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## So-Called "Partial-Birth Abortion" Bans: Bad Medicine? Maybe. Bad Law? Definitely!

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# SO-CALLED "PARTIAL-BIRTH ABORTION" BANS: BAD MEDICINE? MAYBE. BAD LAW? DEFINITELY!

Ann MacLean Massie\*

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## I. INTRODUCTION

The so-called "Partial-Birth Abortion Ban Act of 1997,"<sup>1</sup> the federal government's latest venture into the abortion controversy, represents its most arrogant, its most irresponsible, and its least thought-out foray into this minefield. As many have observed, this bill—like the state statutes which mirror it<sup>2</sup>—bans a medical procedure described in terminology that is virtually meaningless to the profession qualified to perform abortions. Furthermore, the purpose and phraseology of these enacted or proposed laws demonstrate both the lawmakers' lack of understanding of Supreme Court precedent defining the abortion right and their consequent confusion about the appropriate role of legislation in the practice of medicine.

As subsequent reports have revealed, the highly-touted last-minute support of the federal bill by the Board of Trustees of the American Medical Association<sup>3</sup> clearly does not express the opinion of large segments of its membership.<sup>4</sup> The fact that AMA Executive Vice-President

1. H.R. 1122, 105th Cong. (1997).

2. See *infra* notes 38-41 and accompanying text.

3. See Nancy W. Dickey, M.D., *A.M.A. Supports H.R. 1122 As Amended* (updated May 20, 1997) <<http://www.ama-assn.org/ad-com/releases/1997/hr521.htm>> ("The American Medical Association Board of Trustees has determined to support [H.R.] 1122 because it has now been significantly changed to substantially meet the criteria which the Board established for any abortion legislation."); see also Helen Dewar, *AMA Backs 'Partial Birth' Abortion Curb; Endorsement of Legislation Comes as Senate Vote Nears*, WASH. POST, May 20, 1997, at A1 [hereinafter Dewar, *AMA Backs Curb*] (discussing the AMA's support for the bill and the specific changes to the bill that won their support); David Espo, *AMA Gives Support to Abortion Bill*, BOSTON GLOBE, May 20, 1997, at A1 (discussing changes that led to the AMA's support); Letter from P. John Seward, M.D., Executive Vice President, American Medical Association, to the Hon. Rick Santorum, United States Senate (May 19, 1997) (on file with the author) (informing Sen. Santorum of the AMA's changed position). For an interesting opinion on the AMA's support for the bill, see Abigail Trafford, Editorial, *The Doctors Invite Congress In*, WASH. POST, June 30, 1997, at A19. Trafford observes that, "[i]n effect, the AMA said to Congress: You can come on in to the doctor's office and decide what kind of specific treatments the professional sons and daughters of Hippocrates can—and cannot—provide for their patients." *Id.*

4. See Della De Lafuente, *AMA Delegates Back 'Partial-Birth' Ban*, CHI. SUN-TIMES, June 25, 1997, at 16 [hereinafter De Lafuente, *AMA Delegates*] (stating that some delegates continue to disagree with the ban, although the association's official stance is one of support); Della De Lafuente, *AMA Members on Both Sides in Late-Term Abortion Debate*, CHI. SUN-TIMES, June 24, 1997, at 20 [hereinafter De Lafuente, *AMA Members*] (stating opinions of delegates who want the AMA to recant its support for the bill); Jeremy Manier, *AMA Delegates Object to Stand on Abortion Ban*, CHI. TRIB., June 24, 1997, at 2 (stating that delegates at the AMA's annual meeting were divided on the

John Seward sent another letter to Congress outlining the organization's Medicare agenda<sup>5</sup> on the same day that he penned his support statement further compromises the value of this lobbying group's official stance.<sup>6</sup> On the other hand, the American College of Obstetricians and Gynecologists, the professional group representing those whose medical decision making authority and expertise are at stake here,<sup>7</sup> has remained adamant in its opposition to legislative prohibitions on "Intact Dilatation and Extraction" ("Intact D&X"). ACOG cogently observes that "[t]he intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous."<sup>8</sup> ACOG's position has been reiterated in

issue of the organization's support of the ban and that some who did support the ban did so because " '[w]e would prefer to have no legislation on this issue . . . [b]ut when Congress decides it wants legislation, we want to be sure it addresses the procedure correctly' "; Robert Pear, *A.M.A. Abortion Stand Splits Its Members*, N.Y. TIMES, May 22, 1997, at A16 (discussing the "rift in the organization" caused by its support of the bill); Trafford, *supra* note 3 (noting that the AMA says it only supported the bill because it was seen as the lesser of the possible evils; "[t]o the AMA board . . . the question was not how to preserve physician autonomy, but how to prevent the most restrictive proposals from getting passed into law").

5. See Jonathan Gardner, *Was AMA's Abortion Stand A Quid Pro Quo?*, MOD. HEALTHCARE, May 26, 1997, at 3 (stating that the two letters were both sent by John Seward to Congress on the same day); Judith Havemann, *AMA Adversaries Question Timing of Abortion Ban Stance, Legislative Requests*, WASH. POST, May 30, 1997, at A7 (stating that "[t]he American Medical Association sent Congress an eight-page list of legislative requests on the same day the powerful physicians organization announced its crucial support for a Republican bill to restrict 'partial birth' abortions").

6. See Gardner, *supra* note 5 (suggesting that the "AMA's support for the legislation could give the association more leverage in the upcoming battle over Medicare payments" but also stating that both the AMA and the Republican party deny any such deal); Havemann, *supra* note 5 (discussing the possibility of a deal but also noting the denial on both sides); Albert R. Hunt, *Politics and People: Daschle Charts Common Ground on Abortion*, WALL ST. J., May 22, 1997, at A15 (stating that "there are credible reports the doctor's lobby secretly struck a deal with GOP leaders over Medicare reimbursement in return for the endorsement"). For an interesting discussion, see Frank Rich, Editorial, *AMA's Switcheroo on Abortion Replays its '64 Sell-out on Tobacco*, MILWAUKEE J. SENTINEL, June 1, 1997, at 2, which compares this recent AMA move with its 1964 deal with the tobacco lobby in which the AMA opposed health warnings on cigarette packages to insure tobacco-state opposition to Medicare.

7. The American College of Obstetricians and Gynecologists was founded in 1951 and has a membership of 38,000 physicians specializing in fields pertaining to women's health and reproduction. See 1 ENCYCLOPEDIA OF ASSOCIATIONS Part 2, 1510 (Christine Maurer & Tara E. Sheets eds., 33d ed. 1998).

8. American College of Obstetricians and Gynecologists, Statement on Intact Dilatation and Extraction 2 (Jan. 12, 1997) [hereinafter ACOG, Statement on Intact D&X] (on file with the author). ACOG contends:

An intact D & X . . . may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women.

*Id.*

statements issued by both the American Medical Women's Association<sup>9</sup> and the American Nurses Association.<sup>10</sup>

These organizations understand what Congress and state legislatures which have acted similarly do not: the law (whether derived by judges under the Constitution or enacted by legislatures) can set the parameters of the *sphere* of acceptable physician/patient decision making—for example, by defining the abortion right;<sup>11</sup> by determining the status of physician-assisted suicide;<sup>12</sup> or by establishing the norms of informed consent that protect the patient from overreaching and help to ensure basic trust and mutuality in the physician/patient relationship itself.<sup>13</sup> The law oversteps its bounds, however, when, having identified an appropriate health care objective, it attempts *for reasons other than patient health and welfare* to intrude into the physician/patient relationship by detailing the precise medical procedures that will be considered permissible or impermissible for achieving the valid objective.

In any given situation covered by the laws under consideration here, it is to be assumed that the basic choice of the woman and her physician to perform an abortion at all is a constitutionally protected choice under the parameters established by the Supreme Court in 1973 in *Roe v. Wade*,<sup>14</sup> as modified in 1992 by *Planned Parenthood of Southeastern Pennsylvania v. Casey*.<sup>15</sup> This means either that the abortion, although

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9. See 143 CONG. REC. S4708 (daily ed. May 20, 1997) (Letter from Debra R. Judelson, M.D., President, American Medical Women's Association, to Sen. Rick Santorum (May 20, 1997)) ("AMWA does not endorse legislation which interferes with medical decisionmaking, particularly when it fails to consider the health of the woman patient . . . [W]e are gravely concerned that this legislation does not protect a woman's physical and mental health, including future fertility, or consider other pertinent issues such as fetal abnormalities.").

10. See *id.* (Letter from Geri Marullo, M.S.N., R.N., Executive Director, American Nurses Association, to Senator Barbara Boxer (May 20, 1997)) ("It is the view of the American Nurses Association that this proposal would involve an inappropriate intrusion of the federal government into a therapeutic decision that should be left in the hands of a pregnant woman and her health care provider.").

11. See *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 856 (1992); *Roe v. Wade*, 410 U.S. 113, 154 (1973).

12. See Oregon Death with Dignity Act, OR. REV. STAT. ANN. §§ 127.800-127.995 (Supp. 1996); *Washington v. Glucksberg*, 117 S. Ct. 2258, 2271, 2275 (1997) (holding that there is no constitutionally protected right to physician-assisted suicide, but noting that states may pass laws allowing assisted suicide and encouraging public debate to continue on this issue); *Vacco v. Quill*, 117 S. Ct. 2293, 2296 (1997) (same).

13. See generally 1 BARRY R. FURROW ET AL., *HEALTH LAW* §§ 6-9 to 6-19 (1995) (discussing doctrine of informed consent as developed in both common law and statutes).

14. 410 U.S. 113 (1973).

15. 505 U.S. 833 (1992).

late term, is pre-viability<sup>16</sup> or that, even if the fetus is viable, abortion is necessary to protect the life or health of the pregnant woman.<sup>17</sup> In the latter instance, physicians may be required to take steps to preserve the life of the post-viable fetus, but not at the expense of endangering the woman's life or health.<sup>18</sup>

At the center of the current controversy is a procedure for late term abortions which, so far as anyone knows, is seldom practiced (albeit more frequently than first claimed), and may indeed be regularly conducted by only one physician in the country.<sup>19</sup> Other doctors, however, do utilize the technique from time to time;<sup>20</sup> perform abortion procedures

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16. See *id.* at 846 ("Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure.").

17. See *id.* at 879 (reaffirming that "subsequent to viability, the 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") (quoting *Roe*, 410 U.S. at 164-65).

18. See *Planned Parenthood Ass'n of Kansas City, Mo. v. Ashcroft*, 462 U.S. 476, 485 n.8, 486 (1982) (upholding second physician requirement for post-viability abortions on grounds that law contained an implied medical emergency exception); see also *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768-71 (1986) (finding a provision of a Pennsylvania law unconstitutional because it could result in a "trade-off" between the woman's health and fetal survival since it only contained an exception if care for the fetus would result in a "significantly greater medical risk to the life or health of the pregnant woman," and also finding a provision requiring the attendance of a second physician in post-viability abortions unconstitutional because, unlike the situation in *Ashcroft*, it did not contain an adequate medical emergency exception); *Colautti v. Franklin*, 439 U.S. 379, 400 (1978) (striking down a provision of an earlier Pennsylvania law requiring a physician to take steps to save the life of an aborted viable fetus because it was "uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a 'trade-off' between the woman's health and additional percentage points of fetal survival"); *Jane L. v. Bangert*, 61 F.3d 1493, 1503-04 (10th Cir. 1995) (invalidating provision of Utah law that required physicians performing post-viability abortions to use method that would have best possibility of saving life of fetus because exception was provided only when the method would cause "grave danger" to the woman and also noting that "The importance of maternal health is a unifying thread that runs from *Roe* to *Thornburgh* and then to *Casey*"), *rev'd on other grounds*, 518 U.S. 137 (1996).

19. See *infra* notes 65-77 and accompanying text (noting that the actual number of D&X procedures performed is higher than first thought and that more doctors use the technique, or a variant, than first reported, and in a broader variety of situations; nonetheless, the number is not high—likely no more than a few thousand per year).

20. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995) (in a suit brought by Dr. Haskell and others, the trial court, after describing various abortion procedures and reviewing several physicians' testimony in detail, specifically found that "[a]t least three doctors in Ohio perform some variation of the D & X procedure: Plaintiff Haskell; Dr. John Doe Number One; and Dr. John Doe Number Two"), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934) (citations omitted); see also *Voinovich*, 130 F.3d at 200 (noting testimony of the three doctors).

that represent some variation of the basic technique;<sup>21</sup> or may find the technique useful at some future date.<sup>22</sup> In their eyes, as well as in the views of many of their colleagues, the issue involves not only women's rights to choose a safe, legal abortion, but also their rights as physicians to determine, in consultation with their patients, the best and most appropriate medical treatment for any given patient under her particular circumstances.<sup>23</sup>

This article will explore the movement to ban the targeted abortion procedure and examine the evidence that emerges from the congressional hearings and from other sources in an attempt to tease out the underlying issues and subject the proffered arguments to analytical scrutiny. Are these laws, as some claim, nothing more than part of the pro-life political

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21. See Diane M. Gianelli, *Abortion Rights Leader Urges End to 'Half Truths,'* AM. MED. NEWS, Mar. 3, 1997, at 3 (stating that many doctors already do a variation on intact D&E); see also *infra* note 75 and accompanying text (discussing data that emerged late in 1996 and early 1997 concerning frequency of use of the procedure).

