directed to preserving the woman's health, and not to protecting the actual life of those fetuses who survive the abortion procedure. Viable fetuses will be in immediate and grave danger because of their premature birth. A second physician, in situations where Missouri permits third-trimester abortions, may be of assistance to the woman's physician in preserving the health and life of the child.

By giving immediate medical attention to a fetus that is delivered alive, the second physician will assure that the State's interests are protected more fully than the first physician alone would be able to do. And given the compelling interest that the State has in preserving life, we cannot say that the Missouri requirement of a second physician in those unusual circumstances where Missouri permits a third-trimester abortion is unconstitutional. Preserving the life of a viable fetus that is aborted may not often be possible,[9] but the

[7] The courts below found, and JUSTICE BLACKMUN's dissenting opinion agrees, *post*, at 6–7, that there is no possible justification for a second-physician requirement whenever D&E is used because no viable fetus can survive a D&E procedure. 483 F. Supp., at 694; 655 F. 2d, at 865. Accordingly, for them, § 188.030.3 is overbroad. This reasoning rests on two assumptions. First, a fetus cannot survive a D&E abortion, and second, D&E is the method of choice in the third trimester. There is general agreement as to the first proposition, but not as to the second. Indeed, almost all of the authorities disagree with JUSTICE BLACKMUN's critical assumption, and as the Court of Appeals noted, the choice of this procedure after viability is subject to the requirements of § 188.030.2. See *id.*, at 865, and n. 28. Nevertheless, the courts below, in conclusory language, found that D&E is the "method of choice even after viability is possible." 655 F. 2d, at 865. No scholarly writing supporting this view is cited by those courts or by the dissent. Reliance apparently is placed solely on the testimony of Dr. Robert Crist, a physician from Kansas, to whom the District Court referred in a footnote. 483 F. Supp., at 694, n. 25. This testimony provides slim support for this holding. Dr. Crist's testimony, if nothing else, is remarkable in its candor. He is a member of the National Abortion Federation, "an organization of abortion providers and people interested in the pro-choice movement." 2 Record 415–416. He supported the use of D&E on 28-week pregnancies, well into the third trimester. In some circumstances, he considered it a better procedure than other methods. See 2 Record 427–428. His disinterest in protecting fetal life is evidenced by his agreement "that the abortion patient has a right not only to be rid of the growth, called a fetus in her body, but also has a right to a dead fetus." *Id.*, at 431. He also agreed that he "[n]ever ha[s] any intention of trying to protect the fetus, if it can be saved," *id.*, and finally that "as a general principle" "[t]here should not be a live fetus," *id.*, at 435. Moreover, contrary to every other view, he thought a fetus could survive a D&E abortion. *Id.*, at 433–434. None of the other physicians who testified at the trial, those called both by the plaintiffs and defendants, considered that *any* use of D&E after viability was indicated. See 1 Record 21 (limiting use of D&E to under 18 weeks); 2 Record 381, 410–413 (Dr. Robert Kretzschmar) (D&E up to 17 weeks; would never perform D&E after 26 weeks); 4 Record 787 (almost "inconceivable" to use D&E after viability); 7 Record 52 (D&E safest up to 18 weeks); *id.*, at 110 (doctor not performing D&E past 20 weeks); *id.*, at 111 (risks of doing outpatient D&E equivalent to childbirth at 24 weeks). See also 8 Record 33, 78–81 (deposition of Dr. Willard Cates) (16 weeks latest D&E performed). Apparently Dr. Crist performed abortions only in Kansas, 2 Record 334, 368, 428, a state having no statutes comparable to § 188.030.1 and § 188.030.2. It is not clear whether he was operating under or familiar with the limitations imposed by Missouri law. Nor did he explain the circumstances when there were "contraindications" against the use of any of the procedures that could preserve viability, or whether his conclusory opinion was limited to emergency situations. Indeed, there is no record evidence that D&E ever will be the method that poses the least risk to the woman in those rare situations where there are compelling medical reasons for performing an abortion after viability. If there were such instances, they hardly would justify invalidating § 188.030.3.

