

Summer 1980

State Regulation of Late Abortion and the Physician's Duty of Care to the Viable Fetus

Mary Anne Wood

Lisa Bolin Hawkins

Follow this and additional works at: <https://scholarship.law.missouri.edu/mlr>



Part of the [Law Commons](#)

Recommended Citation

Mary Anne Wood and Lisa Bolin Hawkins, *State Regulation of Late Abortion and the Physician's Duty of Care to the Viable Fetus*, 45 Mo. L. REV. (1980)

Available at: <https://scholarship.law.missouri.edu/mlr/vol45/iss3/2>

This Article is brought to you for free and open access by the Law Journals at University of Missouri School of Law Scholarship Repository. It has been accepted for inclusion in Missouri Law Review by an authorized editor of University of Missouri School of Law Scholarship Repository. For more information, please contact bassettcw@missouri.edu.

STATE REGULATION OF LATE ABORTION AND THE PHYSICIAN'S DUTY OF CARE TO THE VIABLE FETUS

Mary Anne Wood*
Lisa Bolin Hawkins**

I. INTRODUCTION

Seven years after *Roe v. Wade*,¹ its legacy of unresolved issues² surrounding the abortion decision appears larger than ever before, despite the growing number of legal opinions interpreting the various ramifications of *Roe v. Wade* and its companion case, *Doe v. Bolton*.³ Perhaps none of the unresolved issues is more troubling than those concerning the extent to which a state can regulate the abortion process as the fetus approaches and attains viability.

Two widely publicized criminal prosecutions and two recent Supreme Court decisions illustrate these issues. In *Commonwealth v. Edelin*,⁴ a doctor who was convicted of manslaughter following the death after an abortion of a twenty-one to twenty-four week fetus appealed his conviction to the Massachusetts Supreme Judicial Court. Dr. Edelin and his supervisor, Dr. Penza, unsuccessfully attempted to abort the fetus by saline amniocentesis.⁵ After repeated attempts failed to produce conditions suitable for the introduction of the saline solution, Dr. Edelin performed a hysterotomy.⁶ He made an incision in the patient's abdomen and then detached the placenta from the uterine wall, thus cutting off the fetus' oxygen supply. According to the testimony of a doctor who was observing the surgery, Dr. Edelin then left his hand in the uterus for three minutes.⁷ After removing the fetus and finding no signs of life, he placed it in a basin.⁸ The prosecution argued that the fetus was alive after the placenta was separated from the uterine wall, and that Dr. Edelin had a duty to care for it. According to the prosecution, the three minute delay in remov-

*Associate Professor of Law, J. Reuben Clark Law School, Brigham Young University. B.A., 1966, Brigham Young University; J.D., 1976, National Law Center, George Washington University.

**B.A., 1976, Brigham Young University; J.D., 1980, J. Reuben Clark Law School, Brigham Young University.

1. 410 U.S. 113 (1973).

2. *Id.* at 165 n.67.

3. 410 U.S. 179 (1973).

4. 371 Mass. 497, 359 N.E.2d 4 (1976).

5. For a description of the saline abortion technique, see notes 29-32 and accompanying text *infra*.

6. 371 Mass. at 502-03, 359 N.E.2d at 7. For a description of the hysterotomy abortion technique, see notes 48-52 and accompanying text *infra*.

7. 371 Mass. at 506-07, 359 N.E.2d at 9.

8. *Id.* at 503-04, 359 N.E.2d at 7.

ing the fetus from the uterus caused the infant's death and constituted manslaughter.⁹ The defense maintained that the manslaughter statute was inapplicable unless the fetus was "born alive completely outside the mother's body."¹⁰ Edelin's conviction was reversed by a unanimous Massachusetts Supreme Judicial Court. Five justices voted for acquittal because of insufficient evidence of the wanton and reckless omission of care required for manslaughter.¹¹ Three of the five also would have granted acquittal because there was insufficient evidence of live birth and a variance between the charges in the indictment and the charges proved.¹² A sixth justice would have remanded for a new trial because of an inadequate jury instruction.¹³

A second case involving the death of an aborted fetus was *State v. Waddill*.¹⁴ In 1978 a California obstetrician was prosecuted for the death of an infant born alive after an abortion. The defendant performed an abortion by saline instillation,¹⁵ and instead of the anticipated twenty-two week fetus, the abortion resulted in the live birth of a thirty-one week infant. The hospital's chief pediatrician alleged that Dr. Waddill purposely strangled the infant when it did not expire after the abortion.¹⁶ Two trials both resulted in hung juries. The judge exercised his discretion to dismiss the case in the interests of justice after the second jury voted eleven to one for acquittal.¹⁷

The United States Supreme Court recently considered the case of another doctor charged with the death of an aborted fetus. In *Anders v. Floyd*,¹⁸ Dr. Floyd sought to enjoin his prosecution in a South Carolina state court on charges of illegal abortion and murder. The doctor was indicted after the death of a baby boy, who was aborted by Dr. Floyd at twenty-five weeks gestation via prostaglandin instillation,¹⁹ and lived for twenty days.²⁰ The three-judge district court enjoined the prosecution, inferring that the fetus was not viable,²¹ but the Supreme Court vacated the injunction and remanded the case to the district court for reconsideration in the light of *Colautti v. Franklin*.²² In a per curiam opinion, the

9. *Id.* at 507-08, 359 N.E.2d at 9-10.

10. *Id.* at 508, 359 N.E.2d at 10.

11. *Id.* at 499, 359 N.E.2d at 5.

12. *Id.*

13. *Id.* at 533, 359 N.E.2d at 23.

14. No. C37815 (Cal. Super. Ct., dismissed June 11, 1979).

15. For a description of the saline abortion technique, see notes 29-32 and accompanying text *infra*.

16. NEWSWEEK, Apr. 3, 1978, at 35.

17. Telephone conversation with Orange County, California, District Attorney's office (Dec. 12, 1979).

18. 440 U.S. 445 (1979).

19. For a description of prostaglandin instillation, see notes 33-36 and accompanying text *infra*.

20. *Floyd v. Anders*, 440 F. Supp. 535, 538 (D.S.C. 1977).

21. *Id.* at 539-40.

22. 439 U.S. 379 (1979).

Court suggested that the district court may have based its conclusion on an erroneous concept of "viability."²³

Pennsylvania's attempt to avoid the tragic situations represented by the cases of Drs. Edelin, Waddill, and Floyd was invalidated by the United States Supreme Court in the recent case of *Colautti v. Franklin*.²⁴ The Court declared unconstitutional sections of the Pennsylvania Abortion Control Act which had imposed a standard of care on the physician performing an abortion. The statute required the doctor to exercise the same care to preserve the fetus' life and health as would be required in the case of a fetus intended to be born alive, and to use the abortion technique providing the best opportunity for the fetus to be born alive, so long as a different technique would not be necessary to preserve the pregnant woman's life or health, when a fetus is viable or "may be viable."²⁵ The Court found the statute to be void for vagueness.²⁶

The Edelin, Waddill, and Floyd prosecutions illustrate the need for states to define the appropriate relationship between the doctor, the pregnant woman, and the fetus during the performance of late abortions.²⁷ The *Colautti* decision, however, may foreshadow the difficulties states will have in drafting legislation that will effectively define that relationship and be acceptable to the Supreme Court. The purpose of this article is to explore the possibility of state legislation defining the relationship between the aborting physician and the fetus so as to protect the state's interest in potential life. A discussion of late abortion methods will be followed by a study of the Supreme Court's rulings on late abortion. The *Colautti* decision and the problems posed by the decision will be discussed in detail. The article will conclude with a discussion of current and suggested state legislation.

II. BACKGROUND: LATE ABORTIONS

A. *Late Abortion Methods*

An understanding of the problems involved in regulating late abortions is enhanced by familiarity with the techniques used to induce late abortion and the potential complications of each method. Abortions performed in the United States at a time late enough for the fetus to be viable usually

23. 440 U.S. at 445.

24. 439 U.S. 379 (1979).

25. 35 PA. CONS. STAT. ANN. § 6605(a) (Purdon 1977).

26. 439 U.S. at 401.

27. An additional case illustrating the need for clarifying legislation involved a physician at the University of Nebraska hospital. Dr. Charles J. LaBenz was charged with criminal violation of the state's abortion law following the live birth after a saline abortion of a two-pound, nine-ounce boy of 26 weeks' gestational age who lived nearly three hours. Dr. LaBenz had estimated the fetus to be 19 gestational weeks old, thus allowing the abortion under the then applicable university policy prohibiting nontherapeutic abortions after the 20th week. The University's Board of Regents subsequently banned nontherapeutic abortions at the hospital. *MEDICAL WORLD NEWS*, Nov. 26, 1979, at 36-37.

involve one of three methods: saline or prostaglandin instillation, or hysterotomy.²⁸

I. Saline or Prostaglandin Instillation

The most commonly used late abortion method in the United States is hypertonic saline instillation, sometimes called saline amniocentesis or "salting out." This method involves the use of a hollow needle, which is inserted through the abdomen and the uterine wall and into the amniotic sac. Some of the amniotic fluid is then withdrawn and an equal or greater amount of saline solution is injected in its place.²⁹ The fetus dies of acute salt poisoning,³⁰ usually within one and one-half hours. Labor begins, usually within twenty-four hours, and continues until the fetus is expelled, thirty-six to seventy-two hours after the saline was injected.³¹ Reports of live births following saline instillation are extremely rare.³²

Prostaglandin instillation is similar to saline instillation, except that instead of the saline solution, a chemical compound causing muscular contractions is injected into the amniotic sac.³³ "In contrast to hypertonic saline, prostaglandin is not directly lethal to the fetus. The occasional delivery of a fetus with a heartbeat suggests that fetal death usually occurs close to the time of abortion, probably secondary to anoxia [deprivation of oxygen] during labor."³⁴ Thus, the chances of fetal survival following prostaglandin abortion are greater than the chances of fetal survival following saline abortion.³⁵ In fact, "many fetuses show signs of life at expulsion but die shortly thereafter."³⁶

Saline and prostaglandin abortion both involve possible complications including hemorrhage, infection, uterine fundal and cervical rupture, and retained products of conception.³⁷ Saline abortion patients also risk cardiovascular effects, coagulation disorders, tissue damage, and hypernatremia (a potentially life-threatening increase in the amount of sodium in the blood),³⁸ if the physician inadvertently introduces the saline solution

28. C. TIETZE, *INDUCED ABORTION*: 1979, at 70-71 (3d ed. 1979).

29. *Id.* at 68.