22. See *Voinovich*, 911 F. Supp. at 1070 (noting that "the D & X procedure appears to have the potential of being a safer procedure than all other abortion procedures," implying that future development and more widespread use of the technique might be both anticipated and desirable, if permitted); accord *Carhart v. Stenberg*, 972 F. Supp. 507, 531 (D. Neb. 1997) (issuing temporary restraining order against Nebraska's ban, as applied to the practice of Dr. LeRoy Carhart); *id.* at 525-27 (citing expert testimony in that case and others detailing the potential benefits of D & X over conventional D & E).

23. See *The Partial-Birth Abortion Ban Act of 1995: Hearing Before the Senate Comm. on the Judiciary*, 104th Cong. 248 (1995) [hereinafter *Senate Hearing*] (statement of Warren M. Hern, M.D., M.P.H., Ph.D., Dir. Boulder Abortion Clinic, Asst. Clinical Prof., Dept. of Obstetrics and Gynecology, Univ. of Colorado Health Sciences Center) ("I support the right of my medical colleagues to use whatever methods they deem appropriate to protect the woman's safety during this difficult procedure. It is simply not possible for others to second guess the surgeon's judgment in the operating room. That would be dangerous and unacceptable."); *Partial-Birth Abortion: Hearing Before the Subcomm. on the Constitution of the House Comm. on the Judiciary*, 104th Cong. 64 (1995) [hereinafter *House Hearing*] (statement of J. Courtland Robinson, M.D., Assoc. Prof., Dept. of Gynecology and Obstetrics, Johns Hopkins Univ.) ("The physician needs to be able to decide, in consultation with the patient, and based on her specific physical and emotional needs, what is the appropriate methodology. The practice of medicine by committee is neither good for patients or for medicine in general."); American College of Obstetricians and Gynecologists, Statement on H.R. 1833, *The Partial-Birth Abortion Ban Act of 1995* (Nov. 1, 1995) [hereinafter ACOG, Statement on H.R. 1833] (on file with the author) ("The College finds very disturbing any action by Congress that would supersede the medical judgment of trained physicians and that would criminalize medical procedures that may be necessary to save the life of a woman."); National Abortion Federation, *Later Abortions: Questions and Answers* 5 (1995) (on file with the author) ("Passing federal legislation against a surgical procedure places Congress in an inappropriate position of deciding for women and for doctors what is the best treatment for them to receive or give."); National Abortion and Reproductive Rights Action League, *Late Term Abortion: The Myth of "Abortion on Demand"* 2 (June 20, 1995) (on file with the author) ("When an abortion is needed, the physician's decision about which procedure to use should be based on the health needs of the woman."); see also *supra* note 8 and accompanying text.



agenda—an attempt to chip away at the abortion right itself?<sup>24</sup> Or are they, as others assert, simply an effort to halt an unnecessarily cruel and inhumane procedure under circumstances where alternatives for safe, effective abortions already exist?<sup>25</sup> Are the restrictions constitutional—ei-

24. See, e.g., *Senate Hearing*, *supra* note 23, at 66 (statement of Sen. Feingold) ("I am concerned as well that, although the focus of this legislation is, in fact, one particular type of abortion used in late-term abortions, I fear that this is really an assault upon the basic right to have an abortion."); *id.* at 61 (statement of Sen. Feinstein) ("This bill is a calculated effort to undermine *Roe v. Wade* and to undercut subsequent Supreme Court decisions that have affirmed a woman's constitutional right to choose to have an abortion."). Senator Kennedy stated:

The so-called Partial-Birth Abortion Ban Act is extremist legislation at its worst. It is the latest tactic in the strategy of those who want to overturn the Supreme Court's decision in *Roe v. Wade* and outlaw all abortions. . . .

. . . .

The street war against a woman's right to choose now comes before Congress in the form of this bill. Its proponents have boasted that if they prevail, they will move on to outlaw more and more abortions in the United States, procedure by procedure.

*Id.* at 13-14 (Statement of Sen. Kennedy). J. Courtland Robinson, M.D. testified:

So then I have to wonder what you are trying to ban with this legislation. It sounds as if you are trying to leave any later abortions open to question, to create a right of action and, in fact, a criminal violation, to force doctors to affirmatively prove that they have not somehow violated such a law. . . .

. . . Because the law is so vague and based on erroneous assumptions, it would leave doctors wondering if they were open to prosecution or not each time they performed a late abortion. That means that by banning this technique, you would in practice ban most later abortions altogether by making them virtually unavailable. And that means that women will probably die.

*Id.* at 104-05 (Statement of J. Courtland Robinson, M.D.); see also *House Hearing*, *supra* note 23, at 29-30 (testimony of Rep. Schroeder) ("We all know that what people are really trying to get at here is the fundamental right of women to receive medical treatment that they and their doctors determined to be safest and best for them. . . . This is a beginning of chopping away at a right we have spent much too long in trying to ascertain."); David J. Garrow, Editorial, *A LOOK AT . . . The New Politics of Abortion; When 'Compromise' Means Caving In*, WASH. POST, June 1, 1997, at C3 [hereinafter Garrow, Editorial] ("Santorum and other enemies of women's choice hope to create a slippery slope in which a 'partial-birth' ban leads to prohibition of all second- and third-trimester abortions."); Kim Painter, *Fueling the Debate: Late Abortions Spark New Controversy; Congress Rethinks Ban on 'Partial-Birth' Method*, USA TODAY, Mar. 11, 1997, at 1D ("It's no secret that the National Right to Life Committee believes all children should be protected," says its legislative director, Douglas Johnson. "We think anything that can be done to start moving things back is worthwhile." "). Cf. *Senate Hearing*, *supra* note 23, at 142 (statement of Helen M. Alvare, Esquire., on behalf of the National Conference of Catholic Bishops Secretariat for Pro-Life Activities) ("We are willing to work incrementally to save as many lives as possible, disabled or able-bodied, a bit at a time.").

25. See, e.g., *Senate Hearing*, *supra* note 23, at 116 (statement of Helen M. Alvare, Esq.) ("No reasonable person can disagree, once he or she has read a description or seen an accurate drawing of the partial-birth abortion method: it is one-fifth abortion and four-fifths infanticide. It kills a child when 80 percent of his or her body is already outside the womb."); *id.* at 112 (statement of Nancy G. Romer, M.D.) ("In my research and in talking with physicians who perform late term abortions I found nothing preferable and safer than what I currently do. In fact when reading the description of the D&X procedure I found several things that made this procedure very unattrac-

ther before or after fetal viability? Even if they are, do they represent sound social policy?

This article takes the position that much of the evidence offered to date represents political bias as much as it does scientific fact; that at least some of the restrictions are blatantly unconstitutional, while others are highly questionable under *Casey*; and that they do not, in any event, constitute sound social policy. Even if the contemplated restrictions could be framed in a manner to comport with current Supreme Court jurisprudence defining the abortion right, it is the special province of medical practitioners—not lawmakers—to determine the safest and most effective means of performing medical procedures appropriate for their patients' optimal health. This is true whether the medical treatment at issue happens to be a technique for performing safe, legal abortions or whether it concerns any other form of appropriate medical care.

Granted, the medical profession is extensively regulated: every state has licensure laws;<sup>26</sup> and both state and federal regulations seek, *inter alia*, to prevent fraud;<sup>27</sup> to insure informed consent to experimentation involving human subjects<sup>28</sup> (or any human tissue);<sup>29</sup> and to assure the

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tive."); *id.* at 81 (statement of Pamela Smith, M.D.) ("Partial-birth abortion is not a standard of care for anything. In fact, partial-birth abortion is a perversion of a well-known technique used by obstetricians to deliver breech babies when the *intent* is to deliver the child alive. However . . . this technique is rarely used in this country because of the well known associated risks of maternal hemorrhage and uterine rupture."); Helen Dewar, *Abortion Compromise Rejected; Daschle Plan to Restrict Late-Term Procedure Falls Short*, WASH. POST, May 16, 1997, at A1 [hereinafter Dewar, *Abortion Compromise Rejected*] ("It is 'barbaric . . . shockingly close to infanticide,' said Sen. Tim Hutchinson (R-Ark.). . .") (omission in original); Dewar, *AMA Backs Curb*, *supra* note 3 (quoting then Chair of the AMA's Board of Trustees, Nancy W. Dickey, as saying that the bill bans a procedure that is "never the only appropriate procedure and has no history in peer reviewed medical literature or in accepted medical practice development"); Laurie Goodstein, *Catholic Cardinals Vow to Lobby Congress to Overturn Clinton's Abortion Veto*, WASH. POST, Apr. 17, 1996, at A14 (" 'Partial birth abortion is an even more intense, more moving pro-life issue than many others that have gone before,' [Helen M.] Alvare said. 'Killing a baby that's mostly born is very physically and emotionally gripping.' "); Nancy Romer et al., Editorial, *Partial-Birth Abortion Is Bad Medicine*, WALL ST. J., Sept. 19, 1996, at A22 ("Contrary to what abortion activists would have us believe, partial-birth abortion is *never* medically indicated to protect a woman's health or her fertility. In fact, the opposite is true: The procedure can pose a significant and immediate threat to both the pregnant woman's health and her fertility.") (emphasis added).

26. See 1 FURROW ET AL., *supra* note 13, § 3-1.

27. See, e.g., 42 U.S.C. §§ 263a-1 to a-7 (1994) (reproductive technology reporting provisions); 42 U.S.C. §§ 1320a-1 to a-7 (1994 & Supp. 1996) (Medicare/Medicaid anti-fraud and abuse provisions); VA. CODE ANN. §§ 32.1-310 to -321 (Michie 1992) (Medicaid anti-fraud provisions).

28. See 45 C.F.R. §§ 46.101-.124 (1996) (Department of Health and Human Services Policy for Protection of Human Research Subjects); VA. CODE ANN. § 32.1-162.18 (Michie 1992).

29. See, e.g., 45 C.F.R. §§ 46.208-.210 (pertaining to research involving fetuses); Woman's Right-To-Know Act, 1997 Fla. Laws ch. 97-151 (forbidding experimentation involving fetuses).

safety and effectiveness of drugs and medical devices.<sup>30</sup> These laws share a common concern for the safe and effective practice of their craft by health care professionals and for the health and welfare of the patients they treat. Within the parameters of those concerns, it is up to physicians, acting in good faith and in consultation with their patients, to use their best professional judgment to determine how to treat each patient.

From a legal perspective, what constitutes "accepted medical procedure"<sup>31</sup> has always rested upon the only source capable of defining such a standard—namely, the medical profession itself. Thus, for example, any medical malpractice lawsuit depends for its proof upon the expert testimony of physicians as to what the reasonably skilled physician would have done under the circumstances.<sup>32</sup> With respect to the procedure under consideration here, the medical debate has not been resolved. One can find in the medical literature both staunch support<sup>33</sup> and horrified castiga-

30. See Federal Food, Drug, and Cosmetic Act, 21 U.S.C. §§ 301-95 (1994).

31. See 1 FURROW ET AL., *supra* note 13, § 6-2, at 359-62:

The liability of health care providers is governed by general negligence principles. Malpractice is usually defined as unskillful practice resulting in injury to the patient, a failure to exercise the "required degree of care, skill and diligence" under the circumstances. . . .

. . . .

The standard of care by which the conduct of both general practitioners and specialists is measured is treated as national by most state courts. A good statement is found in *Hall v. Hilbun* [466 So. 2d 856, 872-73 (Miss. 1985)]:

The duty of care . . . takes two forms: (a) a duty to render a quality of care consonant with the level of medical and practical knowledge the physician may reasonably be expected to possess and the medical judgment he may be expected to exercise, and (b) a duty based upon the adept use of such medical facilities, services, equipment and options as are reasonably available.

. . . .

The standard of care applied in a tort suit or hospital peer review process does not normally derive from an external authority such as a government standard. In the medical profession, as in other professions, standards develop in a complicated way through the interaction of leaders of the profession, professional journals and meetings, and networks of colleagues.

*Id.* (footnotes omitted).

32. See *id.* § 6-2, at 365:

The standard or customary practice by those in the defendant doctor's specialty or area of practice is normally established through the testimony of medical experts. . . .

. . . .

. . . Expert testimony is needed to establish both the standard of proper professional skill or care and a failure by the defendant to conform. . . . The expert must however be able to say that the defendant's failure breached a general medical practice; a simple statement that the expert would have done differently may not be sufficient.

*Id.* (footnotes omitted).