In addition to citing Dr. Crist in its footnote, the District Court cited—with no elaboration—Dr. Schmidt. His testimony, reflecting no agreement with Dr. Crist, is enlightening. Although he conceded that the attendance of a second physician for a D&E abortion on a viable fetus was not necessary, he considered the point mostly theoretical, because he "simply [did] not believe that the question of viability comes up when D&E is an elected method of abortion." 4 Record 836. When reminded of Dr. Crist's earlier testimony, he conceded the remote possibility of third-trimester D&E abortions, but stated: "I personally cannot conceive that as a significant practical point. It may be important legally, but [not] from a medical standpoint. . . ." *Ibid.* Given that Dr. Crist's discordant testimony is wholly unsupported, the State's compelling interest in protecting a viable fetus justifies the second-physician requirement even though there may be the rare case when a physician may think honestly that D&E is required for the mother's health. Legislation need not accommodate every conceivable contingency.

[8] There is no clearly expressed exception on the face of the statute for the performance of an abortion of a viable fetus without the second physician in attendance. There may be emergency situations where, for example, the woman's health may be endangered by delay. Section § 188.030.3 is qualified, at least in part, by the phrase "provided that it does not pose an increased risk to the life or health of the woman." This clause reasonably could be construed to apply to such a situation. Cf. *H.L.* v. *Matheson*, 450 U. S. 398, 407, n. 14 (1981) (rejecting argument that Utah statute might apply to individuals with emergency health care needs).

[9] See ACOG Technical Bulletin No. 56, *supra* n. 7, at 4 (as high as 7% live-birth rate for intrauterine instillation of uterotonic agents); Stroh & Hinman, Reported Live Births Following Induced Abortion: Two and One-Half Years' Experience in Upstate New York, 126 Am. J. Obstet. Gynecol. 83, 83–84 (1976) (26 live births following saline induced-abortions; 9 following hysterotomy; 1 following oxytocin-induced abortion) (one survival out of 38 live births); 4 Record 728 (50–62% mortality rate for fetuses 26 and 27 weeks); id., at 729 (25–92% mortality rate for fetuses 28 and 29 weeks); id., at 837 (50% mortality rate at 34 weeks).

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THE PHILADELPHIA INQUIRER
August 2, 1981

Document #28

How Things Sometimes Go Wrong

Of the various ways to perform an abortion after the midpoint of pregnancy, there is only one that never, ever results in live births.

It is D&E (dilatation and evacuation), and not only is it foolproof, but many researchers consider it safer, cheaper and less unpleasant for the patient. However, it is particularly stressful to medical personnel. That is because D&E requires literally cutting the fetus from the womb and, then, reassembling the parts, or at least keeping them all in view, to assure that the abortion is complete.

Ten years ago it was considered reckless to do an abortion with cutting instruments after the first trimester of pregnancy. Now, improved instruments, more skilled practitioners and laminaria — bands of seaweed that expand when moist and are used to gently dilate the cervix, creating an opening through which to extract fetal parts — allow the technique to be used much later.

D&E is being hailed as extending the safe and easy techniques used for first-trimester abortions (cutting or vacuuming out the contents of the womb) well into the second three months of pregnancy. But there are dissenters. Dr. Bernard Nathanson, formerly a top New York City abortionist, now an anti-abortion author and lecturer, says that D&E "is a very dangerous technique in the hands of anyone less than highly skilled."

Besides, D&E puts all the emotional burden on the physician. And there are other techniques that allow the doctor, as one physician put it, to "stick a needle in the [patient's] tummy," then leave the patient to deliver the fetus vaginally as in normal childbirth and nurses to assist and clean up.

These more common methods for abortions after the midpoint of pregnancy use the instillation of either saline solution or prostaglandin. In these procedures, some of the woman's nurturing amniotic fluid is drawn out of the womb by an injection through her belly and is replaced with the abortion-inducing drug. (The amount of fluid in the womb is kept relatively constant to make sure the womb does not rupture.)

The two instillation substances work in different ways. Saline solution poisons the fetus, probably though ingestion, though the process is not completely understood. Usually within six hours, the fetal heartbeat stops. At the same time, the saline induces labor, though supplemental doses of other labor-inducing drugs often are given to speed this effect.

Prostaglandin, on the other hand, is a distillate of the chemical substance that causes muscles to move. It is thought not to affect the fetus directly but instead is potent at inducing labor. Fetal death, if it does occur, is from prematurity and the trauma of passage through the birth canal.