30. Galen, Chauhan, Wietzner & Nauvarro, *Fetal Pathology and Mechanism of Fetal Death in Saline-Induced Abortion*, 120 AM. J. OBSTETRICS & GYNECOLOGY 347, 347 (1974).

31. C. TIETZE, *supra* note 28, at 68.

32. GEO. WASH. U. MED. CENTER: DEP'T OF MED. & PUB. AFF., SERIES F, POPULATION REP. 68 (Sept. 1976).

33. C. TIETZE, *supra* note 28, at 68-69.

34. Globus & Erickson, *Mid-Trimester Abortion Induced by Intra-Amniotic Prostaglandin F_{2α}: Fetal Tissue Viability*, 119 AM. J. OBSTETRICS & GYNECOLOGY 268, 268 (1974).

35. Stroh & Hinman, *Reported Live Births Following Induced Abortion: Two and One-half Years' Experience in Upstate New York*, 126 AM. J. OBSTETRICS & GYNECOLOGY 83, 83 (1976).

36. C. TIETZE, *supra* note 28, at 69.

37. Brenner, *The Current Status of Prostaglandins as Abortifacients*, 123 AM. J. OBSTETRICS & GYNECOLOGY 306, 319-20 (1975).

38. GEO. WASH. U. MED. CENTER: DEP'T OF MED. & PUB. AFF., SERIES F, POPULATION REP. 70 (Sept. 1976).

Wood and Hawkins: Wood: State Regulation of Late Abortion and the Physician's Duty of Care to the Viable Fetus into the patient's vascular system.³⁹ Prostaglandin abortion patients often experience vomiting and some diarrhea, though these side effects are controllable with medication. Rare, potentially serious complications of prostaglandin instillation are bronchospasm (constriction of air passages in the lungs), cardiovascular changes, and grand mal seizure, usually due to inadvertant systemic (rather than intra-amniotic) administration.⁴⁰ Inadvertant intravascular injection of prostaglandins is less dangerous than inadvertant intravascular injection of saline.⁴¹

The relative merits of the prostaglandin and saline techniques have been debated in the medical literature. Although prostaglandin results in a shorter induction-to-abortion time and involves no danger of the coagulopathy, hypernatremia, and tissue damage associated with saline, repeat procedures are more frequently necessary, and heavy uterine bleeding requiring a transfusion or surgical evacuation of the uterus is more common in prostaglandin abortion.⁴² One study found higher rates of fever, endometritis, hemorrhage, retained products of conception, and convulsions in prostaglandin patients when compared to saline patients. The authors noted possible explanations for the differences as inexperience with the prostaglandin technique and selection of sub-optimal dosage schedules.⁴³ Most of the literature appears to support the contention that prostaglandin abortion is safer than saline abortion.⁴⁴

Possible psychological complications of the two instillation methods are similar. While any abortion may precipitate a psychological crisis in a susceptible individual, the most common psychological reaction to abortion is a feeling of relief.⁴⁵ The instillation methods may involve more complex psychological reactions, however, because a saline or prostaglandin abortion patient may not be attended by her physician when the fetus is

39. Brenner, *supra* note 37, at 320.

40. *Id.* at 319.

41. Dillon, Phillips, Risk, Horiguchi, Mohajer-Shojai & Mootabar, *The Efficacy of Prostaglandin F_{2α} in Second-Trimester Abortion*, 118 AM. J. OBSTETRICS & GYNECOLOGY 688, 696-97 (1974).

42. C. TIETZE, *supra* note 28, at 69, 80-81.

43. Grimes, Schulz, Cates & Tyler, *Midtrimester Abortion by Intraamniotic Prostaglandin F_{2α} Safer Than Saline?*, 19 OBSTETRICS & GYNECOLOGY 612, 614-15 (1977).

44. One comprehensive study noted five reasons why prostaglandins may be safer than saline: fewer cardiovascular effects, no coagulation problems, no sodium load, no hypernatremia, and no tissue damage due to inappropriate administration. Disadvantages of prostaglandin listed in the same study are the more frequent necessity of repeat procedures, higher rates of gastrointestinal side effects, higher costs (which may be offset by briefer hospitalization), and higher incidence of cervicovaginal fistulas. Brenner, *supra* note 37, at 320-21, 323; Edelman, Brenner, Mehta, Philips, Bhatt & Bhivandiwalla, *A Comparative Study of Intra-Amniotic Saline and Two Prostaglandin F_{2α} Dose Schedules for Midterm Abortion*, 125 AM. J. OBSTETRICS & GYNECOLOGY 188, 194 (1976); Fraser & Brash, *Comparison of Extra- and Intra-Amniotic Prostaglandins for Therapeutic Abortion*, 43 OBSTETRICS & GYNECOLOGY 97, 101 (1974).

45. C. TIETZE, *supra* note 28, at 77-78.

delivered, usually in the patient's hospital bed.⁴⁶ One study of prostaglandin abortion patients noted that, because the procedure is really an induction of labor, the patient had "a long and painful experience. . . . Anger at the attending physician for being unavailable was prominent."⁴⁷

In summary, the instillation methods involve the injection into the amniotic sac of a strong saline solution or a chemical that stimulates muscular contractions. Both methods cause the pregnant woman to go into labor and deliver the fetus. The prostaglandin method is more likely to result in fetal survival than is the saline method. Both methods involve a risk of physical complications, but the prostaglandin method may be safer than the saline method. The risk of psychological complications resulting from the two techniques is similar, with problems possibly related to the usual absence of the attending physician when the fetus is delivered.

2. Hysterotomy

Hysterotomy is similar to caesarean section, except the fetus is assumed to be nonviable. Hysterotomy is rarely used unless other methods fail because it is considered major surgery and involves more risk of complications to the pregnant woman.⁴⁸ As with prostaglandin instillation,⁴⁹ the hysterotomy procedure is not directly lethal to the fetus. Rather, the fetus is born alive and dies shortly thereafter due to its inability to survive outside the uterus. As alleged in the case of Dr. Edelin,⁵⁰ however, the obstetrician may deprive the fetus of oxygen and wait for it to die before removing it from the uterus. The possible complications of hysterotomy are similar to those for any major abdominal surgery, including hemorrhage, infection, fever, and the risks associated with general anesthesia.⁵¹ In addition, many

46. See M. DENES, IN NECESSITY AND SORROW 58 (1976); UTAH WOMEN'S CLINIC, FACTS ABOUT PREGNANCY 10 (n.d.).

47. Kaltreider, Goldsmith & Margolis, *The Impact of Midtrimester Abortion Techniques on Patients and Staff*, 135 AM. J. OBSTETRICS & GYNECOLOGY 235, 236 (1979). A similar reaction was expressed by the nurses caring for the prostaglandin patients:

On the gynecology hospital floor amnio [i.e., instillation method] abortions are viewed by the nurses as the most upsetting experiences which occur and a symbol of abandonment by the medical staff. The ward nurses' comments speak clearly to the point of being left to cope with an upset patient who delivers late at night. The house staff, although technically available, made clear their preference to be in the delivery room where "live births" occur.

Id. Because the attitudes of the nurses and other professionals involved may be closely associated with the level of emotional stress experienced by abortion patients, C. TIETZE, *supra* note 28, at 78, the saline or prostaglandin patient may be exposed to a higher risk of psychological complications, due to the adverse effects of the attending physician's absence, than are patients aborted by other techniques.

48. C. TIETZE, *supra* note 28, at 78.

49. See note 34 and accompanying text *supra*.

50. 371 Mass. at 502-03, 359 N.E.2d at 7. See H. BROWN, DEATH BEFORE BIRTH 104-05 (1977).

51. See C. TIETZE, *supra* note 28, at 69.

physicians believe that future abortions or deliveries experienced by hysterotomy patients must be effected by hysterotomy or caesarean section, because of the danger that the abortion-related scar will rupture during labor.⁵²

Psychological complications of hysterotomy may be less frequent than those experienced with the instillation methods. Because the hysterotomy patient receives general anesthesia, she may be able to avoid the potentially disturbing reality of the abortion choice, and any attendant psychological problems.⁵³

In order to understand recent Supreme Court pronouncements on abortion after viability, it is important to note the differences between the three common late abortion methods, the risks to the woman, and the impact on the fetus. Hysterotomy and prostaglandin instillation are more likely to result in the delivery of a live fetus than is saline instillation. Hysterotomy is more physically dangerous to the pregnant woman than are the instillation methods, but may involve fewer psychological risks. Prostaglandin abortion is likely to be safer for the pregnant woman than saline abortion. It must be emphasized that all of these methods involve some degree of danger to the pregnant woman. As one physician wrote, "Few risks in obstetrics are more certain than that which occurs to a . . . [woman] undergoing abortion after the 14th week of pregnancy."⁵⁴

B. *The United States Supreme Court's Rulings on Late Abortion*

Under the Supreme Court's decision in *Roe v. Wade*,⁵⁵ states have the option to regulate post-viability abortions. In that decision, the Supreme Court was confronted with the constitutionality of the Texas criminal abortion laws which prohibited abortion except when necessary to save the woman's life.⁵⁶ The Supreme Court maintained that a woman's right of privacy encompassed the decision whether or not to have an abortion, although this right was not absolute.⁵⁷ The Court divided pregnancy into trimesters and delineated appropriate state regulation of abortion during each period. The Court in *Roe* held that, in the first trimester, the abortion

52. *Id.*

53. One study comparing dilatation and extraction (D & E) patients, who, like hysterotomy patients, underwent general anesthesia, with prostaglandin patients reported that the D & E patients felt the abortion went smoothly and that the general anesthesia made the experience seem unreal. The D & E patients were able to avoid the stark details of the procedure and experienced less depression, anger, and guilt than the prostaglandin patients, who experienced more pain and described the abortion as being like labor or the loss of a child. Kaltreider, Goldsmith & Margolis, *supra* note 47, at 236.