33. See, e.g., *Senate Hearing*, *supra* note 23, at 248 (statement of Warren M. Hern, M.D.); *id.* at 149 (testimony of Dr. Mary Campbell) ("This is far and away the safest procedure after 24 weeks. Well, dilation and intact extraction is far and away the safest procedure in the third trimester. . . ."); *id.* at 144 (letter from Dru Elaine Carlson, M.D., Dir. Reproductive Genetics, Dept. of

tion.<sup>34</sup> If in fact this abortion technique turns out to be "bad medicine," however, well established and trustworthy procedures for its regulation are already in place: peer review mechanisms; state medical board licensure decisions; and the medical malpractice system itself.

On the other hand, the abortion procedure sought to be regulated may in fact turn out to represent an advance over existing techniques, helping—in those apparently rare situations where it might be employed—to insure better patient health and future fertility. If legislatures foreclose a potential avenue of progress by freezing into stone, so to speak, the current state of this medical art, they will have indeed done a disservice to women often caught in tragic circumstances. Legislators simply are not equipped to make that call.

## II. THE PROCEDURE

### A. What is a "Partial-Birth Abortion"?

House Bill 1122 defines a "partial-birth abortion" as "an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery."<sup>35</sup> The

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Obstetrics and Gynecology, Cedars-Sinai Medical Center, Los Angeles, CA, to Rep. Schroeder); Angela Bonavoglia, *Separating Fact From Fiction: The Latest Battle Over a Woman's Right to Terminate a Pregnancy Has Generated a Lot of Heat but Very Little Light*, Ms., May-June 1997, at 54, 59 (quoting David Grimes, M.D., Vice Chair of Obstetrics and Gynecology at the Univ. of California, San Francisco, as saying, "[t]here's been no question about the safety of the D & E or its variants for 20 years"); Diane M. Gianelli, *Shock-Tactic Ads Target Late-Term Abortion Procedure*, AM. MED. NEWS, July 5, 1993, at 3 ("But the classic D&E, in which the fetus is broken apart inside the womb, carries the risk of perforation, tearing and hemorrhaging, [Dr. Haskell] said. So he turned to the D&X, which he says is far less risky to the mother."); *infra* notes 377-78 and accompanying text.

34. See, e.g., *Senate Hearing*, *supra* note 23, at 112 (statement of Nancy G. Romer, M.D.) ("There is no medical evidence that this procedure is safer nor necessary to provide comprehensive health care to women. As currently practiced, it does not meet medical standards set by ACOG nor has it been adequately proven to be safe nor efficacious."); *id.* at 18 (statement of Brenda Pratt Shaffer) ("I have been a nurse for a long time, and I have seen a lot of death—people maimed in auto accidents, gunshot wounds, you name it. I have seen surgical procedures of every sort. But in all my professional years, I had never witnessed anything like this."); *House Hearing*, *supra* note 23, at 79 (statement of Mary Ellen Morton, R.N., neonatal specialist and flight nurse) ("I am greatly disturbed that the same gestational age and weight, human babies that I nurture in the NICU, can suffer unimaginable agony at the hands of an abortionists [sic] before they are put to death, during the Partial-Birth Abortion Procedure."); *id.* at 42 (statement of Pamela Smith, M.D.) ("In fact, when I described the procedure of partial-birth abortion to physicians and lay persons who I knew to be pro-choice, many of them were horrified to learn that such a procedure was even legal."); De Lafuente, *AMA Members*, *supra* note 4, at 20 ("But most of the 64 delegates who testified before a packed committee meeting supported the AMA's board in supporting a ban, describing the technique as 'abhorrent' and 'repugnant.'").

35. H.R. 1122, 105th Cong. § 2 (1997).

Senate amendment adds to the federal bill a further definition: " 'vaginally delivers a living fetus before killing the fetus' means deliberately and intentionally delivers into the vagina a living fetus, or a substantial portion thereof, for the purpose of performing a procedure the physician knows will kill the fetus, and kills the fetus."<sup>36</sup> The purpose of this addition was to tighten the definition and specify the *mens rea* thought appropriate by the drafters to a criminal statute of this kind.<sup>37</sup> Nineteen states have enacted legislation prohibiting the procedure.<sup>38</sup> Of

36. *Id.*

37. See 143 CONG. REC. S4671 (daily ed. May 19, 1997) (statement of Sen. Santorum):

The first thing this bill does, as has been referred to, is to tighten up the language on what we mean by partial-birth abortion. . . .

. . . .

We have tightened up the language with *mens rea*, to use the legal term. That directs the mental state—as to what the doctor was doing when he was delivering the baby for the purpose of a live birth and is not doing an abortion.

. . . .

So we tightened that language up substantially to satisfy that. That kind of situation would no longer be covered under the act.

. . . .

I think to the extent that we have made that clear and that it is positive to the extent that we have put in the requisite *mens rea* for a criminal statute, which arguably was somewhat vague in the original bill, we have now done that.

*Id.*

38. Note that in nine states federal courts have stayed enforcement of the statutes on a temporary or permanent basis: Arizona (*Planned Parenthood of S. Ariz., Inc. v. Woods*, No. CIV. 97-385-TUC-RMB, 1997 WL 679921, at \*13 (D. Ariz. Oct. 27, 1997) (permanent injunction)); Arkansas (*Little Rock Family Planning Servs. v. Jegley*, No. LR-C-97-581 (E.D. Ark. July 31, 1997) (temporary restraining order)); Georgia (*Midtown Hosp. v. Miller*, No. 1:97-CV-1786-JOF (N.D. Ga. July 24, 1997) (order restricting enforcement to post-viability procedures, trial still to be held)); Louisiana (*Causeway Med. Suite v. Foster*, No. 97-2211 (E.D. La. July 14, 1997) (preliminary injunction)); Michigan (*Evans v. Kelley*, 977 F. Supp. 1283, 1320 (E.D. Mich. 1997) (permanent injunction)); Nebraska (*Carhart v. Stenberg*, 972 F. Supp. 507, 531 (D. Neb. 1997) (preliminary injunction against ban as applied to practice of one physician; the court, however, uses very broad language that suggests it would uphold a facial challenge, if presented with one)); New Jersey (*Planned Parenthood v. Verniero*, No. 97-6170 (D.N.J. Dec. 24, 1997) (temporary restraining order)); Ohio (*Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1092 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934) (permanent injunction)); and Rhode Island (*Rhode Island Med. Soc'y v. Pine*, No. 97-416L (D.R.I. July 11, 1997) (temporary restraining order)). See *The State "Partial-Birth Abortion" Bans: Enjoined in the Courts*, REPROD. RTS. UPDATE (ACLU/Reprod. Freedom Project), Jan. 13, 1997, at 1-3. Two state courts have taken similar action: Alaska (*Planned Parenthood of Alaska, Inc. v. Alaska*, No. 3AN-97-06019 (Alaska Super. Ct. July 30, 1997) (temporary restraining order)); and Montana (*Intermountain Planned Parenthood v. State*, No. BDV 97-477 (Dist. Ct. Mont. Oct. 1, 1997) (preliminary injunction)). See *id.*; see also David Garrow, *Despite the 'Partial Birth' Furor, Abortion Foes are Losing in Court*, WASH. POST., Jan. 18, 1998, at C1 [hereinafter, Garrow, *Abortion Foes are Losing*] (summarizing actions in the states). Garrow also reports that "In Alabama, the state attorney general has averted a face-off by declaring that the statute does not pertain to pre-viability procedures, and in Illinois, a

the nineteen laws passed, ten use definitions identical to the original federal bill, which lacks a clear scienter requirement;<sup>39</sup> seven contain slight variations in wording (including Nebraska and New Jersey, which are the only states to attempt any scienter clarification);<sup>40</sup> and two refer to "dilation and extraction."<sup>41</sup>

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courtroom challenge is pending." *Id.*

39. See Alabama Partial-Birth Abortion Ban Act of 1997, 1997 Ala. Acts 97-485; Act of July 31, 1997, ch. 15, 1997 Alaska Sess. Laws 65; Act of April, 10, 1997, ch. 83, 1997 Ariz. Legis. Serv. 2113 (West); Act effective July 1, 1997 Ga. Laws 357; Act effective July 1, 1997, 1997 Ind. Adv. Legis. Serv. 1185; MICH. COMP. LAWS ANN. §§ 333.17016(5)(c), 333.17516(5)(c) (West Supp. 1997); Partial-Birth Abortion Ban Act, ch. 350, 1997 Miss. Laws 1494; Act of April 19, 1997, ch. 314, 1997 Mont. Laws 365; Act of March 26, 1997 S.C. Acts 11, 3502; Act of June 13, 1997, ch. 414, 1997 Tenn. Pub. Acts 1274.

40. See, e.g., Partial-Birth Abortion Ban Act of 1997, 1997 Ark. Acts 984 (reiterating the federal language but adding the qualifying phrase, "or as defined by the United States Supreme Court"). Illinois' variation on the federal wording is "partially vaginally delivers a living human fetus or infant before killing the fetus or infant and completing the delivery. The terms 'fetus' and 'infant' are used interchangeably to refer to the biological offspring of human parents." Partial-Birth Abortion Ban Act, 1997 Ill. Legis. Serv. 90-560 (West). The statute provides for criminal penalties against "[a]ny person who knowingly performs a partial-birth abortion." *Id.* Nebraska uses a definition similar to the federal definition and also adds the following scienter requirement similar to the Senate amendment to the federal bill:

partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery. . . . [T]he term partially delivers vaginally a living unborn child before killing the unborn child means deliberately and intentionally delivering into the vagina a living unborn child, or a substantial portion thereof, for the purpose of performing a procedure that the person performing such procedure knows will kill the unborn child and does kill the unborn child.

Act of June 9, 1997, 1997 Neb. Laws 23. New Jersey specifies a "living human fetus," but is otherwise virtually identical to the federal bill, including the language of the scienter requirement added on the federal level by the Senate amendment. See Partial-Birth Abortion Ban Act of 1997, 1997 N.J. Sess. Law Serv. 262 (West). Rhode Island substitutes for the federal language, "partially vaginally delivers a living human fetus before killing the infant," H.B. 6051, 1997-98 Leg., Reg. Sess. (R.I. 1997). South Dakota similarly substitutes for federal language by using the phrase "partially vaginally delivered before killing the infant." H.B. 1088, 72nd Leg. Sess., Reg. Sess. (S.D. 1997). Louisiana departs substantially from the federal wording by defining partial birth abortion as the following:

[T]he performance of a procedure on a female by a licensed physician or any other person whereby a living fetus or infant is partially delivered or removed from the female's uterus by vaginal means, and with specific intent to kill or do great bodily harm is then killed prior to complete delivery or removal.

H.B. 128, 1997-98 Leg. Sess., Reg. Sess. (La. 1997).

41. See OHIO REV. CODE ANN. § 2919.15(A) (Banks-Baldwin 1997); UTAH CODE ANN. § 76-7-310.5 (Supp. 1996). Ohio, the first state to pass this type of legislation, specifically prohibits "dilation and extraction," defined as "the termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain. 'Dilation and extraction procedure' does not include either the suction curettage procedure of abortion or the suction aspiration procedure of abortion." OHIO REV. CODE ANN. § 2919.15(A). Utah's statute uses both terms:

"[P]artial birth abortion" or "dilation and extraction procedure" means the termination

Health care professionals are quick to point out that no such term as "partial-birth abortion" exists in medical terminology or literature.<sup>42</sup> Rather, the method is variously referred to by its practitioners and other health care professionals as "dilation and extraction," ("D&X");<sup>43</sup> "intact dilation and evacuation" ("intact D&E");<sup>44</sup> or "modified dilation and evacuation" ("modified D&E").<sup>45</sup> This method is generally reserved for late term abortions, meaning those occurring at twenty weeks' gestation and beyond, when the skull of the fetus is too large to be removed by the dilation and evacuation ("D&E") method commonly used for sec-

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of pregnancy by partially vaginally delivering a living intact fetus, purposefully inserting an instrument into the skull of the intact fetus, and utilizing a suction device to remove the skull contents. This definition does not include the dilation and evacuation procedure involving dismemberment prior to removal, the suction curettage procedure, or the suction aspiration procedure for abortion.

UTAH CODE ANN. § 76-7-310.5(1)(a) (Supp. 1996).

42. See generally *infra* notes 143-94 and accompanying text (discussing vagueness objections); see also ACOG, *Statement on Intact D&X*, *supra* note 8 ("The debate regarding legislation to prohibit a method of abortion, such as the legislation banning 'partial birth abortion,' and 'brain sucking abortions,' has prompted questions regarding these procedures. It is difficult to respond to these questions because the descriptions are vague and do not delineate a specific procedure recognized in the medical literature. Moreover, the definitions could be interpreted to include elements of many recognized abortion and operative obstetric techniques."); ACOG, *Statement on H.R. 1833*, *supra* note 23 (stating that "in defining what medical procedures doctors may or may not perform, the bill employs terminology that is not even recognized in the medical community—demonstrating why congressional opinion should never be substituted for professional medical judgment"); National Abortion Federation, *supra* note 23, at 3 ("[The phrase 'partial-birth abortion'] was invented solely for use in this legislation, and is not a medical term. It was made up in an effort to find the most inflammatory and upsetting term to use for this legislation. There is no such thing as a 'partial-birth abortion,' and that is not what this procedure is.").