Each substance also has an undesired side effect. Saline, an anti-coagulant that increases bleeding, can make minor bleeding problems more serious and in rare cases even cause death. Prostaglandin, because it causes muscles to contract indiscriminately, was found to cause vomiting and diarrhea in more than half the patients in early tests. Claims that it causes fewer major complications, which made it preferred to saline by many in the mid-1970s, have now been questioned. And the high incidence of live births (40 times more frequent than with saline, according to one study) also has lessened its popularity.

But saline is not foolproof either in preventing live births. Dr. Thomas F. Kerenyi of Mt. Sinai Hospital in New York, the best-known researcher on saline abortions, said most live births result from "errors in technique" — either administering too small a dosage or getting some of it into the wrong part of the womb.

A wrong estimation of gestational age can cause either a saline or prostaglandin abortion to fail. A larger-than-expected fetus might survive the trauma of labor or might reject a dose of saline (or urea, a third instillation substance sometimes used).

And on the basis of physical examination alone, studies show, doctors miss the correct gestational age by two weeks in one case out of five, by four weeks in one case out of 100, and sometimes by more than that. Pregnancies can be dated more exactly by a sonogram, a test that produces an outline image of the fetus in the womb, but because of its cost (about $100) many doctors continue to rely on physical exams.

There is one other abortion technique, hysterotomy, but it is the least desirable of all from several points of view. Because it is invasive surgery (identical to a Caesarean section), it has a much higher rate of complication than do the instillation techniques. Usually done only after attempts to abort with saline have failed, it has the highest incidence of all of live births.

As the infant is lifted from the womb, said one obstetrician, "he is only sleeping, like his mother. She is under anesthesia, and so is he. You want to know how they kill him? They put a towel over his face so he can't breathe. And by the time they get him to the lab, he is dead."

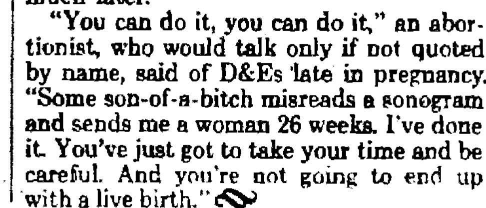
Over the years, the chief criterion in choosing between abortion methods has been safety for the patient. Advocates of D&E contend that bleeding, perforation of the uterus and infection all occur less frequently with D&E than with other methods. Dr. Willard Cates of the Center for Disease Control in Atlanta prefers D&E. Because it can be done — unlike instillation — in the early part of the second trimester, he has said, the need for as many as 80 percent of the very late abortions could be eliminated.

How very late are abortions performed?

His own clinic at Mt. Sinai, Dr. Kerenyi said, screens patients closely to make sure they are not past the legal 24-week limit. But in theory, he said, there is nothing to prevent successful saline abortions from being performed "virtually all the way to birth. At 30 weeks, say, you would just have to draw off and inject that much more of the solution."

Most practitioners who were interviewed say they stop doing D&E at 18 to 22 weeks. But again, there appears to be nothing to prevent the technique from being used much later.

"You can do it, you can do it," an abortionist, who would talk only if not quoted by name, said of D&Es late in pregnancy. "Some son-of-a-bitch misreads a sonogram and sends me a woman 26 weeks. I've done it. You've just got to take your time and be careful. And you're not going to end up with a live birth."



Nurse to Senate: 'ashamed' of profession

By DICK CONKLIN

It was a "good news, bad news" story. Florida's call for a human life amendment, via special constitutional convention, gained new support in the state senate this year, and easily won committee approval. But in the state house of representatives, opponents defeated it in committee and shouted it down on the floor.

One could go on for pages analyzing what happened. Why one house of the legislature was prolife and the other not... where lobbying efforts paid off... when support of the Senate leadership made the difference... which areas of the state were best organized, etc.

Testimonies at the hearings were important too. Not only for the benefit of the Senate Rules Committee members, but for other senators watching later on TV. One simple testimony, given by Kathleen Malloy, a Jacksonville nurse, received the hushed attention of even the pro-abortion lobbyists in the room, and thanks to Florida Public Television, was watched by thousands at home. When she finished, the pro-life resolution passed with a 12-4 vote, including the support of Dade's Sen. Vernon Holloway, and Broward's Sen. Jim Scott. The sponsor was Sen. Van Poole, Ft. Lauderdale.

NURSE'S TESTIMONY

"I'm a housewife and a registered nurse from Jacksonville. I retired from the nursing profession when I became pregnant with my first child and stayed retired until my fourth child was in the sixth grade. I then returned to work in my local hospital in the labor and delivery room. Many things progressed in those years—some things regressed. I learned by seeing with my own eyes that to have an abortion is to rid oneself of a human being!