54. Duenhoelter & Gant, *Complications Following Prostaglandin F_{2α}-Induced Midtrimester Abortion*, 46 *OBSTETRICS & GYNECOLOGY* 247, 250 (1975).

55. 410 U.S. 113 (1973).

56. *Id.* at 117 n.1.

57. *Id.* at 153.

decision and its effectuation must be left to the pregnant woman and her attending physician. In the second trimester, the state's interest in maternal health is sufficiently compelling to allow the state to regulate abortion in ways reasonably related to maternal health, but the state cannot prohibit abortion altogether. When the fetus attains viability, the state may regulate or prohibit abortion except when it is necessary to preserve the life or health of the pregnant woman. Viability was designated as the point at which the state's interest in potential life becomes compelling.⁵⁸ The only available constitutional protection of the fetus' life in the abortion context stems from that compelling state interest. The interest of the fetus in its own life, if such an interest exists, was not considered worthy of legal protection, as the fetus is not a "person" within the meaning of the fourteenth amendment.⁵⁹

Because any state attempt to regulate late abortions in order to protect the state's interest in potential life must wait until the fetus attains viability, the definition of viability is crucial. In *Roe v. Wade* the observation that the medical and scientific communities consider a fetus to be viable if it is "potentially able to live outside the mother's womb, albeit with artificial aid,"⁶⁰ was further defined to include the "capability of meaningful life."⁶¹ The Court pointed out that viability is "usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks."⁶² The medical nature of the judgment of viability and the necessity of leaving that point flexible, as a matter for the judgment of the physician on a case-by-case basis, were emphasized in *Doe v. Bolton*,⁶³ and reaffirmed in *Planned Parenthood v. Danforth*.⁶⁴ The *Danforth* Court upheld a definition of viability as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems."⁶⁵ The Court noted that its definition of viability in *Roe v. Wade* was purposely left flexible for "professional determination dependent upon developing medical skill and technical ability."⁶⁶

In summary, the Supreme Court has found a state interest in potential life which rises to the level of a compelling state interest when the fetus attains viability. Viability is defined in terms of potential ability to live outside the womb and is a flexible concept calling for a case-by-case determination by the physician.

58. *Id.* at 164-65.

59. *Id.* at 158.

60. *Id.* at 160.

61. *Id.* at 163.

62. *Id.* at 160.

63. 410 U.S. 179, 192 (1973).

64. 428 U.S. 52, 64-65 (1976).

65. *Id.* at 63-65.

66. *Id.* at 64.

C. Pennsylvania's Attempt to Regulate Late Abortions

One state's attempt to regulate late abortions was recently invalidated by the Supreme Court in *Colautti v. Franklin*.⁶⁷ Section 5(a) of the Pennsylvania Abortion Control Act required every person performing an abortion to determine that the fetus was not viable. If the fetus was viable, or if there was sufficient reason to believe the fetus might be viable, the Act required the abortionist to exercise the same degree of professional care to preserve the life of the fetus as would be exercised if the fetus was intended to be born rather than aborted. The Act also required that the abortion technique used be one which would provide the best opportunity for the fetus to be aborted alive, so long as a different technique was not necessary to preserve the life or health of the pregnant woman.⁶⁸ A three-judge district court declared section 5(a) to be unconstitutionally vague and overbroad, and enjoined its enforcement.⁶⁹ The United States Supreme Court affirmed. The Pennsylvania statute was considered faulty in two major respects: first, in failing to describe precisely when the statutory standard of care was required; second, in failing to define precisely the parameters of the standard of care.⁷⁰

The *Colautti* Court further clarified the definition of viability:

Viability is reached 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. Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or fetal weight or any other single factor—as the determinant of when the State has a compelling interest in the life or health of the fetus.⁷¹

Pennsylvania's definition of viability was vague in two respects. First, the Court feared that the statutory standard for finding that a fetus "may be viable" might rest on an objective standard or a mixed subjective/objective standard.⁷² Such confusion and ambiguity were considered impermissibly vague.⁷³ In addition, the "may be viable" condition was considered problematic in itself. Since the constitutionally acceptable definition of viability, that is, "potentially able to live outside the mother's womb, albeit with

67. 439 U.S. 379 (1979).

68. 35 PA. CONS. STAT. ANN. § 6605 (Purdon 1977).

69. *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554 (E.D. Pa. 1975). The three-judge court assumed jurisdiction under 28 U.S.C. § 2281 (1970), which was later repealed by Act of Aug. 12, 1976, Pub. L. No. 94-381, § 1, 90 Stat. 1119. The repeal was not applicable to actions commenced on or before August 12, 1976. 439 U.S. at 381 n.2.

70. 439 U.S. at 390-94, 397-401.

71. *Id.* at 388-89.

72. See 35 PA. CONS. STAT. ANN. § 6605(a) (Purdon 1977).

73. 439 U.S. at 391, 394-95.

artificial aid,"⁷⁴ already included the notion of reasonable potential ability to live,⁷⁵ the words "may be viable" were considered ambiguous. The Court concluded that either "viable" or "may be viable," as used in the statute, differed in some way from the constitutionally accepted notion of viability, and thus the statute was impermissibly vague.⁷⁶ The statute failed to "afford broad discretion to the physician" due to the ambiguity of the criteria used to define viability.⁷⁷

The vagueness associated with the definition of viability in the Pennsylvania statute was exacerbated because no element of culpability or scienter was required in connection with the viability determination.⁷⁸ The Court pointed out that the "constitutionality of a vague statutory standard is closely related to whether that standard incorporates a requirement of mens rea."⁷⁹ Although the Court did not hold that civil or criminal liability for an erroneous determination of viability must be predicated on scienter, the Court did hint that the subjective, individualized nature of the viability determination may be inconsistent with the imposition of strict liability in any case:

[I]t is not unlikely that experts will disagree whether a particular fetus in the second trimester has advanced to the stage of viability. The prospect of such disagreement, in conjunction with the statute imposing strict civil and criminal liability for an erroneous determination of viability, could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment.⁸⁰

In summary, the "may be viable" language was faulty because the standard on which the determination was based was ambiguous, and the "may be viable" phrase injected an element of uncertainty as to whether the concept of viability was being expanded beyond constitutional limits.⁸¹ The vagueness problems were compounded by the statute's failure to incorporate an element of scienter prior to the imposition of liability for an erroneous determination of nonviability.⁸²

The Pennsylvania statutory standard of care provision was also declared impermissibly vague by the *Colautti* Court because it failed to delineate the parameters of the standard of care. The standard involved two requirements. The first required the physician to exercise that degree of professional skill, care, and diligence to preserve the life and health of the fetus as would be exercised if the fetus were intended to be born alive and

74. *Roe v. Wade*, 410 U.S. at 160.

75. *Colautti v. Franklin*, 439 U.S. at 388-89.

76. *Id.* at 391-94.

77. *Id.* at 393-94.

78. *Id.* at 394.

79. *Id.* at 395.

80. *Id.* at 396.

81. *Id.* at 391-94.

82. *Id.* at 394.

not aborted. The second part of the standard required the physician to use the abortion technique which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary to preserve the life or health of the pregnant woman.

In focusing on the second part of the standard,⁸³ the Court's main concern was that the statute did not expressly state that the woman's life and health must prevail over that of the fetus if the two conflict. The Court perceived ambiguity in the provision that a different technique must be "necessary" to the woman's life or health. The Court believed that this language suggested that the technique must be indispensable rather than "merely desirable." In addition, the phrase "life or health of the mother" did not necessarily allow the physician to consider "all factors relevant to the welfare of the woman."⁸⁴ The vagueness of the standard of care provision, like that of the definition of viability, was aggravated by the lack of a scienter requirement.⁸⁵

Mr. Justice White, joined in dissent by the Chief Justice and Mr. Justice Rehnquist, criticized the majority for narrowing the permissible scope of state power to regulate abortion after viability.⁸⁶ The dissent argued that the Pennsylvania statute, through the use of the "may be viable" phrase, was not enlarging the period of abortion regulation to further the state's interest in the life of the fetus. Rather, the state was merely attempting to protect the same potential for survival outside the womb that the Court itself had incorporated in the definition of viability.⁸⁷ Moreover, the dissent chided the majority for refusing to interpret the standard of care as incorporating the scienter requirement of the Pennsylvania criminal homicide statute, and for refusing to abstain pending an interpretation by the state court.⁸⁸ Finally, the dissent argued that the Court should not declare the standard of care provisions unconstitutional in the first instance, since the complaint did not attack the standard of care provisions of the Pennsylvania statute. The district court invalidated the statute only on the basis of the definition of viability and did not address the standard of care issue.⁸⁹

D. Problems Posed by the Colautti Decision

The Court's decision in *Colautti v. Franklin* is not a simple invalidation of a faulty state abortion statute. Rather, the Court arguably has limited the states' ability to protect their interest in potential life, contrary to the implications of *Roe v. Wade*.

One of the problems posed by *Colautti* stems from the Court's con-

83. *Id.* at 397.

84. *Id.* at 400.