43. Dr. Martin Haskell, of Dayton, Ohio, first described his technique of "dilation and extraction," or "D&X," in 1992 at a meeting of abortion providers. See Martin Haskell, M.D., *Dilation and Extraction for Late Second Trimester Abortion*, Presented at the National Abortion Federation Risk Management Seminar (Sept. 13, 1992), reprinted in *Senate Hearing*, *supra* note 23, at 5-12. Dr. Haskell was the plaintiff in *Women's Medical Professional Corp. v. Voinovich*, 911 F. Supp. 1051 (S.D. Ohio 1995) (enjoining enforcement of Ohio's statute banning his technique), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934). Dr. Haskell coined the term "Dilation and Extraction," or "D&X" to distinguish his technique "from dismemberment-type D&E's." *Id.* at 1066. This terminology is employed by the laws in both Ohio and Utah. See *supra* note 41 and accompanying text. Nonetheless, the United States Court of Appeals for the Sixth Circuit found the language unconstitutional because in its view Ohio's statutory definition encompassed both the D&E and D&X procedures. See *Voinovich*, 130 F.3d at 200-02.

44. See *infra* notes 48-49 and accompanying text (explaining that "Intact dilation and evacuation" was the name Dr. McMahon gave to his version of the technique).

45. See *Voinovich*, 911 F. Supp. at 1066-67 n.19 (noting that "Dr. John Doe Number Two, who uses Haskell's D & X procedure in situations where an intact fetus is requested, or if the fetus is breech (feet first), testified that he considers the D & X procedure to be a modification of the D & E procedure"); see also *Voinovich*, 130 F.3d at 200 (noting doctors' testimony).

ond trimester abortions before the twentieth week.<sup>46</sup> Dr. Martin Haskell, of Dayton, Ohio, the developer of D&X (the procedure most commonly singled out by proponents of the ban and the term that will be used throughout most of this article), has stated that he "routinely performs this procedure on all patients 20 through 24 weeks."<sup>47</sup> The late Dr. James T. McMahon, of Los Angeles, California,<sup>48</sup> was reputed to have performed his similar "intact D&E" procedure not only on late second trimester pregnancies but also in circumstances involving non-elective abortions arising during the third trimester.<sup>49</sup>

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46. See generally WARREN M. HERN, *ABORTION PRACTICE* 126-56 (1984). The first step in a dilation and evacuation (D&E) procedure is the dilation of the woman's cervix. See *id.* at 126. This is accomplished through the use of laminaria which are placed in the cervix before the procedure and which gradually cause the dilation and softening of the cervix that are necessary to make the cervix large enough for the fetus to pass through. See *id.* Very early in the second trimester, this can be accomplished using one laminaria placed twenty-four hours before the procedure; however, by the fifteenth week more laminaria changed more frequently are necessary for the required amount of dilation and softening of the cervix. See *id.* at 126, 148. Twenty minutes before the procedure, the laminaria are removed and the vagina is rinsed. See *id.* at 148. Having been softened with the laminaria, the cervix is then manually dilated to the appropriate size. See *id.* The appropriate size of the cervix increases as the gestational length increases to accommodate the larger size of the fetus as well as of the instruments required as time goes on. See *id.* at 148-49. Once the cervix is adequately dilated, the physician, using forceps and/or suction curettage, dismembers the fetus and removes it, piece by piece, from the uterus. See *id.* at 149-50. The physician must proceed gently so as not to damage the cervix or the uterine wall. See *id.* at 150.

47. Haskell, *supra* note 43, at 28, reprinted in *Senate Hearing, supra* note 23, at 6. Specifically, Dr. Haskell was referring to gestation measured since the patient's last menstrual period. See *id.* Haskell also stated that he performed the procedure "on selected patients 25 through 26 weeks LMP." *Id.* He has since stated that the latest he will perform an abortion is in the 24th week. See *Senate Hearing, supra* note 23, at 36 (transcript from the Voinovich trial). The "exceptions" cited in the text include women over 22 weeks' gestation with a history of a prior cesarean section, obese patients, patients beyond 21 weeks pregnancy with twins, and patients seeking abortions at 26 weeks or beyond. See Haskell, *supra* note 43, at 28, reprinted in *Senate Hearing, supra* note 23, at 6.

48. Dr. McMahon specialized in late term abortions, including those performed as a result of medical necessity in the third trimester. See Roy Rivenburg, *Partial Truths in the PR War Over a Form of Late-Term Abortions, Both Sides Are Guilty of Manipulating the Facts. Here's What They Are (and Aren't) Saying*, L.A. TIMES, Apr. 2, 1997, at E1. His work at the Eve Surgical Center in Los Angeles led to the development of the intact D&E procedure. See *id.* Dr. McMahon performed late term abortions, usually of deformed fetuses or on sick mothers, until his death in 1995. See *id.* Before his death, Dr. McMahon submitted to Congress his research analyzing the reasons for many of his patients' abortions. See *id.* He reported that 9% were for maternal health reasons, most often depression or rape, and 54% were for serious fetal defects such as anencephaly or congenital heart disease. See *id.*; see also Bonavoglia, *supra* note 33, at 59 (describing Dr. McMahon's research).

49. See Bonavoglia, *supra* note 33, at 59 ("Dr. McMahon, on the other hand, performed primarily medically indicated abortions in both the late second and third trimester, by intact D&E."); David Brown, *Late Term Abortions; Who Gets Them and Why*, WASH. POST, Sept. 17, 1996, at Z12 ("In a letter written in 1993 to doctors who referred patients to him, [Dr. McMahon] said that in 1991 he'd done 65 third-trimester abortions. All of these cases, he said, were 'nonelective.'").



The surgical technique referred to involves removal of the fetus in an intact condition—that is, without the prior dismemberment which characterizes D&E.<sup>50</sup> According to Dr. Haskell, he begins by administering dilators to the patient on each of two succeeding days before surgery.<sup>51</sup> The brief surgery itself entails the use of ultrasound and forceps to extract the lower extremities and torso of the fetus from the woman's body, after which the physician inserts a suction device into the skull and removes its contents, in order to facilitate complete extraction without the dangers of hemorrhage or tearing of the woman's membranes.<sup>52</sup>

The D&X procedure differs from the D&E abortion method routinely used from weeks thirteen through nineteen in that the latter involves dilation followed by dismemberment in the uterus prior to removal.<sup>53</sup> After nineteen weeks' gestation, the skull—particularly the jawbone—is likely to be too large for the safe utilization of the D&E method.<sup>54</sup> In the first case to challenge a state legislative prohibition of D&X on constitutional grounds, *Women's Medical Professional Corp. v. Voinovich*,<sup>55</sup> the trial judge described the procedure as "a variant of the D & E technique."<sup>56</sup> In support of his order staying enforcement of Ohio's restrictive law, the trial judge noted that "doctors who use the procedure may not know which procedure they will perform until they encounter particular surgical variables and circumstances after they begin the procedure to terminate the pregnancy."<sup>57</sup>

50. See Haskell, *supra* note 43, at 27, reprinted in *Senate Hearing*, *supra* note 23, at 5.

51. See *id.* at 29.

52. See *id.* at 29-31.

53. See *id.* at 27.

54. See *id.* at 28; *House Hearing*, *supra* note 23, at 16 (citing sources); see also *infra* notes 61-64, 377-80 and accompanying text (discussing advantages of D&X or intact D&E); cf. HERN, *supra* note 46, at 154 (noting difficulties of using D&E after the fetal tissue becomes cohesive).

55. 911 F. Supp. 1051 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

56. *Id.* at 1066.

57. *Id.* at 1066-67; cf. *House Hearing*, *supra* note 23, at 65 (statement of J. Courtland Robinson, M.D.). Dr. Courtland stated the following:

Sometimes, as any doctor will tell you, you begin a surgical procedure expecting that it will go one way, only to discover that a unique demand, the case requires you to do something different. Telling a physician that it's illegal for him or her to adapt a certain surgical method for the safety of the patient is absolutely criminal and flies in the face of the standards for the quality of medical care.

For many physicians, this law [the federal "Partial-Birth Abortion Ban Act of 1995"] would amount to a ban on D&E entirely, because they would not undertake a surgery if they were legally prohibited from completing it in the best way they saw fit at the time the procedure was being done.

*Id.*; accord *Evans v. Kelley*, 977 F. Supp. 1283, 1298-99 (E.D. Mich. 1997) (statement of Dr. Evans).

### B. *Advantages Claimed for D&X Over the Alternatives*

The current alternative for abortion during the twentieth week of a pregnancy and beyond is induction or instillation, which involves the use of a saline substance to effectuate fetal demise, followed by administration of a drug to induce labor.<sup>58</sup> The process typically takes between twelve and twenty-four hours, but may last longer.<sup>59</sup> Another possibility is a hysterotomy, which is basically a caesarean section performed before term; however, doctors today prefer to avoid this method, because of its attendant surgical risks.<sup>60</sup>

The advantages cited by proponents of D&X over available alternatives are that, compared to induction, D&X involves less potential blood loss; is less likely to result in tearing of the woman's membranes; is more protective of future fertility; does not require hospitalization; and requires less time.<sup>61</sup> Genetic testing, useful for tracing the source of fetal

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58. See *Voinovich*, 911 F. Supp. at 1068 ("Induction methods are also known as 'instillation' methods. In one type of induction method, the physician injects some substance—typically saline, or a combination of a prostaglandin and urea—into the amniotic cavity of the woman. In another type, the physician places prostaglandin suppositories into the patient's vagina. In both cases, the end result is labor: the substances cause the uterus to contract, resulting in the eventual expulsion of the fetus."); see also *HERN*, *supra* note 46, at 123-26 (describing this method in more detail).

59. See *Voinovich*, 911 F. Supp. at 1068.

60. See *id.* at 1070 ("Finally, the Court finds that the D & X procedure appears to pose less of a risk to maternal health than either a hysterotomy or a hysterectomy, both of which are major, traumatic surgeries."); *HERN*, *supra* note 46, at 123 ("Hysterotomy has been almost completely abandoned because of its associated high morbidity.").

61. See *Voinovich*, 911 F. Supp. at 1069; *accord* *Carhart v. Stenberg*, 972 F. Supp. 507, 516 (D. Neb. 1997) (citing expert who "believes the D & X procedure is 'an advance in technology' because by removing the fetus intact there is 'less instrument manipulation,' which means, 'of course, the higher your safety' ") (citation omitted); see also *Senate Hearing*, *supra* note 23, at 50 (containing portions of the trial transcript introduced into the record by Sen. Hatch, Chairman of the Senate Judiciary Committee); *infra* notes 377-80 and accompanying text (discussing advantages as seen by advocates of the technique). Dr. Haskell, in response to a question stated that:

The advantage of [the D&X] procedure is that because it is done intact with ultrasound guidance to do the version to remove intact, the placenta is not disrupted. Even with a bad lie, the procedure, the placenta is not disrupted. And there's no bleeding until after the fetus is removed.

So, it passes a lot of the common sense techniques of surgery that we learn in our very basic surgery day [by] minimizing trauma, minimizing blood loss, and shortening surgical time.

*Id.* Also, Martin Ruddock, an Ohio physician, believes D&X is safer than its most common alternative,

which is called "dismemberment dilation and evacuation." In that procedure, the fetus is removed in pieces, generally limbs first. It requires that the surgeon exert a great deal of force on the fetus inside the uterus, and it often produces sharp, bony fragments that can damage a woman's reproductive organs.

*Brown*, *supra* note 49; see also *Painter*, *supra* note 24 ("But after 20 weeks, 'dismembering the fe-

abnormalities and in helping a couple's future family planning, is also possible when the fetus is intact.<sup>62</sup> Additionally, the patient experiences less discomfort and stress.<sup>63</sup> Finally, the psychological benefit of seeing and even holding an intact fetus is an advantage the patient realizes by choosing the D&X method.<sup>64</sup>

### C. Incidence of Use of the Procedure

Despite the attention and publicity accorded to the D&X abortion procedure, the potential extent of its use is actually quite small. According to the Alan Guttmacher Institute,<sup>65</sup> which tracks abortion statistics, as of 1992 only about 1% of all abortions (about 16,450 in that year)<sup>66</sup> are performed at twenty-one weeks LMP<sup>67</sup> or more.<sup>68</sup> This 1% represents the

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tus becomes more difficult,' Hern says. 'It increases the risk of the operation. It increases the discomfort for the woman.' '').

62. See *House Hearing*, *supra* note 23, at 75 (statement of Tammy Watts).

We made another painful decision shortly after the abortion. Dr. McMahon called and said, "This will be very difficult, but I have to ask you this. Given the anomalies [Watts' aborted daughter] had, so vast and different, there is a program at Cedars-Sinai which is trying to find out the causes for why this happens. They would like to accept her into this program." I said, "I know what that means. Autopsies and the whole realm of testing." But we decided, how can we not do this? If I can keep one family from going through what we went through, it would make her life have some meaning. So they're doing the testing now. And because Dr. McMahon does the procedure the way he does, it made the testing possible.