"I worked the 11 p.m. to 7 a.m. shift, and when we weren't busy I'd go out to help with the newborns. One night when I went to the nursery I saw a bassinet outside the nursery. There was a baby in this bassinet—a crying, perfectly formed baby— but there was a difference in this child. She had been scalded. She was the child of a saline abortion.

"This little girl looked as if she had been put in a pot of boiling water. No doctor, no nurse, no parent to comfort this hurt, burned child. She was left alone to die in pain. They wouldn't let her inside the nursey — they didn't even bother to cover her.

"I was ashamed of my profession that night! It's hard to believe this can happen in our modern hospital but it does. It happens all the time. I thought a hospital was a place to heal the sick— not a place to kill.

"I asked a nurse in another hospital what they do with their babies who are aborted by saline. Unlike the hospital where I work, where the baby was left alone struggling for breath, their hospital puts the infant in a bucket and puts the lid on. Suffocation! Death by suffocation!

"Another nurse said she had to stop helping with abortions. The little severed arms and legs from a suction abortion were just too much for her to look at.

"Gentlemen... ladies... aren't you happy our moms weren't born in this generation. It could have been one of us that ended in that lonely bassinet —or in that ugly bucket. We must respect life. Please, I ask you to support a constitutional convention... thanks for listening."

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THE VOICE (Miami)
May 25, 1979

Must Infanticide Be Tolerated as Part of Abortion?

That troubling abortion-murder case involving California obstretician-gynecologist Dr. William Waddill is over, after two months-long trials.

But the second mistrial (the jury deadlocked 11 to 1 for acquittal this week after eight days of deliberation) and the subsequent dismissal of charges against the doctor still leave a nasty residual question: Have we come one step closer to tolerating infanticide as a necessary adjunct to abortion?

IT LOOKS THAT way, from the refusal of two juries to convict Dr. Waddill after repeated testimony that he not only orderd hospital nurses not to try to help a 2 pound, 14 ounce, girl born following a saline abortion, but also that a pediatrician heard him debate aloud how he could kill her and saw him actively strangle her. (A first trial ended in a 7 to 5 deadlock after 11 days of deliberation.)

Testimony in both trials indicated that the baby girl had survived the abortion performed on her 17 year old mother, that she was alive in the newborn nursery of Westminster Community Hospital about an hour after her birth; and that she had some chance of survival as a normal child.

BY FAILING TO convict the physician, jurors also managed to si-

Joan Beck

destep another troubling moral issue: How could it be all right for Dr. Waddill to kill the Weaver baby on the morning of March 2, 1977, while still in the womb of her mother — but murder if he killed the same baby several hours later in the newborn nursery?

Two mistrials, of course, do not set legal precedents. But they sometimes reflect public opinion — and perhaps influence it. And what the Waddill juries seem to suggest is that infanticide is all right if it can be considered just another phase of abortion, that a mother is entitled not only to be free of an unwanted pregnancy, but also to have the infant dead. (Never mind that had the infant survived and particularly if her mother had carried her a few weeks longer, dozens of couples would have wanted to adopt her.)

WE'VE ALREADY come close to extending the concept of abortion to include infanticide in a few other cases, Notes John T. Noonan Jr., law professor at the University of California, Berkeley, in his new book, *A Private Choice*.

But how dangerous and repugnant it is to cross that line morally, legally and medically. For it erases the pro-abortion argument that an unborn child is not a living human being, but merely a glob of tissue until its rights and protections as a human person begin at the instant of birth. And it leaves open-ended the question of when, then, can a life be terminated because it is "unwanted" by someone else.

Many states do have laws requiring active resuscitation of infants born alive following abortion. But babies who survive abortion do face grave risks of permanent mental and-or physical damage because of extreme prematurity and the injuries inflicted by the abortion process. What kind of a people are we, to let life begin like this — or end with infanticide?

THE WADDILL case points up, dramatically and sadly, the unresolved legal, medical and moral dilemmas in our current abortion practices. We do not like to see ourselves as a cruel people. Yet our sympathy for women with unwanted pregnancies has led us to kill unborn children by the painful process of dismembering them alive or poisoning them in the womb — and now, occasionally, to kill them deliberately after birth.