85. *Id.* at 401.

86. *Id.* (White, J., dissenting).

87. *Id.* at 406-07 (White, J., dissenting).

88. *Id.* at 407-08 (White, J., dissenting).

89. *Id.* at 408 (White, J., dissenting).

tinued reliance on viability as the point at which the state's interest in fetal life becomes a compelling justification for state regulation. This aspect of *Roe v. Wade* and other pre-*Colautti* abortion cases has been criticized elsewhere,⁹⁰ but the *Colautti* opinion further illustrates the difficulty of converting a matter of medical judgment into a legislative standard. A state attempting to protect its interest in potential life is faced with Supreme Court rulings that the determination of viability is a medical matter left to the judgment of the attending physician. The *Colautti* decision emphasizes the seemingly absolute role of the physician in the determination of fetal viability or nonviability.⁹¹ The Court's willingness to leave the determination of viability solely to the discretion of the attending physician makes regulation of that discretion virtually impossible and consequently makes it difficult for the state to vindicate its compelling interest in the life of the fetus after viability. The doctor whose conduct is to be regulated is the person who decides when the state's regulatory interest comes into being.

The scant protection of state interest offered by the doctor's subjective determination of viability is further eroded by the fact that the physician's choice of abortion methods and conduct during the abortion may affect or determine the viability of the fetus.⁹² The physician's determination of nonviability may become a self-fulfilling prophecy. The testimony of the physicians in *Colautti* indicated that the choice of abortion methods in late abortions does affect fetal survival.⁹³ A fetus who would be viable if the abortion were performed by hysterotomy or prostaglandin amniocentesis might not be viable if the abortion were performed by saline amniocentesis. Similarly, the rigors of labor and delivery after prostaglandin instillation might affect the viability of a fetus who could survive a hysterotomy, where the fetus could be lifted out of the uterus and placed in intensive care.

Fetal viability is affected not only by the choice of abortion methods, but also by the conduct of the physician during abortion. Dr. Edelin's actions were an extreme example. His deprivation of oxygen to a fetus for three minutes allegedly insured its nonviability.⁹⁴ In a less extreme case, a fetus who might survive an induced premature birth, with the attention of all involved parties focused on the life and good health of the mother and the baby, might not survive the rigors of an abortion during which the fetus' safety was ignored. Thus, the Supreme Court's reliance on the

90. *E.g.*, H. BROWN, *supra* note 50, at 79-80; Destro, *Abortion and the Constitution: The Need for a Life-Protective Amendment*, 63 CALIF. L. REV. 1250, 1311-13 (1975); Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920, 924-26 (1973); Horan, *Viability, Values, and the Vast Cosmos*, 22 CATH. LAW. 1, 23-28 (1976).

91. 439 U.S. at 388, 391-92, 394-97, 400-01.

92. See notes 28-54 and accompanying text *supra*.

93. 439 U.S. at 398-400.

94. 371 Mass. at 506-07, 359 N.E.2d at 9.

judgment of the attending physician, without any objective element added to the viability determination,⁹⁵ makes it more difficult for a state adequately to indicate the time and circumstances under which the state's interest is to be compelling and its regulations in effect.

Another problem involved in the *Colautti* decision results from the Court's criticism of the language of the Pennsylvania statute, which required a standard of care when a fetus "is viable or there is substantial reason to believe that the fetus may be viable."⁹⁶ The Court believed that the "may be viable" provision could carve out an area of state regulation inconsistent with the Court's definition of viability, which already included reasonable potential ability to live.⁹⁷ This apparent insistence on almost fanatic attention to detail by state legislators in drafting abortion regulations is most troubling. The Court seems unwilling to give the states the benefit of the doubt in interpreting abortion legislation, despite the accepted rule of statutory construction that a state is entitled to a constitutional interpretation of a statute if both constitutional and unconstitutional interpretations are possible.⁹⁸ Apparently there is no room for states to develop language of their own; rather, legislatures are obliged to quote from the Supreme Court's abortion opinions in order to phrase statutes acceptably.⁹⁹ Such a requirement is especially ironic, as the Supreme Court is protecting a constitutional "right" derived by implication and not from express constitutional language.¹⁰⁰

The majority's fastidiousness was criticized by the dissent. Justice White reiterated the *Roe v. Wade* definition of viability as "potentially able to live outside the mother's womb, albeit with artificial aid."¹⁰¹ Thus, he continued, the Supreme Court's definition of viability actually embraces two periods, first, the period of actual ability to live outside the womb, and second, the period of potential ability to live outside the womb. The state of Pennsylvania could have defined viability in terms of potential ability to live and could have regulated abortions after that stage in pregnancy. Instead, Pennsylvania defined viability in terms of *actual* ability to live, thus covering the first period contained in the Supreme Court's definition of viability, and then regulated abortions when the fetus "is viable or there

95. 439 U.S. at 388-89.

96. 35 PA. CONS. STAT. ANN. § 6605(a) (Purdon 1977).

97. 439 U.S. at 390-94.

98. *United States v. Delaware & Hudson Co.*, 213 U.S. 366, 407 (1909); L. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 714 (1978). See also *Ashwander v. TVA*, 297 U.S. 288, 348 (1936) (Brandeis, J., concurring); *Crowell v. Benson*, 285 U.S. 22, 62 (1932).

99. State legislators who adopt Supreme Court language, however, must do so carefully. A federal district court recently held there was a reasonable likelihood that the Illinois abortion statute's definition of viability was unconstitutional because it adopted Supreme Court language explaining what viability does *not* mean in order to define what viability *does* mean. *Charles v. Carey*, 48___ F. Supp. ___, ___ (N.D. Ill. 1979).

100. *Roe v. Wade*, 410 U.S. at 152-53.

101. 439 U.S. at 401 (White, J., dissenting).

is sufficient reason to believe the fetus may be viable,"¹⁰² thus including the second period covered by the Supreme Court's definition of viability.¹⁰³ Rather than giving the language this perfectly plausible reading, the Court insisted that the "viable or . . . may be viable" language carved out a new time period for state regulation. While the Court is consistent in holding that a legislature may not enlarge the period in which the state may further its compelling interest in potential life, the Court appears to be reaching to find that the state was in fact attempting to enlarge the period of regulation.¹⁰⁴

Probably the most distressing and far-reaching implications of the *Colautti* opinion stem from the invalidation of the standard of care provision. The Pennsylvania statute, in attempting to protect the state's interest in potential life, did not unconstitutionally prohibit post-viability abortions. The statute did, however, go beyond the mere prohibition of non-necessary abortions to impose on the physician a duty of care toward the fetus during the post-viability abortion. The statute, as discussed above,¹⁰⁵ attempted to describe the standard of care in two ways. The general requirement that a physician "exercise that degree of professional skill, care, and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted" was not attacked in *Colautti*.¹⁰⁶

The Court criticized the second duty of care, which required that the abortion technique be that "which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother."¹⁰⁷ The majority contended that this provision did not specify that the woman's life and health must always prevail over the fetus' life and health if they conflict. Nor did the standard imply that all factors relevant to the health of the woman would be taken into account by the physician in deciding on the abortion technique.¹⁰⁸

While it is true that doctors must have wide latitude for the exercise of medical judgment in choosing an abortion technique that will be safest for the pregnant woman, it can be argued that the Pennsylvania statute provided just such latitude. By requiring the physician to use the abortion method most likely to preserve the life of the fetus unless another method was necessary to preserve the life or health of the woman, the statute appeared to provide the physician with discretion to select the best procedure for the woman needing an abortion. The Supreme Court inexplicably

102. 35 PA. CONS. STAT. ANN. § 6605(a) (Purdon 1977).

103. 439 U.S. at 402-03 (White, J., dissenting).

104. See *id.* at 406-07 (White, J., dissenting).

105. See notes 83-85 and accompanying text *supra*.

106. 439 U.S. at 397.

107. *Id.*

108. *Id.* at 400.

argued that, in this context, the word *necessary* implied that a particular technique must be indispensable to the woman's health and not "merely desirable."¹⁰⁹ In reaching that conclusion the Supreme Court gave great weight to testimony that saline amniocentesis was generally the method of choice for post-first trimester abortions and it was "commonly assumed" that this procedure was prohibited by the Pennsylvania statute.¹¹⁰ It is curious that the Court would attribute such relevance to this testimony when the assumption is at variance with another, more plausible reading of the statute, particularly in the absence of an authoritative interpretation by the state supreme court. The language of the statute would not ban saline amniocentesis, or any procedure, if it were the preferred method of abortion for the sake of the woman's life or health. Moreover, the Court emphasized the disadvantages of other abortion methods while ignoring the substantial risks involved in saline amniocentesis.¹¹¹ Finally, the Court failed to see one plausible explanation for the popularity of saline amniocentesis; it generally results in the delivery of a dead fetus,¹¹² thus saving the physician and the woman the inconvenience and emotional stress of a live birth.¹¹³

109. *Id.* The Court rejected similar quibbling over the meaning of *necessary* in *Doe v. Bolton*. The Georgia statute challenged in that decision made abortion criminal unless "based upon [the physician's] best clinical judgment that an abortion is necessary." 410 U.S. at 191. That statute was saved from vagueness because the physician's judgment would be exercised in the light of all attendant circumstances, including the psychological and physical well-being of the pregnant woman. *Id.* at 191-92. The Pennsylvania statute invalidated in *Colautti* was arguably susceptible of a similar broad interpretation as it also required the exercise of professional skill. 35 PA. CONS. STAT. ANN. § 6605(a) (Purdon 1977). The Court distinguished the Pennsylvania statute from the Georgia statute, saying the former was doubly ambiguous and had not been interpreted broadly as had the statutes discussed in *Doe v. Bolton*. 439 U.S. at 393-94. The *Colautti* majority neglected to mention that neither the district court nor the Pennsylvania Supreme Court had had the opportunity to interpret the standard of care provision. See note 89 and accompanying text *supra*.