*Id.*; see also H.R. REP. NO. 104-267, at 32 (1995) (letter from Dru Elaine Carlson, M.D., to Rep. Schroeder) ("[Fetuses] are delivered intact and that allows us . . . to evaluate them carefully. . . . We work with Dr. McMahon in evaluating many of the malformed fetuses . . . to try and provide the clearest and most precise diagnosis we can for our families as to why this happened to them.").

63. See, e.g., *Voinovich*, 911 F. Supp. at 1068 ("One obvious disadvantage of the induction method is that it results in labor, with all of its potential complications. These may include: fear, lack of control, mild to severe abdominal pain, nausea, and diarrhea, and extreme discomfort, over a lengthy period of time.").

64. See, e.g., *House Hearing*, *supra* note 23, at 72 (statement of Tammy Watts) ("Thanks to the [intact D&E] procedure that Dr. McMahon uses in terminating these pregnancies, we got to hold her and be with her and love her and have pictures for a couple of hours, which was wonderful and heartbreaking all at once. They had her wrapped in a blanket. We spent some time with her, said our goodbyes, and went back to the hotel."); H.R. REP. NO. 104-267, at 32 (letter from Dru Elaine Carlson, M.D., to Rep. Schroeder) ("[T]hey are delivered intact and that allows . . . families to touch and acknowledge their baby in saying goodbye.").

65. The Institute describes itself as a "Not-for-Profit Corporation for Reproductive Health Research, Policy Analysis and Public Education." Alan Guttmacher Institute, *Facts in Brief: Abortion in the United States 1* (1995).

66. See Bonavoglia, *supra* note 33, at 58.

67. "LMP" as a measure of pregnancy refers to a woman's last menstrual period. See Alan Guttmacher Institute, *supra* note 65, at 2.

68. See *id.* The Institute states that of the 1.5 million abortions performed annually as of 1992, over 89% take place in the first trimester of pregnancy. See *id.* Another 6% occur at thirteen-to-fifteen weeks LMP, with 4% at sixteen-to-twenty weeks. See *id.*

population for whom the D&X procedure might be an option.<sup>69</sup> The Alan Guttmacher Institute further estimates that only about six hundred abortions annually, or 0.04%, occur after twenty-six weeks;<sup>70</sup> some of these women *may* also be candidates for D&X or a similar procedure.<sup>71</sup>

Although information about actual frequency of D&X procedures is difficult to obtain, the number is clearly far less than even the 1% figure might suggest. However, the figure is also clearly higher than that suggested by statements published at the time of the public debate on the "Partial-Birth Abortion Ban Act of 1995,"<sup>72</sup> when the National Abortion Federation estimated that "[b]ased on documentation from the two primary physicians using the procedure, approximately 450 abortions per year are performed this way."<sup>73</sup> When the issue resurfaced in the spring of 1997, Ron Fitzsimmons, Executive Director of the National Coalition of Abortion Providers, admitted that the numbers were considerably higher than previously reported.<sup>74</sup> Other abortion rights leaders agreed, and eventually statistics emerged suggesting the possibility of several thousand abortions per year that employ D&X or a variation of D&X.<sup>75</sup>

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69. Dr. Martin Haskell has stated that he "routinely performs this procedure on all patients 20 through 24 weeks." Haskell, *supra* note 43, at 28, reprinted in *Senate Hearing*, *supra* note 23, at 6.

70. See Alan Guttmacher Institute, *supra* note 65, at 2.

71. See Brown, *supra* note 49 (stating that the late Dr. James T. McMahon performed this procedure for therapeutic post-viability abortions). On the other hand, despite an earlier statement that he would sometimes perform his D&X procedure on selected patients 25 through 26 weeks LMP, Dr. Haskell recently testified that he now only uses the D&X procedure for abortions during the 21st to 24th week of gestation. See *Senate Hearing*, *supra* note 23, at 36. Note that this statement also contrasts with Dr. Haskell's earlier indications that he would use the D&X procedure for abortions performed during the twentieth week. See *supra* note 47 and accompanying text. In 1993, a reporter who interviewed Dr. Haskell quoted him as stating that he performed abortions " 'up until about 25 weeks' " gestation, but specifically noted the importance that he attached to the distinction between second trimester and third trimester abortions, "adding that his cutoff point is within the viability threshold noted in *Roe v. Wade*." Gianelli, *supra* note 33, at 16. He has not published exact figures reflecting his own practice, although his testimony in the lawsuit where he served as plaintiff refers to "approximately 1,000 D&X procedures performed after the twentieth week of pregnancy." *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1069 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934). Dr. Haskell particularly noted that in that number "there were no serious complications." *Id.*

72. See H.R. 1833, 104th Cong. (1995).

73. National Abortion Federation, *supra* note 23, at 3 (citing personal interviews with Dr. Martin Haskell and Dr. James McMahon, as well as National Abortion Federation quarterly statistics).

74. See Gianelli, *supra* note 21, at 3.

75. See *id.* Vicki Saporta, of the National Abortion Federation, was quoted as saying "the numbers are greater than we initially estimated." *Id.* Other sources referred to numbers that, taken together, suggest that several thousand such procedures are performed each year. See *id.* ("[D]octors who use the technique acknowledged doing thousands of such procedures a year. . . . [A Bergen County, N.J.] paper reported last fall that physicians at one facility perform an estimated 3,000 abor-

Undoubtedly, legislative stirrings on state and federal levels over the past two years have contributed to underreporting of the incidence of the use of D&X, although available data still indicate that the procedure is rare.<sup>76</sup> In any event, so long as the decisions to abort at all (using any medically acceptable procedure) are legal under the *Roe/Casey* framework, the number of doctors using the D&X technique or the number of such procedures performed should make no difference with respect to the legal status of the D&X procedure itself.<sup>77</sup>

#### D. Reasons for Use of the Procedure

Like the controversy surrounding the numbers, the reasons why the D&X procedure is used have also been the subject of conflicting reports. When the issue first appeared on the public stage in 1995, forces opposed to the ban offered statements that the D&X technique was used only in extreme cases of wanted pregnancies where the woman's life or health was placed at serious risk or where severe fetal abnormalities were discovered too late in the pregnancy for the D&E method to be used safely and effectively.<sup>78</sup> President Clinton's veto of the "Partial-Birth

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tions a year on fetuses between 20 and 24 weeks, of which at least half are by intact D&E."). At the *Voinovich* trial, Dr. Martin Haskell testified to approximately 1,000 D&X procedures performed by him after the twentieth week of pregnancy with "no serious complications." *Voinovich*, 911 F. Supp. at 1069. The trial judge in that case also found that "[a]t least three doctors in Ohio perform some variation of the D & X procedure: Plaintiff Haskell; Dr. John Doe Number One; and Dr. John Doe Number Two." *Id.* at 1070 (citation omitted). Note, however, that some doctors reporting themselves as performing "intact D&E" procedures administered lethal drugs to the fetus beforehand. See Gianelli, *supra* note 21, at 3 (citing a doctor in Bellevue, Neb.). This fact would take their behavior outside the scope of the federal bill and any similarly worded laws that refer to "a living fetus." See *supra* notes 35-41 and accompanying text.

76. See Bonavoglia, *supra* note 33, at 58 ("Overall, the number of abortions performed in the late second and third trimester is comparatively low. According to the Alan Guttmacher Institute, of the 1.5 million abortions done annually in the U.S., 1 percent, or 16,450, are done after 20 weeks. Of those, around 10,340 are done from 21 to 22 weeks; 4,940 from 23 to 24 weeks; 850 from 25 to 26 weeks; and after 26 weeks, somewhere between 320 and 600, or an estimated 4/100ths of one percent, are performed."); Rivenburg, *supra* note 48 (explaining conflicting data but concluding that procedure is rare).

77. Pro-choice leaders have made the same point. See, e.g., Gianelli, *supra* note 21, at 3.

78. See National Abortion Federation, *supra* note 23, at 3. The National Abortion Federation, the professional association of abortion providers, claimed that this was the situation "in the majority of cases." *Id.* Other factors identified in a statement issued by the Federation in 1995 included such maternal health problems as cancer, kidney failure, or the sudden flare-up of a previous condition, such as brittle diabetes; situations of rape or incest, where the woman had been unable to confront the reality earlier; and difficulties in diagnosing the pregnancy itself, which may occur, for example, when women believe they are undergoing early menopause, or when they have irregular menstrual cycles. See *id.* at 2, 5. Burdensome laws, including parental consent statutes, mandatory waiting periods, and prohibitions against government financial aid for poor women seeking abortions were also

Abortion Ban Act of 1995" was premised largely on the fact that the targeted procedure was primarily used for reasons of maternal health, a concern which he apparently considered broad enough to encompass severe fetal anomaly.<sup>79</sup>

Accompanying President Clinton at that veto ceremony were "five women [who] sometimes tearfully described having had such [late term D&X] abortions after being told by their doctors that they faced potentially fatal harm if they carried their pregnancies to term."<sup>80</sup> One of these women, Vicki Stella of Chicago, had been told that "her fetus had no brain," and, because she is a diabetic she doesn't "heal as well as other people, so other procedures just were not the answer."<sup>81</sup> Upon choosing the D&X method Vicki reasoned that, "I didn't make the decision for my child to die, God made the decision for my child to die."<sup>82</sup>

Testimony at both the House<sup>83</sup> and Senate<sup>84</sup> committee hearings in 1995 bore out the President's perceptions. For example, a woman named Tammy Watts related to the House Judiciary Committee's Subcommittee on the Constitution her experience upon learning, seven months into her pregnancy, that the fetus was afflicted with trisomy-13, a syndrome of severe fetal anomalies with which the child cannot live.<sup>85</sup> Ms. Watts had

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cited as factors in some late-term cases cited by the Federation as typical D&X factual situations. See *id.* at 6.

79. See Ann Devroy, *Late-Term Abortion Ban Vetoed; 'Small But Vulnerable' Group of Women Needs Procedure*, *Clinton Says*, WASH. POST, Apr. 11, 1996, at A1 (noting that "Clinton had said he could allow the ban only if it contained an exception for women who faced serious health consequences"); see also Goodstein, *supra* note 25 (noting that in rejecting the ban, Clinton had said "that this particular procedure was used very rarely and usually only when the fetus was suffering severe birth defects, or when the health of the mother was at risk").

80. Devroy, *supra* note 79.

81. *Id.*

82. *Id.*

83. See *House Hearing*, *supra* note 23, at 71-76 (statement of Tammy Watts).

84. See *Senate Hearing*, *supra* note 23, at 158-65 (testimony of Coreen Costello, statement of Vicki Wilson, and statement of Jeannie French).

85. See *House Hearing*, *supra* note 23, at 71-72 (statement of Tammy Watts). Trisomy-13 is a severe form of mental retardation that occurs when the fetus has three, instead of only two, copies of Chromosome 13. See Laura Muha, *Learning Terrible Truths; Heart-Wrenching Choices After Testing Fetuses for Gene Defects*, *Series: ON THE GENETIC FRONTIER*, NEWSDAY, Oct. 22, 1990, at 7. Common effects of Trisomy-13 are incomplete brain development, small head size, cleft palate, and deformities of the hands, feet, and heart. See *id.* Trisomy-13 occurs in one out of every 10,000 births in the United States; ninety percent of those born with Trisomy-13 die within the first year, and only about one percent live to be ten. See Peggy Fletcher, *Ethics of Intervention; Treat Babies With Genetic Defect? Yes, Parents Say*, SALT LAKE TRIB., Nov. 30, 1995, at C1. A common cause of death of children with Trisomy-13 is apnea, which occurs because the brain is often so poorly developed that it does not signal the lungs to breathe. See Jonathan Bor, *A Sentence of Death, A Life of Hope Support: Group Defies the Odds in Genetic Disorder*, BALT. SUN, June 28, 1992, at 1A.

undergone routine testing, including ultrasound and an alphafetoprotein test, earlier in her pregnancy, but the condition had remained undetected.<sup>86</sup> The decision she and her husband made to terminate the pregnancy was "elective" in the sense that she could have carried the child to term, knowing it would die shortly after birth.<sup>87</sup> Feeling, however, that "[w]e could never have survived that," the Watts made an immediate appointment with Dr. McMahon in Los Angeles.<sup>88</sup> They were particularly grateful that the procedure enabled them to "say goodbye" to the intact fetus that was handed to them in a blanket.<sup>89</sup> Also gratifying to the Watts, under the circumstances, was the fact that the procedure permitted the fetus to be used, with their permission, for research into trisomy-13 in an effort to discover its underlying cause.<sup>90</sup>

In a document of Dissenting Views appended to the House Report, women members of the House Judiciary Committee buttressed Ms. Watts' testimony with citations to the experiences of other women forced to terminate wanted pregnancies at late stages.<sup>91</sup> These poignant cases—in each of which the attending physician thought that D&X or intact D&E was more preservative of maternal health and future fertility than any alternative method—offered strong examples of reasons not to ban the D&X procedure.<sup>92</sup>

Recent evidence, however, suggests that it would be erroneous to consider these cases typical or to think that they constitute a majority of the pre-viability cases, as previously claimed. Instead, abortion rights leaders have acknowledged that a large percentage of pre-viability D&X

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86. See *House Hearing*, *supra* note 23, at 71 (statement of Tammy Watts).