The nation is deeply and intransigently split on abortion. But as a beginning, could we not re-examine our policies of permissiveness toward second trimester abortion (except in medical necessity)? Stopping second trimester abortion would prevent babies from being born alive, like the Weaver infant. And it would eliminate some of the current cruelties to living, unborn children — who can feel pain and do try to escape painful stimuli as early as the 9th week after conception.

IT IS URGENT that we define unborn children as human beings and not globs of tissues for another reason, too. Much mental retardation and many congential disabilities that result in lifelong handicaps can be prevented if parents and doctors take good care of unborn children from the beginning of their lives. Public opinion must consider the unborn as real children — not tissue globs — if we are to assure they will get the care they need.

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A BABY'S DEATH RAISES QUESTIONS:
Is There No Longer Any Difference?

The baby was born with a cleft palate, clenched hands and a number of internal defects, including a heart problem that could have killed him in a few months.

But that's not what he died of. An autopsy report listed the cause of death as cranial cerebral injury, skull fracture and blunt trauma. The baby's father, 35-year-old John McKay, described by a neighbor as a man with "a heart of gold," is charged with pounding the child to death.

According to United Press International, several nurses at Ingalls Memorial Hospital in Harvey, Ill., said they saw McKay, who 30 minutes earlier had witnessed the baby's birth, take the infant out of the incubator. McKay, it is alleged, then repeatedly bashed the baby's head against the floor and then flung him into a corner of the room.

It's such an awful, gruesome thing that it may be gratuitous to try to draw any conclusion, except, possibly, temporary insanity. (McKay is free on $200,000 bond on the condition that he undergo psychiatric tests.) And yet there are other conclusions – questions, anyway – that won't go away.

For instance: In what way is the thing McKay is charged with different from what doctors in other cases have freely (if agonizingly) admitted? I think of "Infant Doe," the deformed Indiana baby that doctors allowed to starve to death rather than repair his incomplete esophagus. (The baby also had Down's syndrome.)

Does it matter, except, perhaps, esthetically, whether death comes as a result of withheld medical care, starvation, injection or bashing?

Is there a moral distinction between bashing the head of a half-hour-old baby or using a saline injection to kill the same baby a half-hour before birth?

Does it matter whether the killing is performed by a doctor as agent of the parents or by the parents directly?

Does it matter whether the act involved malice against the infant or only sympathy for the parents? Whether the killer is nasty or kind?

McKay, a veterinarian with a "heart of gold," apparently is kind enough. "I had to put my dog to sleep last week," a neighbor said,

William Raspberry

"but he worked for two days trying to save her before he would do it. He cared for animals and he cared about people."

Few of us would see anything objectionable if the kindhearted veterinarian had "put to sleep" a pitifully deformed puppy, although even in that case we might have been a little squeamish if he had simply bashed the poor animal's head in. But aren't babies and puppies different?

And then there is this question: What is the crucial difference between killing a defective newborn infant whose deformities were previously unknown and killing an unborn baby as soon as serious defects are discovered? Is there a moral distinction between bashing the head of a half-hour-old baby or using a saline injection to kill the same baby a half-hour before birth?

Some who describe themselves as being "pro-choice" insist that there is a crucial difference between killing a baby and interrupting a pregnancy, no matter how far advanced. Is this a distinction without a moral difference?

I don't pretend that the answers are, in all cases, easy. I do say that the allegations against McKay give the questions new urgency.

The doctor in the McKay case permitted himself one interesting conclusion: "I think this is a fine example," he said, "of the faults of having a father present at childbirth."

I won't try to guess what he would have said if it had been the mother who was charged in the case.

By William Raspberry. Mr. Raspberry is a nationally syndicated columnist. Reprinted by permission of the Washington Post.

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concerned. Assuming that legislative bodies are able to engage in this exacting task,[4] it is difficult to believe that our Constitution *requires* that they do it as a prelude to protecting the health of their citizens. It is even more difficult to believe that this Court, without the resources available to those bodies entrusted with making legislative choices, believes itself competent to make these inquiries and to revise these standards every time the American College of Obstetricians and Gynecologists (ACOG) or similar group revises its views about what is and what is not appropriate medical procedure in this area. Indeed, the ACOG standards on which the Court relies were changed in 1982 after trial in the present cases. Before ACOG changed its standards in 1982, it recommended that all mid-trimester abortions be performed in a hospital. See *Akron Center for Reproductive Health, Inc.* v. *City of Akron*, 651 F. 2d 1198, 1209 (CA6 1981). As today's decision indicates, medical technology is changing, and this change will necessitate our continued functioning as the nation's "*ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States." *Planned Parenthood* v. *Danforth*, 428 U. S. 52, 99 (1976) (WHITE, J., concurring in part and dissenting in part).