110. 439 U.S. at 398.

111. *Id.* at 399. The Court listed several "undesirable side effects" associated with prostaglandins, while ignoring those associated with saline. See notes 36-44 and accompanying text *supra*. The Court also indicated that prostaglandin abortion may be "unsafe" for patients with histories of asthma, glaucoma, hypertension, cardiovascular disease, or epilepsy, while neglecting to mention that saline abortion may be unsafe for patients with histories of sickle cell anemia, other moderate or severe anemia, cardiovascular disease, or renal disorders. GEO. WASH. U. MED. CENTER: DEP'T OF MED. & PUB. AFF., SERIES F, POPULATION REP. 70 (Sept. 1976).

112. 439 U.S. at 398. See notes 29-32 and accompanying text *supra*.

113. The idea that a physician may choose an abortion method more physically dangerous or psychologically disconcerting to the pregnant woman for the sake of the physician's own psychological comfort is not farfetched. One study comparing dilatation and extraction (D & E) with "amnio" (*i.e.*, instillation method) mid-trimester abortion patients concluded that, although "the D and E technique is safer, less painful, quicker, more convenient, and less expensive than amnio methods," physicians were slow in adopting the D & E method during midtrimester due to "the psychological problems raised [for the physician] by the fetal dismemberment in the procedure." Kaltreider, Goldsmith & Margolis, *supra* note 47, at 237. Similarly, physicians may be reluctant to adopt the prostaglandin technique,

A live birth resulting from an abortion can be problematic for the mother and the doctor. For this reason the standard of care provision criticized by the Court can be described as Pennsylvania's attempt to insure that a woman's right to decide whether or not to terminate her pregnancy is not expanded to include an absolute right to terminate the life of the fetus. The standard also attempted to define the doctor's role by making it clear that the doctor is not in an adversary relation to the fetus, and that a termination of a pregnancy after viability does not require the termination of fetal life. It may be assumed that some women who seek abortions after viability do not want the unborn child. The survival of an unwanted child following abortion is undoubtedly an emotional and psychological burden for the woman involved and, to a lesser extent, for her physician and the other medical personnel caring for her. The Supreme Court has defined *health* in some contexts to include "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient."¹¹⁴ The Court has also listed other "factors the woman and her responsible physician necessarily will consider":

Specific and direct harm medically diagnosable even in early pregnancy may be involved. 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 child care. 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, . . . the additional difficulties and continuing stigma of unwed motherhood may be involved.¹¹⁵

If the post-viability abortion is performed because it is "necessary" to avoid the burdens that pregnancy, childbirth, and motherhood would place on a woman's emotional and psychological health, could not her doctor assume that it would be better if a method were chosen and every step taken during the abortion itself to insure that the fetus did not survive?¹¹⁶

though it could be safer than saline for a particular patient, because of the psychological stress of coping with the possible delivery of a live fetus.

114. *Doe v. Bolton*, 410 U.S. at 192. See *Colautti v. Franklin*, 439 U.S. at 400.

115. *Roe v. Wade*, 410 U.S. at 153.

116. One commentator discussed a similar result based solely on *Roe v. Wade* and *Doe v. Bolton*:

[I]t can be argued that *Roe* bars the state from restricting the physician's option to deliberately destroy the viable fetus. The Court explicitly excepted from the range of permissible state regulation those abortions necessary to preserve the woman's health; no mention is made of a qualification or condition on that exception. Furthermore, those very health considerations that justify the abortion decision may also entail the destruction of the fetus; for example, a woman's psychological health might be impaired unless she were assured that the fetus was dead. . . . Nevertheless, it may be troubling to read *Roe* as allowing the deliberate destruction of a viable fetus when there is a possibility of removing it alive without increased danger to the mother.

Comment, *Medical Responsibility for Fetal Survival Under Roe and Doe*, 10 HARV. C.R.-C.L. L. REV. 444, 465 (1975).

The prospect of a physician or a pregnant woman choosing a method of abortion more likely to kill the fetus, or of a physician taking steps during the abortion to insure the death of the fetus, for the sake of the woman's psychological and emotional comfort, seems to reduce the state's interest in potential life to meaningless proportions. Under such circumstances, the Supreme Court's invitation to states to regulate abortions after viability except when the abortion is necessary to preserve the life or health of a pregnant woman becomes a matter of the "life and health" exception swallowing the "compelling state interest" rule. Yet, the Court's decision in *Colautti* that the woman's health must prevail over the life and health of the fetus, augmented by the Court's broad definition of health,¹¹⁷ would appear to lend support to such a result.

A different, narrower definition of health in the context of choosing abortion methods and of the physician's duty of care to the fetus would raise the state's interest in potential life above the level of exhortation and powerless concern. By the time a fetus attains viability, the pregnant woman has already had a considerable amount of time in which to consider the broader, more *convenience-oriented* aspects of the Court's definition of *health*. Such a broad definition applied to post-viability abortions would make regulation in this area ineffectual, particularly if a threat to "health" includes the inconvenience caused by an unwanted child. Hopefully, the Supreme Court will see the necessity of a narrower definition of health after viability in order to give some meaning to the states' compelling interest in potential life.

In summary, the *Colautti* decision is problematic in its reliance on the viability standard and on the physician's judgment in determining viability. The Court's refusal to give an available constitutional interpretation to the Pennsylvania statute is troubling. Finally, the invalidation of the standard of care provision, in conjunction with the Court's broad definition of *health*, seems to inhibit meaningful advancement of a state's compelling interest in potential life.

III. THE EFFECT OF THE *Colautti*

DECISION ON CURRENT STATE STATUTES

The decision of the Supreme Court in *Colautti v. Franklin* has far-reaching effects on current state regulation of late abortions. Many state statutes regulating post-viability abortions may be rendered unconstitutional by *Colautti*.

A survey of current state abortion statutes indicates that twenty-eight states and the District of Columbia have failed to respond to the Supreme Court's invitation to prohibit abortion after viability except where neces-

117. See note 114 and accompanying text *supra*.

sary to the life or health of the pregnant woman.¹¹⁸ There are several possible reasons for the lack of state action in this area. First, some states may feel that the problem of late abortion is insignificant. Only two or three percent of abortions performed in the United States in 1976 were performed during or after the twenty-first week of pregnancy, and the percentage of late abortions has diminished every year since 1972.¹¹⁹ Nevertheless, two or three percent of more than one million abortions¹²⁰ amounts to a significant number of potential lives worthy of state protection. In addition, there may be abortions performed before the twenty-first week of pregnancy in which the fetus is viable,¹²¹ increasing the number of potential lives in which the state has a compelling interest.

Second, some states may be willing to rely on the judgment of physicians involved in late abortions. Many physicians will refuse to perform an abortion after the twentieth week of pregnancy unless the abortion is medically necessary. Nonetheless, there are enough doctors who are willing to perform late abortions, as indicated by the above statistics,¹²² to justify state regulation aimed at protecting the state's interest in the potential life of the fetus.

Third, some state legislators may believe the Supreme Court's abortion decisions are improper and they do not wish to respond with conforming legislation. This idea is reinforced by language in statutes passed by the Illinois and Nebraska legislatures. The Illinois statute declares the Court's abortion decisions to be inconsistent with the state's longstanding policy that the unborn child is a human being, and provides that the state's former abortion statute, prohibiting abortions unless they are necessary to preserve the mother's life, will automatically come into effect should the Court reverse or modify its decisions or should a prolife constitutional amendment be enacted.¹²³ The Nebraska statute characterizes the Supreme Court's abortion decisions as a "legislative intrusion" and expresses the policy that the people of Nebraska desire to provide protection to the unborn child whenever possible.¹²⁴

Finally, many state legislators may be confused as to constitutional

118. The states that have enacted such a prohibition are Florida, Illinois, Indiana, Iowa, Kentucky, Louisiana, Maine, Massachusetts (prohibition after 24 weeks), Minnesota ("potentially viable"), Missouri, Montana, Nebraska, Nevada (prohibition after 24 weeks), New York (prohibition after 24 weeks, life only), North Carolina (prohibition after 20 weeks), North Dakota, Oklahoma, Pennsylvania, South Dakota (prohibition after 24 weeks), Tennessee, Utah, and Wyoming.

119. C. TIETZE, *supra* note 28, at 62, Figure 5.

120. *Id.* at 35, Table 2.

121. Horan, *supra* note 90, at 24-28. See Hack, Fanaroff & Merkatz, *The Low-Birth-Weight Infant—Evolution of a Changing Outlook*, 301 NEW ENGLAND J. MED. 1162 (1979); Horan, *Abortion and the Conscience Clause: Current Status*, 20 CATH. LAW. 289, 297-302 (1974).

122. See notes 119 & 120 and accompanying text *supra*.

123. ILL. ANN. STAT. ch. 38, § 81-21 (Smith-Hurd Supp. 1979).

124. NEB. REV. STAT. § 28-325(1) (1978).

requirements relating to the regulation of post-viability abortions, or may believe that the effort to effectively regulate late abortions is futile. The following survey of existing state statutes indicates that the legislative task is indeed difficult in this area, where the Supreme Court has defined the state's interest so narrowly and appears to be narrowing the definition further each time it reviews a state's abortion statute. The discussion below involves only those statutes defining viability and regulating post-viability or late abortions, and includes the Pennsylvania statute invalidated in *Colautti* as well as some other statutes with obviously or arguably unconstitutional provisions. The survey delineates five provisions included in current state abortion statutes, discussing each one in the light of the *Colautti* decision, and suggesting an approach to each area of regulation.