87. See *id.* at 72 ("I had a choice. I could have carried this pregnancy to term, knowing that everything was wrong. I could have gone on for 2 more months doing everything that an expectant mother does, but knowing my baby was going to die, and would probably suffer a great deal before dying.").

88. *Id.*

89. *Id.*; see also *supra* note 64 and accompanying text.

90. See *House Hearing*, *supra* note 23, at 73 (statement of Tammy Watts) ("Because Dr. McMahon does the procedure the way he does, it made the testing possible."); see also H.R. REP. NO. 104-267, at 32 (1995) (letter from Dru Elaine Carlson, M.D., to Rep. Schroeder, discussing, *inter alia*, the fact that Dr. McMahon's technique made possible post-abortion examination and testing).

91. See H.R. REP. NO. 104-267, at 28-29 (additional dissenting views of Congresswomen Schroeder, Lofgren, and Jackson-Lee) (describing the situations of Viki Wilson and Vicky Smith, as well as Tammy Watts, and attributing the preservation of their health and fertility to the use of "this safe procedure").

92. See *Senate Hearing*, *supra* note 23, at 158 (statement of Coreen Costello). Costello, an anti-abortionist, described her experience with intact D&E after her seven-month fetus with severe abnormalities became life-endangering to her when she stated: "This was the safest way for me to deliver. This left open the possibility of more children, it greatly lowered the risk of my death, and most important to me, it offered a peaceful, painless passing for Katherine Grace." *Id.* at 159.

cases, like the overwhelming percentage of pre-viability abortions, generally, are elective procedures involving healthy women and fetuses.<sup>93</sup> To the extent that the D&X procedure is employed for post-viability abortions, the cases described undoubtedly would be typical, as the *Roe/Casey* framework permits a state to prohibit all post-viability abortions except those necessary to preserve the woman's life or health.<sup>94</sup> However, just as the number of D&X procedures performed is irrelevant to the issue of the legality of the technique, so are the reasons for the abortion, where the decision in favor of abortion—whether pre-viability or post-viability—is otherwise legal under established Supreme Court precedent.

### III. THE CURRENT LEGAL PICTURE

#### A. *The Controversy on the Federal Level*

So-called "partial-birth abortion" legislation first came to public attention in the late spring of 1995, when Representative Charles Canady introduced into the House of Representatives<sup>95</sup> the bill that became the "Partial-Birth Abortion Ban Act of 1995."<sup>96</sup> A great deal of public media attention<sup>97</sup> accompanied the bill as it made its way through commit-

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93. See Gianelli, *supra* note 21, at 3 (citing Ron Fitzsimmons, Executive Director of the National Coalition of Abortion Providers, as stating that abortion rights supporters in the past had failed to acknowledge that "the vast majority of these abortions are performed in the 20-plus week range on healthy fetuses and healthy mothers"). The same article goes on to note that other doctors who utilize the procedure have discredited earlier claims about both the numbers and the reasons involved. See *id.*

94. See *supra* notes 17-18 and accompanying text.

95. See *House Hearing*, *supra* note 23, at 4 (exhibiting letter dated June 18, 1995, from the office of Charles T. Canady, signed by him and Rep. Vucanovich, informing colleagues of their plan to introduce the bill the following week).

96. H.R. 1833, 104th Cong. (1995).

97. See, e.g., Ann Hardie, *Abortion Procedure is Rare But Divisive*, ATLANTA J. & CONST., Mar. 31, 1996, at A8 ("The U.S. House of Representatives voted 286 to 129 . . . to ban the rare late-term abortion procedure, but President Clinton's promised veto of the bill probably will stick. . . . Still, it marked the first time Congress has moved to ban a specific abortion method since the U.S. Supreme Court legalized abortion in 1973."); Carol Jouzaitis, *Senate to Hold Hearings on Abortion Bill: Both Sides View Delay as Potential Victory for Their Cause*, CHI. TRIB., Nov. 9, 1995, at 8 ("In an immediate victory for abortion rights forces, the Senate voted Wednesday to delay action on a bill outlawing certain late-term abortions until the Judiciary Committee holds public hearings."); Kevin Merida, *Antiabortion Measures Debated: House Republicans Push for New Restrictions in Several Areas*, WASH. POST, June 14, 1995, at A4 ("One highly emotional issue that will get an airing . . . before a House Judiciary subcommittee chaired by [Rep. Charles T.] Canady is his proposal to ban 'partial-birth' abortions."); *Panel OK's a Curb on Abortions: House Measure Targets a Late-Term Procedure*, BOSTON GLOBE, July 19, 1995, at 3 ("A bill to outlaw some late-term abortions gained the House Judiciary Committee's approval . . . . After nearly three hours of passionate and partisan debate, the panel sent the measure to the House floor on a party-line vote of 20-12."); John E. Yang, *House Sends Clinton Curb on Abortions; Late-Term Method Would Be Banned*, WASH.



tees of both houses of Congress.<sup>98</sup> In April 1996, the House passed the measure by a veto-proof margin of 286-129, but the Senate support of 54-44 fell short of the two-thirds majority necessary for a veto override.<sup>99</sup> President Clinton vetoed the measure on April 10, 1996, stating that it concerned a "potentially life-saving, certainly health-saving" procedure for "a small but extremely vulnerable group of women and families in this country, just a few hundred a year."<sup>100</sup> Reaction from both pro-choice and pro-life groups was swift and sharp: the former tended to see the issue as one more attempt by anti-abortion forces to chip away at a woman's basic right to choose,<sup>101</sup> while the latter considered this particular treatment of "unborn human beings"<sup>102</sup> to amount to homicide during what was essentially a birth process.<sup>103</sup>

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Post, Mar. 28, 1996, at A1 ("The House intensified the emotionally wrenching election-year debate over abortion . . . by giving final congressional approval to a bill that would outlaw a rarely used technique to end pregnancies in their late stages.").

98. Hearings were held before the Subcommittee on the Constitution of the House Judiciary Committee on June 15, 1995. See *House Hearing*, *supra* note 23. By a 20-12 vote, the Subcommittee issued a favorable Report on September 27. See H.R. REP. NO. 104-267, at 17 (1995). The Report contained a minority report of Dissenting Views, subscribed by the fourteen committee members who had voted against it: Representatives John Conyers, Jr.; Pat Schroeder; Barney Frank; Charles E. Schumer; Howard L. Berman; John Bryant; Jack Reed; Jerrold Nadler; Bobby Scott; Melvin L. Watt; Xavier Beccera; Jose E. Serrano; Zoe Lofgren; and Sheila Jackson-Lee. See *id.* at 27. An additional Dissenting Views statement was submitted by the three female Representatives in this group, Pat Schroeder, Zoe Lofgren, and Sheila Jackson-Lee, along with an Appendix consisting of a letter to the Hon. Patricia Schroeder from Dru Elaine Carlson, M.D., the Director of Reproductive Genetics and a perinatologist and geneticist at Cedars-Sinai Medical Center in Los Angeles. See *id.* at 28, 31. The Senate Committee on the Judiciary held extensive hearings on November 17, 1995. See *Senate Hearing*, *supra* note 23.

99. See Devroy, *supra* note 79.

100. *Id.*

101. See, e.g., Letter from Ann Thompson Cook, Executive Director, Religious Coalition for Reproductive Choice (an organization representing 38 national religious groups) to President Clinton (Apr. 10, 1996) (on file with the author) ("We salute you for taking a strong stand in solidarity with women and their families."); Letter from Ralph W. Hale, M.D., Executive Director, ACOG, to President Clinton (Apr. 9, 1996) ("[I]n defining what medical procedures doctors may or may not perform, HR 1833 employs terminology that is not even recognized in the medical community—demonstrating why Congressional opinion should never be substituted for professional medical judgment. Accordingly, ACOG supports your decision to veto this legislation."); National Abortion Federation, News Release: Families Who Needed Later Abortions to Join President Clinton for Veto of Anti-Choice Legislation (Apr. 10, 1996) ("President Clinton is putting a stop to one of the most anti-family bills ever passed in Congress.").

102. *House Hearing*, *supra* note 23, at 2 (In his opening statement, Subcommittee Chairman Charles Canady used this phrase and went on to note: "Partial-birth abortion procedures go a step beyond abortion on demand. The baby involved is not unborn. His or her life is taken during a breech delivery.").

103. See *id.* at 1 (opening statement of Chairman Canady) ("This hearing focuses on partial-birth abortion because while every abortion sadly takes a human life, this method takes that life as

The issue never died down during the Presidential election year of 1996,<sup>104</sup> particularly as further information surfaced concerning both greater usage of the D&X procedure than previously believed and a wider variety of contextual medical circumstances than earlier portrayed.<sup>105</sup> In the meantime, a number of states began to enact or at least consider bills banning the D&X procedure.<sup>106</sup>

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the baby emerges from the mother's womb while the baby is in the birth canal. The difference between the partial-birth abortion procedure and homicide is a mere 3 inches."); *Senate Hearing, supra* note 23, at 116 (statement of Helen M. Alvare, Esq., on behalf of the National Conference of Catholic Bishops Secretariat for Pro-Life Activities). Alvare testified:

No reasonable person can disagree, once he or she has read a description or seen an accurate drawing of the partial-birth abortion method: it is one-fifth abortion and four-fifths infanticide. It kills a child when 80 percent of his or her body is already outside the womb. And there should certainly be a moral and legal consensus in our country that infanticide is a crime. That it simply cannot be tolerated in a civilized society. That it is a particularly heinous kind of killing because the victims are small, weak and defenseless as the very youngest infants are.

*Id.* But see *Senate Hearing, supra* note 23, at 200 (comment of Louis Michael Seidman, Prof. of Law, Georgetown Univ. Law Center, Washington, D.C.) ("If people seriously thought it was infanticide, they wouldn't be talking about punishing it for 2 years. The reason why Congress is interested in punishing this—why some Members of Congress are interested in punishing it is not because it is infanticide. It is precisely because it is abortion.").

104. See Chris Black, *House Overrides Abortion Bill Veto: Late-Term Procedure Vote Called Election-Year Ploy*, BOSTON GLOBE, Sept. 20, 1996, at A1 ("The House yesterday voted to override President Clinton's veto of a bill that outlaws a controversial late-term abortion procedure even as opponents of the bill accused the GOP leadership of playing election-year abortion politics. . . . Dole says he supports the ban."); John F. Harris & Blaine Harden, *Clinton, Dole Spar Over Abortion Veto; Exchange Suggests Long Fight on Social Issues*, WASH. POST, May 24, 1996, at A1 ("With a flushed face, strained voice and pointed finger, President Clinton yesterday defended his 'moral position' in vetoing a ban on a controversial late-term abortion procedure and accused Republicans of using it and other emotionally charged social issues to polarize voters."); Melissa Healy, *Senate Upholds Veto of Late-Term Abortion Ban: Congress Override Attempt Falls Nine Votes Short. Opponents of 'Partial-Birth' Procedure Hope to Make it a Campaign Issue*, L.A. TIMES, Sept. 27, 1996, at A13 ("Republican political analyst Ed Goetz said Clinton's veto has made him potentially vulnerable with Americans and that the president's testy exchanges with reporters on the issue should embolden Dole to go on the attack."); Gerald F. Seib & Hilary Stout, *Dole Advocates Charity Tax Credit, Blasts Clinton for Veto of Abortion Bill*, WALL ST. J., May 24, 1996, at B13 ("In a speech to the Catholic Press Association in Philadelphia, Mr. Dole also stepped up the rhetorical battle with the White House over abortion, drawing an angry reaction from President Clinton. . . . Mr. Clinton, at a news conference in Milwaukee, accused the Republicans of using emotional social issues like abortion and welfare to divide the public and divert voters from more pressing matters in their campaign to reclaim the White House."); Hilary Stout, *Campaign '96: Abortion Remains a Thorny Issue for Clinton and GOP*, WALL ST. J., May 9, 1996, at A20 ("President Clinton hoped to glide through his re-election campaign trumpeting his view that abortion should be 'safe, legal and rare,' while Republicans beat each other up over the emotional issue. The GOP is following the script. But suddenly the president isn't safe from abortion bruises either.").