Just as improvements in medical technology inevitably will move *forward* the point at which the State may regulate for reasons of maternal health, different technological improvements will move *backward* the point of viability at which the State may proscribe abortions except when necessary to preserve the life and health of the mother.

In 1973, viability before 28 weeks was considered unusual. The fourteenth edition of L. Hellman & J. Pritchard, Williams Obstetrics, on which the Court relied in *Roe* for its understanding of viability, stated that "[a]ttainment of a [fetal] weight of 1,000 g [or a fetal age of approximately 28 weeks gestation] is . . . widely used as the criterion of viability." *Id.*, at 493. However, recent studies have demonstrated increasingly earlier fetal viability.[5] It is certainly reasonable to believe that fetal viability in the first trimester of pregnancy may be possible in the not too distant future. Indeed, the Court has explicitly acknowledged that *Roe* left the point of viability "flexible for anticipated advancements in medical skill." *Colautti* v. *Franklin*, 439 U. S. 379, 387 (1979). "[W]e recognized in *Roe* that viability was a matter of medical judgment, skill, and technical ability, and we preserved the flexibility of the term." *Danforth, supra*, 428 U. S., at 64.

The *Roe* framework, then, is clearly on a collision course with itself. As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health is moved further forward to actual childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception. Moreover, it is clear that the trimester approach violates the fundamental aspiration of judicial decision making through the application of neutral principles "sufficiently absolute to give them roots throughout the community and continuity over significant periods of time . . . ." A. Cox, The Role of the Supreme Court in American Government 114 (1976). The *Roe* framework is inherently tied to the state of medical technology that exists whenever particular litigation ensues. Although legislatures are better suited to make the necessary factual judgments in this area, the Court's framework forces legislatures, as a matter of constitutional law, to speculate about what constitutes "accepted medical practice" at any given time. Without the necessary expertise or ability, courts must then pretend to act as science review boards and examine those legislative judgments.

The Court adheres to the *Roe* framework because the doctrine of *stare decisis* "demands respect in a society governed by the rule of law." *Ante*, at 2. Although respect for *stare decisis* cannot be challenged, "this Court's considered practice [is] not to apply *stare decisis* as rigidly in constitutional as in nonconstitutional cases." *Glidden Company* v. *Zdanok*, 370 U. S. 530, 543 (1962). Although we must be mindful of the "desirability of continuity of decision in constitutional questions. . . . when convinced of former error, this Court has never felt constrained to follow precedent. In constitutional questions, when correction depends on amendment and not upon legislative action this Court throughout its history has freely exercised its power to reexamine the basis of its constitutional decisions." *Smith* v. *Allwright*, 321 U. S. 649, 665 (1944) (footnote omitted).

Even assuming that there is a fundamental right to terminate pregnancy in some situations, there is no justification in law or logic for the trimester framework adopted in *Roe* and employed by the Court today on the basis of *stare decisis*. For the reasons stated above, that framework is clearly an unworkable means of balancing the fundamental right and the compelling state interests that are indisputably implicated.

II

The Court in *Roe* correctly realized that the State has important interests "in the areas of health and medical standards" and that "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." 410 U. S., at 149, 150. The Court also recognized that the State has "*another* important and legitimate interest in protecting the potentiality of human life." *Id.*, at 162 (emphasis in original). I agree completely that the State has these interests, but in my view, the point at which these interests become compelling does not depend on the trimester of pregnancy. Rather, these interests are present *throughout* pregnancy.

This Court has never failed to recognize that "a State may properly assert important interests in safeguarding health [and] in maintaining medical standards." 410 U. S., at 154. It cannot be doubted that as long as a state statute is within "the bounds of reason and [does not] assume[] the character of a merely arbitrary fiat. . . . [then] [t]he State . . . must de-

[4] Irrespective of the difficulty of the task, legislatures, with their superior fact-finding capabilities, are certainly better able to make the necessary judgments than are Courts.