A. *The Definition of Viability*

The *Colautti* Court defined viability as the point at which there is a reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial support, and emphasized that the concept is not constitutionally susceptible to a broader or narrower interpretation.¹²⁵ The importance of including potential, and not just actual, ability to live in the definition of viability was significant in the Supreme Court's per curiam opinion in *Anders v. Floyd*.¹²⁶

Current state statutes that define viability do so in four ways. Idaho and Utah basically quote the Supreme Court's statement in *Roe v. Wade* that the viable fetus is "potentially able to live outside the mother's womb, albeit with artificial aid."¹²⁷ Iowa, Kentucky, Maine, Missouri, and Nebraska all follow the *Danforth* definition of viability as "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life supportive systems."¹²⁸ Indiana, Minnesota, Montana, North Dakota, Pennsylvania, Tennessee, and Wyoming define viability in terms of *actual* ability to live,¹²⁹ an unrealistic definition given the current inability of doctors to determine viability with any certainty before performing an abortion. A definition of viability, excluding potential ability to live, may also be unacceptable to the Supreme Court, as implied in the Court's per curiam opinion in *Anders v. Floyd*.¹³⁰

125. 439 U.S. at 388-89.

126. 440 U.S. at 445.

127. IDAHO CODE § 18-604 (1979); UTAH CODE ANN. § 76-7-302 (1978).

128. IOWA CODE § 702.20 (Special Pamphlet 1979); KY. REV. STAT. § 311.720(5) (1978); ME. REV. STAT. ANN. tit. 22, § 1598 (1964); RSMo § 188.015 (1978); NEB. REV. STAT. § 28-326(7) (1978).

129. IND. CODE ANN. § 35-1-58.5-1(e) (Burns 1979); MINN. STAT. ANN. § 145.411 (West Supp. 1979); MONT. REV. CODES ANN. § 50-20-104(5) (1978); N.D. CENT. CODE § 14-02.1-02 (Interim Supp. 1979); 35 PA. CONS. STAT. ANN. § 6602 (Purdon 1977); TENN. CODE ANN. § 39-302(3) (Supp. 1979); WYO. STAT. § 35-6-101(vii) (1977).

130. 440 U.S. at 445.

Oklahoma and Louisiana have somewhat unique provisions defining viability. Although both states follow the *Roe/Doe* definition of viability as "potentially able to live outside the womb," they characterize the potential ability as relating to *premature birth*.¹³¹ In Louisiana and Oklahoma, a fetus with a reasonable chance of surviving a premature birth, but with small likelihood of surviving an abortion, would be considered viable for purposes of state regulation of post-viability abortions. Such a definition, in effect, prohibits the physician from determining viability based upon the method contemplated to terminate the pregnancy.

A constitutional and effective definition of viability would probably include language very similar to the definitions of viability set forth in the *Roe*, *Danforth*, and *Colautti* opinions. Further protection of a state's post-viability interest in potential life would result if a statement similar to the provisions in the Louisiana and Oklahoma statutes were included. It is crucial that a state's definition of viability conform to the Supreme Court's definitions without any express or implied intent to broaden or narrow the scope of viability for purposes of regulating late abortion. A statute might define viability as follows:

Viability is reached when, in the judgment of the attending physician on the particular facts of the case, the fetus is potentially able to live outside the womb, or there is reasonable likelihood of the fetus' sustained survival outside the womb, with or without artificial aid. Viability shall be determined on the fetus' ability to survive premature birth, whether by natural causes, induced labor, or induced abortion.

The *Colautti* Court stated that a legislature may not proclaim any single element of the viability determination as the trigger of the state's interest in the potential life of the fetus.¹³² A state wishing to give some direction to the physician's judgment, however, might include a list of factors to be considered in making the viability determination:

Although the point of viability may differ with each pregnancy, the physician should consider such factors as fetal weight, gestational age, the measurement of the fundus, the presence and strength of fetal heart tones, the pregnant woman's report of the date of her last menstrual period, her health and nutritional status, and the availability of neonatal life-support equipment and personnel in determining viability.

A similar method of giving direction to the physician's viability determination is suggested by provisions in five state statutes creating a presumption for or against viability at a certain stage in pregnancy. The Idaho statute creates an irrebuttable presumption that a fetus is *not* viable until the twenty-fifth week of pregnancy.¹³³ Similarly, South Carolina

131. LA. REV. STAT. ANN. § 40:1299.35.1(3) (West Supp. 1979); OKLA. STAT. ANN. tit. 63, § 1-730 (West Supp. 1978-1979).

132. 439 U.S. at 388-89.

133. IDAHO CODE § 18-604 (1979).

presumes a fetus is not viable until the twenty-fourth week.¹³⁴ Oklahoma and Louisiana presume a fetus is viable after twenty-four weeks,¹³⁵ and Minnesota, which defines viability as actual ability to live, presumes a fetus is potentially viable during the second half of its gestation (approximately twenty weeks).¹³⁶ Tennessee also defines viability in actual terms, and requires a doctor to inform a pregnant woman seeking an abortion that after twenty-four weeks the fetus may be viable.¹³⁷

A statutorily prescribed presumption of viability would be unconstitutional if its only effect were to cause the automatic application of post-viability regulations to any abortion involving a fetus who met the presumption. Similarly, a presumption of nonviability based on the single factor of estimated gestational age would be unconstitutional if it automatically precluded the attending physician from determining that such a fetus is viable. Both presumptions would deprive the attending physician of the opportunity to ascertain viability in accordance with his or her best medical judgment. A presumption may be allowed, however, if it requires a physician only to rebut it in a manner similar to that described in the following language:

Any fetus who, in the judgment of the attending physician, has attained the age of twenty weeks' gestation, is presumed viable. A physician planning to abort a fetus presumed viable must conform to all [state] laws and regulations of post-viability abortion unless he or she certifies in good faith that, despite the presumption, the fetus is not viable, and gives the reasons for the determination of non-viability. The certificate shall become a part of the patient's medical record as described under [the statutory record-keeping provision].

An additional measure that could be employed to protect the state's interest in potential life after viability would be a requirement that the attending physician use ultrasonography¹³⁸ to aid in the viability determination after the fetus is presumed viable.

B. *The Prohibition of Post-Viability Abortions*

A state desiring to protect its interest in the potential life of a viable fetus should accept the Supreme Court's invitation to prohibit any post-

134. S.C. CODE § 44-41-10(1) (1976).

135. LA. REV. STAT. ANN. § 40:1299.35.4 (West Supp. 1979); OKLA. STAT. ANN. tit. 63, § 1-732 (West Supp. 1978-1979).

136. MINN. STAT. ANN. § 145.411 (West Supp. 1979). The definition of viability and the presumption of viability created by the Minnesota statute were held unconstitutional in *Hodgson v. Lawson*, 542 F.2d 1350, 1354 (8th Cir. 1976).

137. TENN. CODE ANN. § 39-302 (Supp. 1979).

138. Ultrasonography involves the use of high-frequency sound waves to evaluate the size and position of a structure within the body, allowing the creation of a two-dimensional "picture" of the structure. The diagnostic use of ultrasound is much less hazardous than exposure to X-rays, and allows more accurate estimation of gestational age than do other means. OBSTETRICS AND GYNECOLOGY 493-97, 507-11 (3d ed. D. Danforth 1977).

viability, abortion unless it is necessary to preserve the life or health of the pregnant woman. Seventeen states presently conform to that standard.¹³⁹ Massachusetts, Nevada, and South Dakota impose the same prohibition at twenty-four weeks, and North Carolina imposes the prohibition after twenty weeks.¹⁴⁰ In New York, abortions are prohibited after twenty-four weeks unless necessary to save the woman's life.¹⁴¹

In many states, the exception to the prohibition of post-viability abortions is allowed only to prevent death or "permanent impairment," "imminent peril," "severe and long-lasting," or other variously described threats to the woman's health.¹⁴² The constitutionality of such descriptions is questionable, as they appear to require something more than the necessary preservation of health. An acceptable statute would probably include a simple statement paralleling the Supreme Court's language that post-viability abortions may be prohibited unless they are "necessary in appropriate medical judgment, for the preservation of the life or health of the mother."¹⁴³ Any state attempt to begin the prohibition at a point other than viability—at certain number of weeks, for example—would be unconstitutional.¹⁴⁴

It is difficult to determine whether an abortion statute should define *health* broadly, to include "all factors relevant to the welfare of the woman,"¹⁴⁵ in the context of the prohibition of post-viability abortions unnecessary to the pregnant woman's life or health. As discussed earlier,¹⁴⁶ a broad definition of health in the post-viability context undermines such a prohibition and effectively establishes "abortion on demand" at all

139. FLA. STAT. ANN. § 458.225 (West Supp. 1979); ILL. ANN. STAT. ch. 38, § 81-25 (Smith-Hurd Supp. 1979); IND. CODE ANN. § 35-1-58.5-2 (Burns 1979); IOWA CODE § 707.7 (Special Pamphlet 1979); KY. REV. STAT. § 311.780 (1978); LA. REV. STAT. ANN. § 40:1299.35.4 (West Supp. 1979); ME. REV. STAT. ANN. tit. 22, § 1598 (1964); MINN. STAT. ANN. § 145.412 (West Supp. 1979); RSMO § 188.030 (1978); MONT. REV. CODES ANN. § 50-20-109 (1978); NEB. REV. STAT. § 28-329 (1978); N.D. CENT. CODE § 14-02.1-03 (Interim Supp. 1979); OKLA. STAT. ANN. tit. 63, § 1-732 (West Supp. 1978-1979); 35 PA. CONS. STAT. ANN. § 6606 (Purdon 1977); TENN. CODE ANN. § 39-301 (1975); UTAH CODE ANN. § 76-7-302 (1978); WYO. STAT. § 35-6-102 (1977).

140. MASS. GEN. LAWS ANN. ch. 112, § 12M (West Supp. 1979); NEV. REV. STAT. § 442.250 (1973); N.C. GEN. STAT. § 14-45.1 (Supp. 1979); S.D. COMP. LAWS ANN. § 34-23A-5 (1977).