105. See *supra* notes 73-76 and accompanying text.

106. See *infra* notes 122-34 and accompanying text.

In March 1997, "The Partial-Birth Abortion Ban Act of 1997"<sup>107</sup> was introduced into the House of Representatives by Charles Canady;<sup>108</sup> it passed on March 20 by the veto-proof margin of 295-136.<sup>109</sup> Senator Rick Santorum became the primary sponsor in the Senate.<sup>110</sup> That body considered several proposals for amendment<sup>111</sup> and finally accepted one

107. H.R. 1122, 105th Cong. (1997).

108. See 143 CONG. REC. H1202 (daily ed. Mar. 20, 1997) (statement of Rep. Canady) ("I call up the bill (H.R. 1122) to amend title 18, United States Code, to ban partial-birth abortions, and ask for its immediate consideration in the House."); 143 CONG. REC. H766 (daily ed. Mar. 5, 1997) (Public Bills and Resolutions) (Mr. Canady, for himself and with many others introduced "[a] bill to amend title 18, United States Code, to ban partial-birth abortions; to the Committee on the Judiciary.").

109. See 143 CONG. REC. H1201-02 (daily ed. Mar. 20, 1997) (recorded House vote on H.R. 1122); see also Melissa Healy, *'Partial-Birth' Abortion Ban Again Passes House*, L.A. TIMES, Mar. 21, 1997, at A1 ("Abortion foes in the House on Thursday adopted a ban on a controversial late-term abortion procedure for the third time in a year, challenging President Clinton to again veto a bill that he vetoed last April."); Katharine Q. Seelye, *Senate Bans Form of Late Abortion; Bill Faces Veto*, N.Y. TIMES, May 21, 1997, at A1 (listing both House and Senate votes).

110. See 143 CONG. REC. S4431 (daily ed. May 14, 1997) (statement of Sen. Santorum) ("Mr. President, as I spoke last night, we are now moving to consideration of the partial-birth abortion ban that has passed the House of Representatives . . ."); 143 CONG. REC. S2739 (daily ed. Mar. 20, 1997) (statement of Sen. Santorum) ("Mr. President, I understand that H.R. 1122 has arrived from the House, and I would now ask for its first reading."); 143 CONG. REC. S1936 (daily ed. Mar. 5, 1997) (statement of Sen. Santorum) ("Mr. President, this morning I attended a press conference . . . to introduce the House bill, which is companion to the bill I introduced last month, on the issue of partial-birth abortions.").

111. See 143 CONG. REC. S4614 (daily ed. May 15, 1997). Senator Feinstein proposed Amendment Number 288, which would have been called the "Post-Viability Abortion Restriction Act" and which would have prohibited abortions of viable fetuses unless abortion was necessary to save the life of, or prevent "serious adverse health consequences to[, the woman." *Id.* Senator Daschle proposed Amendment Number 289, which would have been called the "Comprehensive Abortion Ban Act of 1997" and would have also prohibited abortions of viable fetuses unless continuing the pregnancy would "threaten the mother's life or risk grievous injury to her physical health." *Id.* at S4614-15. Daschle's amendment defined "grievous injury" as "a severely debilitating disease or impairment specifically caused by the pregnancy," or "an inability to provide necessary treatment for a life-threatening condition" and said it would not include "any condition that is not medically diagnosable or any condition for which termination of pregnancy is not medically indicated." *Id.* at S4615; see also Dewar, *Abortion Compromise Rejected*, *supra* note 25 ("The proposal from Minority Leader Thomas A. Daschle (D-S.D.) was defeated, 64 to 36, underscoring the difficulties of trying to devise a middle-ground position on the volatile abortion issue. . . . Clinton, Vice President Gore and Health and Human Services Secretary Donna E. Shalala made telephone calls on behalf of Daschle's proposal [the day before] . . . Before voting on the Daschle proposal, the Senate rejected, 72 to 28, a proposal sponsored by Sen. Dianne Feinstein (Calif.) and other Democratic female senators . . ."); Clarence Page, Editorial, *Abortion Foes Miss Opportunity*, ST. LOUIS POST-DISPATCH, June 1, 1997, at 3B ("So, while Santorum and his anti-abortion allies claimed they wanted to 'save' babies, they really wanted to embarrass Clinton. . . . So, for the first time since Roe, the Daschle bill actually would have strengthened the ability of states to ban abortions and expand the period during which the lives of fetuses are protected. And, unlike the Santorum bill, Clinton said he would sign it."); Katharine Q. Seelye, *Day of Flurry and Debate On Late-Term Abortions*, N.Y. TIMES, May 15,

offered by Senator Santorum which contained two major provisions: (1) a definition of the term, "vaginally delivers a living fetus before killing the fetus";<sup>112</sup> and (2) a provision for an accused defendant to seek a hearing before the relevant State Medical Board on the question of whether the defendant's conduct was "necessary to save the life of the mother whose life was endangered by a physical disorder, illness or injury."<sup>113</sup> The Board's findings on the issue would be admissible at the defendant's criminal trial, although not binding.<sup>114</sup>

According to Senator Santorum, the amendment was worked out by himself, Senator Frist, Representative Canady, and the AMA in order to tighten the definition of "partial-birth abortion" to ensure the necessary criminal *mens rea* and in order to provide a medical review panel as an intermediary between the physician whose conduct is called into question and the criminal process.<sup>115</sup> This would serve the dual purpose of providing both peer review of the physician's conduct and medical expertise for the benefit of the trial court.<sup>116</sup> On May 20, after a "listless debate,"<sup>117</sup> the Senate passed the amended bill by a vote of 64-36—three votes short of the number needed to override a Presidential veto, which Clinton promised on account of the bill's failure to include an exception to preserve the health, as well as the life, of the pregnant woman.<sup>118</sup> On October 8, the House approved the amended bill overwhelmingly, 296-132, and Clinton signed his veto the following day in the oval office.<sup>119</sup> Charles Canady predicted that Congress would not vote again until 1998,

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1997, at B14 ("The White House did nothing today to clarify the Administration's view. Michael D. McCurry, the White House spokesman, said on Tuesday that President Clinton might support the Daschle bill. Today he said the President could support either the Daschle bill or the Feinstein-Boxer bill.").

112. H.R. 1122, 105th Cong. § 2 (1997); *see also supra* note 36 and accompanying text.

113. H.R. 1122, 105th Cong.

114. *See id.* The relevant portion of the amendment provides:

(d)(1) A defendant accused of an offense under this section may seek a hearing before the State Medical Board on whether the physician's conduct was necessary to save the life of the mother whose life was endangered by a physical disorder, illness, or injury.

(2) The findings on that issue are admissible on that issue at the trial of the defendant. Upon a motion of the defendant, the court shall delay the beginning of the trial for not more than 30 days to permit such a hearing to take place.

*Id.*

115. *See* 143 CONG. REC. S4694 (daily ed. May 20, 1997) (statement of Sen. Santorum).

116. *See id.* at S4696 (statement of Sen. Santorum).

117. Seelye, *supra* note 109.

118. *See id.*

119. *See Clinton Vetoes Ban on Some Abortions*, WASH. POST, Oct. 11, 1997, at A11 [hereinafter *Clinton Vetoes*]; John E. Yang, *House Again Votes to Ban Abortion Procedure*, WASH. POST, Oct. 9, 1997, at A8.

to give Senate leaders time to try to amass sufficient support for an override.<sup>120</sup>

### B. Actions in the States

National attention to this issue also has been reflected in actions taken by state legislatures during the past two years. Already, the states are beginning to keep the courts busy. Ohio, where Dr. Martin Haskell, the developer of D&X, maintains two abortion clinics,<sup>121</sup> was the first state to enact a ban: the law passed Ohio's General Assembly on August 15, 1995,<sup>122</sup> eight months before President Clinton's veto of the first federal bill.<sup>123</sup> Ohio's law was to become effective on November 15, 1995,<sup>124</sup> but enforcement was stayed by a federal district judge on the basis of a substantial likelihood that the proposed statute was unconstitutional.<sup>125</sup> His grant of an injunction was recently affirmed by a divided panel of the United States Court of Appeals for the Sixth Circuit, the first federal appellate court to hear the issue.<sup>126</sup> Utah<sup>127</sup> and Michigan<sup>128</sup> passed similar prohibitions in the spring of 1996, but a federal district court issued a permanent injunction against enforcement of Michigan's law on July 31, 1997.<sup>129</sup>

In 1997, sixteen other states enacted laws prohibiting what they call "partial-birth abortion."<sup>130</sup> Nine of these (besides the laws in Ohio and Michigan) have been stayed by federal courts issuing temporary or per-

120. See Yang, *supra* note 119.

121. See *supra* notes 47-51 and accompanying text.

122. See OHIO REV. CODE ANN. § 2919.15 (Banks-Baldwin 1997).

123. See *supra* note 100 and accompanying text.

124. See OHIO REV. CODE ANN. § 2919.15.

125. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1071 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

126. See *Voinovich*, 130 F.3d at 211.

127. See UTAH CODE ANN. §§ 76-7-310.5, 76-7-314, 76-7-315 (1995 & Supp. 1996).

128. See MICH. COMP. LAWS ANN. §§ 333.17016, 333.17516 (West Supp. 1997).

129. See *Evans v. Kelley*, 977 F. Supp. 1283, 1320 (E.D. Mich. 1997). Michigan, of course, is also in the Sixth Circuit. However, it would be dangerous to extrapolate from the federal appellate court's divided *Voinovich* decision to its possible evaluation of the Michigan law. That act tracks the federal wording, see *supra* note 39 and accompanying text (identifying ten states whose statutes use the federal definition), and in a footnote, the Sixth Circuit majority observed: "We note that the proposed federal legislation prohibiting the performance of 'partial-birth' abortions appears to come closer to describing the D & X procedure [quoted definition of H.R. 1122 omitted]. . . . We express no opinion on the constitutionality of this definition or the federal legislation." *Voinovich*, 130 F.3d at 199 n.9.

130. See *supra* notes 39-41 and accompanying text.

manent restraining orders; two state courts have taken similar action; and at least one other action is pending.<sup>131</sup> Nine states had bills pending in 1997.<sup>132</sup> Fourteen other states have considered similar legislation but have either rejected the proposal outright or allowed the matter to become dormant.<sup>133</sup> That leaves only eight states which appear never to have addressed the issue.<sup>134</sup> Clearly, the question of the constitutionality of these statutes—whether federal or state—is a matter requiring immediate attention. Even more important, perhaps, is the issue of whether, even if these laws can pass constitutional muster, they represent sound social policy.

#### IV. THE CONSTITUTIONAL QUESTION

The House and Senate hearings on the original "Partial-Birth Abortion Ban Act of 1995"<sup>135</sup> included conflicting statements of opinion from

131. See *supra* note 38 and accompanying text. David Garrow noted recently that "[i]n [only] six states [with enacted legislation]—Indiana, Mississippi, South Carolina, South Dakota, Tennessee and Utah—no doctors or clinics have yet contested the laws." Garrow, *Abortion Foes are Losing*, *supra* note 38.

132. See H.B. 5566, 1997-98 Leg., Reg. Sess. (Conn. 1997); H.B. 211, 139th Gen. Ass., Reg. Sess. (Del. 1997); H.B. 1227, 1997-98 Leg., Reg. Sess. (Fla. 1997); H.B. 2889, 181st Gen. Ct., Reg. Sess. (Mass. 1997); S.B. 875, 181st Gen. Ct., Reg. Sess. (Mass. 1997); S.B. 275, 89th Gen. Ass., 1st Reg. Sess. (Mo. 1997); H.B. 303, 1997-98 Leg., Reg. Sess. (N.C. 1997); S.B. 1132, 69th Leg., Reg. Sess. (Or. 1997); H.B. 470, 1997-98 Leg., 64th Biennial Sess. (Vt. 1997); A.B. 220, 93rd Leg., Reg. Sess. (Wis. 1997). [Legislative information current as of early autumn 1997.]

133. See S.B. 102, 1997-98 Leg., Reg. Sess. (Cal. 1997) (in Senate Committee on Health and Human Services; reconsideration granted); H.B. 1136, 61st Gen. Ass., 1st Reg. Sess. (Colo. 1997) (regular session adjourned; no carryover); H.B. 1460, 19th Leg., Reg. Sess. (Haw. 1997) (regular session adjourned; carryover to 1998 regular session); H.B. 2509, 77th Leg., Reg. Sess. (Kan. 1997) (regular session over; no carryover); S.B. 234, 77th Leg., Reg. Sess. (Kan. 1997) (regular session adjourned; carryover to 1998 regular session); H.P. 390, 118th Leg., 1st Reg. Sess. (Me. 1997) (Senate adopted Committee report; ought not to pass); H.B. 426, 1997-98 Leg., Reg. Sess. (Md. 1997) (regular session adjourned; no carryover); S.B. 493, 1997-98 Leg., Reg. Sess. (Md. 1997) (regular session adjourned; no carryover); S.F. 1502, 80th Leg., Reg. Sess. (Minn. 1997) (going to Senate Committee on Health and Family Security); H.B. 768, 1997-98 Leg., Reg. Sess. (N.H. 1997) (failed to pass House); H.J.M. 78, 43rd Leg., 1st Reg. Sess. (N.M. 1997) (regular session adjourned; no carryover); A.B. 5463, 220th Leg., Ann. Leg. Sess. (N.Y. 1997) (going to Assembly Committee on Health); H.B. 2201, 46th Leg. Sess., 1st Sess. (Okla. 1997) (regular session adjourned; carryover to 1998 regular session); H.B. 2898, 1997-98 Leg., Reg. Sess. (Va. 1997) (regular session adjourned; no carryover); S.B. 1149, 1997-98 Leg., Reg. Sess. (Va. 1997) (regular session adjourned; no carryover); H.B. 1031, 55th Leg., 1st Reg. Sess. (Wash. 1997) (regular session adjourned; carryover to 1998 regular session); H.B. 2773, 73rd Leg., Reg. Sess. (W. Va. 1997) (regular session adjourned; House carryover on author's request); S.B. 326, 73rd Leg., Reg. Sess. (W. Va. 1997) (regular session adjourned; no Senate carryover). [Legislative information current as of early autumn 1997.]