[5] One study shows that infants born alive with a gestational age of less than 25 weeks and weight between 500 and 1,249 grams have a 20% chance of survival. See Phillip, et al., *Neonatal Mortality Risk for the Eighties: The Importance of Birth Weight/Gestational Age Groups*, 68 Pediatrics 122 (1981). Another recent comparative study shows that preterm infants with a weight of 1000 grams or less born in one hospital had a 42% rate of survival. Kopelman, *The Smallest Preterm Infants: Reasons for Optimism and New Dilemmas*, 132 Am. J. Diseases Children 461 (1978). An infant weighing 484 grams and having a gestational age of 22 weeks at birth is now thriving in a Los Angeles hospital, and the attending physician has stated that the infant has a "95% chance of survival." Washington Post, March 31, 1983, p. A2, col. 2. The aborted fetus in No. 81-185, *Simopoulos* v. *Virginia*, *post*, weighed 495 grams and was approximately 22 gestational weeks.

Recent developments promise even greater success in overcoming the various respiratory and immunological neonatal complications that stand in the way of increased fetal viability. See, *e. g.*, Beddis, et al., *New Technique for Servo-Control of Arterial Oxygen Tension in Preterm Infants*, 54 Archives of Disease Childhood 278 (1979). "There is absolutely no question that in the current era there has been a sustained and progressive improvement in the outlook for survival of small premature infants." Stern, *Intensive Care of the Pre-Term Infant*, 26 Danish Med. Bull. 144 (1979).

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cide upon measures that are needful for the protection of its people . . . ." *Purity Extract and Tonic Co.* v. *Lynch*, 226 U. S. 192, 204-205 (1912). "There is nothing in the United States Constitution which limits the State's power to require that medical procedures be done safely . . . ." *Sendak* v. *Arnold*, 429 U. S. 968, 969 (WHITE, J., dissenting). "The mode and procedure of medical diagnostic procedures is not the business of judges." *Parham* v. *J. R.*, 442 U. S., 584, 607-608 (1979). Under the *Roe* framework, however, the state interest in maternal health cannot become compelling until the onset of the second trimester of pregnancy because "until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." 410 U. S., at 163. Before the second trimester, the decision to perform an abortion "must be left to the medical judgment of the pregnant woman's attending physician." *Id.*, at 164.[6]

The fallacy inherent in the *Roe* framework is apparent: just because the State has a compelling interest in ensuring maternal safety once an abortion may be more dangerous in childbirth, it simply does not follow that the State has *no* interest before that point that justifies state regulation to ensure that first-trimester abortions are performed as safely as possible.[7]

The state interest in potential human life is likewise extant throughout pregnancy. In *Roe*, the Court held that although the State had an important and legitimate interest in protecting potential life, that interest could not become compelling until the point at which the fetus was viable. The difficulty with this analysis is clear: *potential* life is no less potential in the first weeks of pregnancy than it is at viability or afterward. At any stage in pregnancy, there is the *potential* for human life. Although the Court refused to "resolve the difficult question of when life begins," *id.*, at 159, the Court chose the point of viability—when the fetus is *capable* of life independent of its mother—to permit the complete proscription of abortion. The choice of viability as the point at which the state interest in *potential* life becomes compelling is no less arbitrary than choosing any point before viability or any point afterward. Accordingly, I believe that the State's interest in protecting potential human life exists throughout the pregnancy.

III

Although the State possesses compelling interests in the protection of potential human life and in maternal health throughout pregnancy, not every regulation that the State imposes must be measured against the State's compelling interests and examined with strict scrutiny. This Court has acknowledged that "the right in *Roe* v. *Wade* can be understood only by considering both the woman's interest and the nature of the State's interference with it. *Roe* did not declare an unqualified 'constitutional right to an abortion,' . . . . Rather, the right protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy." *Maher*, *supra*, 432 U. S., at 473-474. The Court and its individual Justices have repeatedly utilized the "unduly burdensome" standard in abortion cases.[8]

The requirement that state interference "infringe substantially" or "heavily burden" a right before heightened scrutiny is applied is not novel in our fundamental-rights jurisprudence, or restricted to the abortion context. In *San Antonio Independent School District* v. *Rodriguez*, 411 U. S. 1, 37, 38 (1973), we observed that we apply "strict judicial scrutiny" only when legislation may be said to have "'deprived,' 'infringed,' or 'interfered' with the free exercise of some such fundamental personal right or liberty." If the impact of the regulation does not rise to the level appropriate for our strict scrutiny, then our inquiry is limited to whether the state law bears "some rational relationship to legitimate state purposes." *Id.*, at 40. Even in the First Amendment context, we have required in some circumstances that state laws "infringe substantially" on protected conduct, *Gibson* v. *Florida Legislative Investigation Committee*, 372 U. S. 539, 545 (1963), or that there be "a significant encroachment upon personal liberty," *Bates* v. *City of Little Rock*, 361 U. S. 516, 524 (1960).