141. N.Y. PENAL LAW § 125.05 (McKinney 1975).

142. IND. CODE ANN. § 35-1-58.5-2 (Burns 1979) ("substantial permanent impairment"); LA. REV. STAT. ANN. § 40:1299.35.4 (West Supp. 1979) ("permanent impairment"); MASS. GEN. LAWS ANN. ch. 112, § 12M (West Supp. 1979) ("substantial risk of grave impairment"); NEB. REV. STAT. § 28-329 (1978) ("imminent peril . . . substantially endangers"); N.C. GEN. STAT. § 14-45.1 (Supp. 1979) ("substantial risk . . . gravely impair"); N.D. CENT. CODE § 14-02.1-03 (Interim Supp. 1979) ("substantial risk of grave impairment"); UTAH CODE ANN. § 76-7-302 (1978) ("serious and permanent damage"); WYO. STAT. § 35-6-102 (1977) ("imminent peril . . . substantially endangers").

143. *Roe v. Wade*, 410 U.S. at 165.

144. *Colautti v. Franklin*, 439 U.S. at 388-89.

145. *Id.* at 400.

146. See notes 112-17 and accompanying text *supra*.

stages of pregnancy, in derogation of the post-viability compelling state interest in potential life. Nevertheless, the Court's dicta seem to require that illogical result.¹⁴⁷

C. *The Requirement of Consultation After Viability*

Six states, Georgia, Idaho, Illinois, Louisiana, Montana, and North Dakota, require that a physician planning to perform a post-viability abortion consult with one or two other physicians and certify that the abortion is necessary for the preservation of the woman's life or health and that the consulting physicians have examined the patient and agree with the attending physician's judgment.¹⁴⁸ Florida, South Carolina, and Virginia impose the same requirement during the last trimester.¹⁴⁹

In *Doe v. Bolton*, the Supreme Court invalidated the Georgia statutory requirement that two physicians confirm the attending physician's judgment that an abortion is necessary. The statute applied throughout pregnancy. The Court stressed that the attending physician's judgment should be sufficient and that the doctor will know when consultation is advisable. The Court stated that "[r]equired acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."¹⁵⁰

An Illinois requirement that two physicians other than the attending physician be consulted prior to a post-viability abortion was invalidated in *Wynn v. Scott*.¹⁵¹ The district court found no direct relationship between the state's interests in preserving maternal and fetal health and "the number of physicians participating in the [abortion] decision."¹⁵²

While the required concurrence arguably has no rational connection to the patient's needs, it may, despite the Illinois district court's conclusion, have a rational connection to the protection of a state's compelling interest in the potential life of a viable fetus. In *Doe v. Deschamps*,¹⁵³ a federal district court upheld a Montana statutory requirement that the aborting physician consult two other physicians before aborting a viable fetus in an abortion not necessary to save the woman's life. The court distinguished *Doe v. Bolton* on the ground that the Georgia statute applied to all abortions, not just those performed after viability. The district court quoted

147. *Colautti v. Franklin*, 439 U.S. at 400; *Doe v. Bolton*, 410 U.S. at 192; *Roe v. Wade*, 410 U.S. at 153.

148. GA. CODE ANN. § 26-1202 (1977); IDAHO CODE § 18-608 (1979); ILL. ANN. STAT. ch. 38, § 81-25 (Smith-Hurd Supp. 1979); LA. REV. STAT. ANN. § 40:1299.35.4 (West Supp. 1979); MONT. REV. CODES ANN. § 50-20-109 (1978); N.D. CENT. CODE § 14-02.1-04 (Interim Supp. 1979).

149. FLA. STAT. ANN. § 458.225 (West Supp. 1979); S.C. CODE § 44-41-20 (1976); VA. CODE § 18.2-74 (1975).

150. 410 U.S. at 199.

151. 449 F. Supp. 1302 (N.D. Ill.), *appeal dismissed*, 439 U.S. 8 (1978).

152. *Id.* at 1319.

153. 461 F. Supp. 682 (D. Mont. 1976).

language from *Roe v. Wade* indicating that the state's compelling interest after viability allows it to prescribe guidelines based on "appropriate medical judgment," rather than the "medical judgment of the pregnant woman's attending physician" relied on exclusively during the first trimester. After viability, the woman's privacy right, which precludes or severely limits pre-viability state regulation, must be balanced against the state's compelling interest in potential life. The Montana district court said that after viability, "[t]he will of the woman and her physician are no longer of primary consideration. Medical judgments may vary greatly in this complex area, and the State may properly require more than the opinion of the woman's attending physician to insure that the potentiality of life is not destroyed."¹⁵⁴

Should the Montana district court's reasoning prove acceptable to the Supreme Court, a state could require consultation with nonattending physicians before a post-viability abortion. A statute might provide:

Any physician planning to perform an abortion after the fetus is viable must certify in good faith that, according to his or her best medical judgment, the abortion is necessary to preserve the life or health of the pregnant woman. In addition, two other physicians must examine the patient and certify in good faith that, according to their best medical judgment, the abortion is necessary to preserve the life or health of the pregnant woman. The certificates shall become a part of the patient's medical record under [the statutory recordkeeping provision].

D. *A Duty of Care to the Viable Fetus During Abortion*

Sixteen states impose on the aborting physician a duty of care to the viable fetus.¹⁵⁵ The provision of the Pennsylvania statute invalidated in *Colautti* was especially extensive in requiring the aborting physician to

exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.¹⁵⁶

154. *Id.* at 689.

155. IDAHO CODE § 18-608(3) (1979); ILL. ANN. STAT. ch. 38, § 81-26 (Smith-Hurd Supp. 1979); IOWA CODE § 707.7 (Special Pamphlet 1979); KY. REV. STAT. § 311.780 (1978); LA. REV. STAT. ANN. § 40:1299.35.4 (West Supp. 1979); MASS. GEN. LAWS ANN. ch. 112, § 120 (West Supp. 1979); MINN. STAT. ANN. § 145.412 (West Supp. 1979); RSMo § 188.035 (1978); MONT. REV. CODES ANN. § 50-20-109 (1978); NEB. REV. STAT. § 28-330 (Supp. 1979); N.D. CENT. CODE § 14-02.1-05 (Interim Supp. 1979); OKLA. STAT. ANN. tit. 63, § 1-732 (West Supp. 1979); 35 PA. CONS. STAT. ANN. § 6605 (Purdon 1977); TENN. CODE ANN. § 39-306 (Supp. 1979); UTAH CODE ANN. § 76-7-307 (1978); WYO. STAT. § 35-6-103 (1977).

156. 439 U.S. at 397.

The chief problem with the statute was that it did not clearly specify that the pregnant woman's life or health must take precedence over that of the fetus if the two conflict.¹⁵⁷

The Court's expectation of greater precision should alert states that careful draftsmanship is necessary when defining the physician's duty of care. An acceptable statute must emphasize the overriding consideration of the woman's life and health and give deference to the medical judgment of the attending physician.

Another desirable component of a duty of care provision is a requirement that the viable fetus be treated similarly to a fetus intended to be born and not aborted, rather than simply requiring medical care for the fetus. The born-and-not-aborted standard avoids the problem of determining when live birth occurs in the abortion context.¹⁵⁸ The standard is also flexible enough to allow medical personnel to make judgments about care of the severely defective fetus similar to those they would make for an equally burdened premature infant.¹⁵⁹

Any statute imposing a duty of care on the aborting physician during the abortion of a viable fetus must give precedence to the pregnant woman's life and health.¹⁶⁰ Such a statute, however, should also prohibit the aborting physician from deliberately destroying or impairing the health of the fetus when such action has no relation to the pregnant woman's life or health. An acceptable statute might be worded thus:

During the abortion of a viable fetus, the aborting physician shall exercise that degree of professional skill, care, and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted. If the life or health of the pregnant woman would be undesirably affected by the physician's actions consistent with the above mandate, the physician is excused from such action insofar as it is inconsistent with the preservation of the woman's life or health. Under no circumstances may a physician harm the fetus or end its life unless such conduct is a necessary part of the abortion method chosen, or unless such conduct is intended to preserve the life or health of the pregnant woman.

This type of statute clarifies the doctor's role in the abortion process. While the doctor's first responsibility is to perform the abortion consistent with

157. *Id.* at 400.

158. See notes 160-64 and accompanying text *infra*.

159. "[Medical personnel] *must* be allowed to make a realistic appraisal of the chances of survival and of quality of life after abortion procedures, and not be forced by legislation and fear of repercussions into providing care they would never give to similarly burdened prematures." Bok, *The Unwanted Child: Caring for the Fetus Born Alive After an Abortion*, 6 HASTINGS CENTER REP. No. 5, 10, 11 (1976). See also Note, *Birth Defective Infants: A Standard for Nontreatment Decisions*, 30 STAN. L. REV. 599 (1978).

160. *Colautti v. Franklin*, 439 U.S. at 400.

the woman's health, he need not find himself in an adversary relation to the fetus beyond the unavoidable harm caused by the abortion itself and the method chosen.

E. Protection of a Fetus Delivered Alive

Twenty states protect the fetus delivered alive, usually declaring that he or she has equal rights to those of a fetus born alive who was intended to be born and not aborted.¹⁶¹ Although the requirement of protection of the viable fetus aborted alive may seem to be so obvious as to render any statutory mandate unnecessary, the allegation of the defense in the *Edelin* trial that a physician cannot be held accountable for the death of a fetus after a lawful abortion¹⁶² would indicate that some clarification is desirable. Such a statutory provision involves problems, however, one of which is the necessity of defining when a fetus is "born alive" if different penalties are to apply after live birth, or if there is no standard of care applicable until live birth. The standard usually requires that the child exist independently and separately from the mother.¹⁶³

At least one state specifically defines "live birth" in the abortion context. Maine requires that the fetus be completely expelled or extracted from the mother, and declares that the fetus is born alive if it "breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached."¹⁶⁴ Such a definition would allow a fetus to be "born alive"—that is, entitled to medical care—although the fetus may not be viable—that is, capable of sustained survival.

A state may not prescribe medical care for a nonviable fetus before he or she is born, but once born alive, whether capable of sustained survival or not, the fetus is a human person entitled to the protection of state law. The purpose of the statute protecting the living aborted infant is not to require extraordinary or futile treatment of the infant, but rather to avoid

161. ARIZ. REV. STAT. ANN. § 36-2301 (Supp. 1979); CAL. HEALTH & SAFETY CODE § 25955.9 (West Supp. 1979); GA. CODE ANN. § 26-1202 (1977); ILL. ANN. STAT. ch. 38, § 81-26 (Smith-Hurd Supp. 1979); IND. CODE ANN. § 35-1-58.5-7(b) (Burns 1979); KY. REV. STAT. § 311.790 (1978); LA. REV. STAT. ANN. § 14:87.5 (West Supp. 1980); ME. REV. STAT. ANN. tit. 22, § 1594 (1964); MASS. GEN. LAWS ANN. ch. 112, § 12P (West Supp. 1979); MINN. STAT. ANN. §§ 415.145, 423 (West Supp. 1980); RSMo § 188.035 (1978); MONT. REV. CODES ANN. § 50-20-108 (1978); NEB. REV. STAT. § 28-331 (Supp. 1979); N.Y. EXEC. LAW § 291-3 (McKinney Supp. 1972-1979); N.D. CENT. CODE §§ 14-02.1-05, 08 (Interim Supp. 1979); OKLA. STAT. ANN. tit. 59, § 524, tit. 63, §§ 1-732, 734 (West Supp. 1979); 35 PA. CONS. STAT. ANN. § 6604 (Purdon 1977); S.D. COMP. LAWS ANN. § 34-23A-16.1 (1977); TENN. CODE ANN. §§ 39-302(3), -306 (Supp. 1979); WYO. STAT. §§ 35-6-103, -104 (1977).

162. Robertson, *After Edelin: Little Guidance*, 7 HASTINGS CENTER REP. No. 3, 15, 16 (1977).

163. Comment, *supra* note 116, at 458-59.

164. ME. REV. STAT. ANN. tit. 22, § 1595 (1964).

the ethically questionable result that it should be "the fact of abortion which should in itself determine the fate of the premature baby."¹⁶⁵

An additional requirement imposed by five states having duty of care provisions, but not yet considered by the Supreme Court, requires that specific facilities for care of the fetus be available during the abortion of a viable fetus. Louisiana and Oklahoma require that a doctor be present to care for the fetus.¹⁶⁶ Indiana requires that the abortion facility contain an intensive care unit for premature infants,¹⁶⁷ while Massachusetts and North Dakota require the presence of life-support equipment.¹⁶⁸

A state could require that medical personnel be present when the fetus is delivered and that a doctor be immediately available to care for a live-born fetus.¹⁶⁹ The requirement that a doctor be present to care for the fetus also may be beneficial to the woman. If the aborting physician is required to stop, examine the fetus for signs of life, and care for the live-born fetus, he or she may be unable simultaneously to give appropriate medical attention to the mother. In addition, the requirement that medical personnel be present when the fetus is delivered may serve to alleviate some of the potential psychological complications associated with instillation method abortions.¹⁷⁰

An acceptable statute providing for adequate medical attendance to the woman and the live-born aborted fetus could be worded as follows:

During any abortion performed after the fetus is viable, a physician in addition to the aborting physician shall be present when the fetus is expelled or extracted from the mother to determine if the fetus has been born alive. Life-support equipment shall be immediately available to the physician for treatment of the live-born fetus. A fetus born alive as the result of an abortion is entitled to the same medical care and treatment that would be provided to a similarly situated premature infant who was intended to be born and not aborted. A fetus shall be deemed "born alive" for the purposes of this statute if he or she is completely expelled or extracted from the mother's body and if he or she breathes or shows any other evidence of life such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

165. Bok, *supra* note 159, at 11.

166. LA. REV. STAT. ANN. § 40:1299.35.4 (West Supp. 1979); OKLA. STAT. ANN. tit. 63, § 1-732 (West Supp. 1979).

167. IND. CODE ANN. § 35-1-58.5-7 (BURNS 1979).

168. MASS. GEN. LAWS ANN. ch. 112, § 12P (West Supp. 1979); N.D. CENT. CODE § 14-02.1-05 (Interim Supp. 1979).

169. The question of allocation of the costs of personnel and equipment intended for the care of the fetus is beyond the scope of this article. One author has suggested, however, that such costs would have to be paid by the state, lest the added expense burden or "chill" the pregnant woman's abortion decision. Comment, *supra* note 116, at 456 n.64.

170. See notes 45-47 and accompanying text *supra*.

IV. CONCLUSION

The decision of the Supreme Court in *Colautti v. Franklin*¹⁷¹ limits the right of the states to regulate abortions after viability. The Court's reluctance to approve arguably constitutional state legislation, its continuing emphasis on the aborting physician's discretion, and its inclination to define the pregnant woman's health in very broad terms, may inhibit state legislators to the point where they believe attempted regulation is futile. Nevertheless, there are still available means of protecting the states' compelling interest in potential life.

It must be emphasized that the language of the Supreme Court in *Roe v. Wade*¹⁷² with regard to state regulation of abortion after viability was permissive rather than mandatory. The Court stated that a state "may, if it chooses," regulate abortion after viability in order to promote its interest in the life of the fetus.¹⁷³ The Court did not say that a state must regulate post-viability abortions. The Court's language is consistent with its unwillingness to find that the fetus is a person within the meaning of the fourteenth amendment.¹⁷⁴ Because the viable or nonviable fetus is not a constitutional "person," it is difficult to articulate a legal argument that a state must protect its own compelling interest in the life of the fetus. There are, however, logical arguments for the proposition that a state should protect its interest in the life of a viable fetus.

First, the state is the sole guardian of the potential life represented by the fetus. The husband of the pregnant woman, the father of the unborn child, and the parents of the pregnant minor are all denied a decisive role in the abortion choice.¹⁷⁵ Unless a state exercises its right to regulate post-viability abortions, only the consciences of the pregnant woman and of the physicians from whom she seeks an abortion are available to prevent the unnecessary abortion of a fetus who could be delivered as a healthy infant in only a few weeks.¹⁷⁶

Second, the Waddill, Edelin, and Floyd prosecutions¹⁷⁷ illustrate the need for legislative clarification of the role of the physician during a post-viability abortion, not only for the protection of the state's interest in

171. 439 U.S. 379 (1979).

172. 410 U.S. 113 (1973).

173. *Id.* at 164-65.

174. *Id.* at 158.

175. *Planned Parenthood v. Danforth*, 428 U.S. at 74-75, invalidated provisions of the Missouri abortion statute requiring spousal or parental consent to abortion. A recent Supreme Court decision, *Bellotti v. Baird*, 443 U.S. 622 (1979), concluded that a pregnant minor must be free to convince a court that she is mature enough to make the abortion decision, or that an abortion is in her best interests despite her immaturity, "without first consulting or notifying her parents." *Id.* at 647-48. The Court recently noted probable jurisdiction in a case upholding the Utah statutory requirement that a physician notify the parents of a minor woman prior to performing an abortion. *H. _____, L. _____ v. Matheson*, 604 P.2d 907 (Utah 1979), *prob. juris. noted*, 100 S. Ct. 1077 (1980).

176. See Hack, note 121 *supra*; Horan, *supra* note 121, at 297-302.

177. See notes 4-23 and accompanying text *supra*.

the life of the fetus, but also for the protection of the physician. Doctors should not have to guess at their peril whether to insure the death of the fetus and risk possible criminal prosecution, or to preserve the fetus' life and face a possible malpractice claim from a woman who thought a properly performed abortion should necessarily involve fetal death. A state statute prohibiting abortion after viability except where it is necessary to preserve the life or health of the pregnant woman, coupled with the imposition on the aborting physician of a duty of care toward the viable fetus both during and after abortion, adequately articulates the state policy of protecting the potential lives of unborn, viable infants.

Third, the states' protection of potential life is consistent with their uniform protection of life after birth. Our legal system continues to place great significance on birth as the point at which various legal rights come into being.¹⁷⁸ The fact that many legal rights are insignificant before an individual is born alive does not prevent a state from doing all it can to insure that a viable individual is born alive and cared for in a manner consistent with the preservation of that life. In earlier ages, when many of the concepts underlying modern statutes were formed, prenatal development was little understood, and birth was viewed as a miraculous and significant occasion. The child within the womb was a mystery. Today, physicians can tap the amniotic fluid and discover the details of the fetus' genetic heritage. They can take ultrasonic "pictures" of the fetus and give it blood transfusions.¹⁷⁹ Modern science tends to view birth as merely one stage in the continuous development of a human being.¹⁸⁰ It is clear that a state has an obligation to protect the life of a live-born child. There is little logical distinction between the live infant and the infant within the uterus who has the capacity to survive outside the uterus—the former has simply completed the brief journey through the birth canal. If a state has an obligation to protect the life of this child the moment after it is born, the state undoubtedly should exercise its right to protect this child the moment before it is born.

178. See, e.g., Comment, *Live Birth: A Condition Precedent to Recognition of Rights*, 4 HOFSTRA L. REV. 805 (1976).

179. OBSTETRICS AND GYNECOLOGY 45-47, 366-69, 493-94 (3d ed. D. Danforth 1977).

180. Natheson, *The Unwanted Child: Caring for the Fetus Born Alive After an Abortion*, 6 HASTINGS CENTER REP. No. 5 (1976).