In *Carey* v. *Population Services International*, 431 U. S. 678 (1977), we eschewed the notion that state law had to meet the exacting "compelling state interest" test "'whenever it implicates sexual freedom.'" *Id.*, at 688, n. 5. Rather, we required that before the "strict scrutiny" standard was employed, it was necessary that the state law "impose[ ] a significant burden" on a protected right, *id.*, at 689, or that it "burden an individual's right to prevent conception or terminate pregnancy by *substantially* limiting access to the means of effectuating that decision . . . ." *Id.*, at 688 (emphasis added). The Court stressed that "even a burdensome regulation may be validated by a sufficiently compelling state interest." *Id.*, at 686. Finally, *Griswold* v. *Connecticut*, 381 U. S. 479, 485 (1965) recognized that a law banning the use of contraceptives by married persons had "a maximum destruc-

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[6] Interestingly, the Court in *Danforth* upheld a recordkeeping requirement as well as the consent provision even though these requirements were imposed on first-trimester abortions and although the State did not impose comparable requirements on most other medical procedures. See *Danforth*, *supra*, 428 U. S., at 65-67, 79-81 (1976). *Danforth*, then, must be understood as a retreat from the position ostensibly adopted in *Roe* that the State had *no* compelling interest in regulation during the first trimester of pregnancy that would justify restrictions imposed on the abortion decision.

[7] For example, the 1982 ACOG Standards, on which the Court relies so heavily in its analysis, provide that physicians performing first-trimester abortions in their offices should provide for prompt emergency treatment or hospitalization in the event of an complications. See ACOG Standards, at 54. ACOG also prescribes that certain equipment be available for office abortions. See *id.*, at 57. I have no doubt that the State has a compelling interest to ensure that these or other requirements are met, and that this legitimate concern would justify state regulation for health reasons even in the first trimester of pregnancy.

[8] See *Bellotti* v. *Baird*, 428 U. S. 132, 147 (1976) (*Bellotti I*) (State may not "impose undue burdens upon a minor capable of giving informed consent." In *Bellotti I*, the Court left open the question whether a judicial hearing would unduly burden the *Roe* right of an adult woman. See 428 U. S., at 147.); *Bellotti* v. *Baird*, 443 U. S. 622, 640 (1979) (*Bellotti II*) (opinion of JUSTICE POWELL) (State may not "unduly burden the right to seek an abortion"); *Harris* v. *McRae*, 448 U. S. 297, 314 (1980) *supra*, 448 U. S., at 314 ("The doctrine of *Roe* v. *Wade*, the Court held in *Maher* 'protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy,' [432 U. S., at 473-474], such as the the severe criminal sanctions at issue in *Roe* v. *Wade*, *supra*, or the absolute requirement of spousal consent for an abortion challenged in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U. S. 52"); *Beal* v. *Doe*, 432 U. S. 438, 446 (1977) (The state interest in protecting potential human life "does not, at least until approximately the third trimester, become sufficiently compelling to justify unduly burdensome state interference . . . ."); *Carey* v. *Population Services International*, 431 U. S. 678, 705 (1977) (POWELL, J., concurring in part and concurring in the judgment) ("In my view, [*Roe* and *Griswold*] make clear that the [compelling state interest] standard has been invoked only when the state regulation entirely frustrates or heavily burdens the exercise of constitutional rights in this area. See *Bellotti* v. *Baird*, 428 U. S. 132, 147 (1976)."). Even though the Court did not explicitly use the "unduly burdensome" standard in evaluating the informed-consent requirement in *Planned Parenthood* v. *Danforth*, 428 U. S. 52 (1976), the informed-consent requirement for first trimester abortions in *Danforth* was upheld because it did not "unduly burden[] the right to seek an abortion." *Bellotti I*, supra, 428 U. S., at 147.

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