134. Idaho (legislative session over for 1997); Iowa; Kentucky (no 1997 session); Nevada; North Dakota; Pennsylvania; Texas; and Wyoming (legislative session over). [Legislative information current as of early autumn 1997.]

135. H.R. 1833, 104th Cong. (1995).

academicians respecting the constitutionality of the proposed law.<sup>136</sup> The House Report concluded that H.R. 1833 was constitutional under *Casey*,<sup>137</sup> although the appended Dissenting Views disagreed.<sup>138</sup> Even when he changed his vote at the last minute to support the 1997 measure, Senator Tom Daschle stated his opinion that the bill would probably be declared unconstitutional if enacted.<sup>139</sup> Notably, as mentioned, in *Women's Medical Professional Corp. v. Voinovich*, the United States Court of Appeals for the Sixth Circuit has upheld the district court's finding that Ohio's ban was unconstitutional.<sup>140</sup> Similarly, in *Evans v. Kelley*, a federal district judge in Michigan issued a permanent injunction against that state's law, on the grounds that it was unconstitutionally vague and overly broad, and imposed an undue burden on a woman's right to choose to terminate her pregnancy; since that time, seven other federal courts and two state courts have followed suit.<sup>141</sup>

Thus, the issue of constitutionality promises to present serious questions with respect to any enacted or pending prohibition of D&X, whether on the federal or state level. The primary objections can be broadly grouped into two categories: those posing questions of vagueness, and those alleging that these measures fail to meet the standards of *Casey* for either pre-viability or post-viability abortions.<sup>142</sup>

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136. See *House Hearing*, *supra* note 23, at 98 (prepared statement of David M. Smolin, Prof. of Law, Cumberland Law School, Samford Univ.) (stating view that the prohibition "is constitutional under current Supreme Court precedent"); *Senate Hearing*, *supra* note 23, at 169 (testimony and statement of Douglas W. Kmiec, Prof. of Law, Univ. of Notre Dame) (stating, "in my judgment, there are no constitutional concerns"). But see *id.* at 188 (testimony and prepared statement of Louis Michael Seidman, Prof. of Law, Georgetown Univ. Law Center) (arguing that the bill was "riddled with unconstitutional provisions").

137. See H.R. REP. NO. 104-267, at 11 (1995).

138. See *id.* at 23-24.

139. See Seelye, *supra* note 109.

140. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1071 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

141. See *Evans v. Kelley*, 977 F. Supp. 1283, 1319-20 (E.D. Mich. 1997); see also *supra* note 129 (noting that Michigan is also located in the federal Sixth Circuit); *supra* note 38 (listing court actions).

142. With respect to the federal bill, specifically, the question has also been raised as to whether the subject matter appropriately falls under Congress' commerce power, as the bill itself recites. See *Senate Hearing*, *supra* note 23, at 193 (prepared statement of Prof. Louis Michael Seidman). Because this article focuses generally on the substance of legislative bans against D&X or intact D&E (state or federal) as they relate to legal precedent concerning a woman's right to decide to have an abortion, the commerce clause debate is beyond the scope of this article. Nonetheless, it is worthwhile at this juncture to note the following aspects of the debate. In his prepared statement to the Senate Committee on the Judiciary, Prof. Louis Michael Seidman, of the Georgetown Law Center, cited *United States v. Lopez*, 514 U.S. 549 (1995), to conclude that "if *Lopez* is taken liter-

### A. Vagueness

The major arguments that these laws should be held void on the grounds of vagueness stem from their definitions of the procedure which they purport to prohibit. In this respect, H.R. 1122, the "Partial-Birth Abortion Ban Act of 1997," uses the same language as its 1995 predecessor:

(b)(1) As used in this section, the term 'partial birth abortion' means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.<sup>143</sup>

As previously noted, seventeen of the nineteen states which have enacted these laws use identical or nearly identical language.<sup>144</sup> Because the only extensive congressional hearings on the matter pertained to the 1995 bill, it is this language which is the subject of the vagueness arguments. To help allay the vagueness problem, the Senate added amendments to the 1997 bill both to tighten up the definition and to inject a scienter requirement, which they regarded as necessary for a criminal statute of this kind.<sup>145</sup> The Senate's amendment adds the following clarification to the

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ally, this measure seems to run afoul of the new standards the Court has announced." *Senate Hearing, supra* note 23, at 193 (prepared statement of Prof. Louis Michael Seidman). Professor Seidman declared that "[h]aving an abortion is no more a commercial activity than possessing a gun. . . . Just as Congress can regulate the interstate purchase of guns, but not the intrastate possession, so, it would seem, it can regulate the interstate purchase of abortions, but not the intrastate procedure itself." *Id.* Prof. Seidman's position was earlier contradicted by Prof. David M. Smolin, Cumberland Law School, Samford Univ., in his prepared statement to the Subcommittee on the Constitution of the House Committee on the Judiciary. Prof. Smolin maintained that "Congress possesses ample authority under the Commerce Clause of the Constitution, U.S. Const., Art. I, § 8, cl. 3, to enact the proposed prohibition." *House Hearing, supra* note 23, at 101 (prepared statement of David M. Smolin). In his view:

*Lopez* does not present any reason to question the Attorney General's conclusion that "[t]he provision of abortion services is commerce" . . . at least where payment is received, from some source, for the services. Abortion services would generally be classed within the broader category of medical and health care services, for purposes of commerce clause analysis. Health care constitutes, as the Congress well knows, a large and significant portion of the national economy, and it would seem absurd to hold that an industry comprising one-seventh of the national economy could not be regulated under the commerce clause.

*Id.* at 102. Professor Smolin also noted that "the statute contains the individualized jurisdiction requirement lacking in *Lopez*." *Id.* On the commerce clause question, this author is more convinced by the views of Prof. Smolin than those of Prof. Seidman.

143. H.R. 1122, 105th Cong. § 2(b)(1) (1997); cf. H.R. 1833, 104th Cong. § 2(b)(1) (1995).

144. See *supra* notes 39-41 and accompanying text.

145. See 143 CONG. REC. S4671 (daily ed. May 19, 1997) (statement of Sen. Santorum): But the AMA was concerned that, because the definition was not specific enough from their reading, some zealous prosecutor could come out and accuse the doctor, who has not performed an abortion—does not intend to perform an abortion—but performed a normal deliv-



above language (which is retained):

(3) As used in this section, the term "vaginally delivers a living fetus before killing the fetus" means deliberately and intentionally delivers into the vagina a living fetus, or a substantial portion thereof, for the purpose of performing a procedure the physician knows will kill the fetus, and kills the fetus.<sup>146</sup>

Among the states who have enacted prohibitions against D&X, only Nebraska and New Jersey have so far incorporated a similar scienter requirement,<sup>147</sup> so that general comments about Congress' 1995 bill remain pertinent to virtually all state legislation. On the federal level, the question then becomes whether the Senate's linguistic change is sufficient to overcome general objections based on a vagueness argument.

The Ohio law, which was originally stayed by a federal district judge partly on the ground of vagueness,<sup>148</sup> prohibited abortion by means of a "dilation and extraction procedure," defined as follows:

"[D]ilation and extraction procedure" means the termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain. "Dilation and extraction procedure" does not include either the suction cu-

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ery and, because of a complication, that somehow he or she could be covered under this act.

We have tightened up the language with mens rea, to use the legal term. That directs the mental state—as to what the doctor was doing when he was delivering the baby for the purpose of a live birth and is not doing an abortion.

....

Second, as was discussed in the AMA letter, the State medical boards, we understand that if the doctor is going to be charged in doing one of those procedures, there is going to be medical evidence presented. The doctor and his team are going to present their medical experts, and the prosecutor will present their medical experts.

....

It is admissible in court but not determinative.

*Id.*

146. H.R. 1122, 105th Cong. § 2(b)(3) (1997).

147. See *supra* note 40 and accompanying text. Interestingly, the Nebraska judge who enjoined application of that state's ban to one physician's practice observed that "[w]e do not reach the merits of Carhart's second argument that the statute is unconstitutionally vague. We note, however, that a similar vagueness argument was recently adopted in a persuasive opinion." *Carhart v. Stenberg*, 972 F. Supp. 507, 509 (D. Neb. 1997) (citing *Evans v. Kelley*, 977 F. Supp. 1283 (E.D. Mich. 1997)).

148. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1063-67 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934). Without using the label of "vagueness" *per se*, two judges on the Sixth Circuit agreed with the trial judge's evaluation that the Ohio definition "includes both the D & E and D & X procedures," *Voinovich*, 130 F.3d at 200, and concluded, "the Act bans the most commonly used second trimester procedure and therefore is an unconstitutional burden on a woman's right to choose to have an abortion." *Id.* at 201.

retage procedure of abortion or the suction aspiration procedure of abortion.<sup>149</sup>

Although this definition sounds more precise than does the language of other state laws or the federal bill, the trial judge in *Voinovich* concluded that "it does not provide physicians with fair warning as to what conduct is permitted, and as to what conduct will expose them to criminal and civil liability."<sup>150</sup> Noting that even a defendant's expert witness who participated in both trials found the language in the Michigan law (a close mirror to the federal definition without the scienter requirement)<sup>151</sup> "much more broad and vague" than Ohio's provision, the judge in *Evans v. Kelley* concluded that "the Michigan statute is hopelessly ambiguous and not susceptible to a reasonable understanding of its meaning."<sup>152</sup>

The trial judges' determinations in *Voinovich*, *Kelley*, and *Planned Parenthood of Southern Arizona, Inc. v. Woods*<sup>153</sup> echo the Supreme Court's discussion of a successful vagueness challenge in another abortion case, *Colautti v. Franklin*.<sup>154</sup>

It is settled that, as a matter of due process, a criminal statute that "fails to give a person of ordinary intelligence fair notice that his contemplated conduct is forbidden by the statute," or is so indefinite that "it encourages arbitrary and erratic arrests and convictions," is void for vagueness. This appears to be especially true where the uncertainty induced by the statute threatens to inhibit the exercise of constitutionally protected rights.<sup>155</sup>

Because the statute in *Colautti* failed to accord to the physician broad discretion in making the determination of viability, the Court found that the statute "conditions potential criminal liability on confusing and ambiguous criteria. It therefore presents serious problems of notice, discrim-

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149. OHIO REV. CODE ANN. § 2919.15(A) (Banks-Baldwin 1997).

150. *Voinovich*, 911 F. Supp. at 1067; see also *Voinovich*, 130 F.3d at 200 (concluding that the law encompassed the D&E procedure, as well as D&X).

151. See MICH. COMP. LAWS ANN. §§ 333.17016, 333.17516 (West Supp. 1997).

152. *Evans*, 977 F. Supp. at 1320. For a contrary comparative view of the definitions contained in the Ohio and Michigan laws, see *Voinovich*, 130 F.3d at 199 n.9 (majority opinion of Judge Kennedy, noting that the federal definition [which the Michigan law tracked] "appears to come closer to defining the D & X procedure" than Ohio's law); see also *id.* at 214 (dissenting opinion of Judge Boggs, expressing view that, contrary to majority's declaration, Ohio's definition was not unconstitutionally vague). But see *Planned Parenthood of S. Ariz., Inc. v. Woods*, No. CIV. 97-385-TUC-RMB, 1997 WL 679921, at \*11 (D. Ariz. Oct. 27, 1997) (holding invalid a state law almost identical to Michigan's and stating that "the Court concludes that the language of the Act is unconstitutionally vague and must be found to be void for vagueness").

153. 982 F. Supp. 1369 (D. Ariz. 1997).

154. 439 U.S. 379 (1979).

155. *Id.* at 390-91 (citations omitted); see also *Evans*, 977 F. Supp. at 1305 (quoting *Colautti*); *Woods*, 982 F. Supp. at 1378-79 (quoting *Colautti*, *Voinovich*, and other cases).

inatory application, and chilling effect on the exercise of constitutional rights."<sup>156</sup>

Is this kind of ambiguity present in the prohibitions under consideration here, especially given that the requisite clarity may be measured by the understanding of the particular persons whose conduct is affected<sup>157</sup>—in this case, physicians? The answers from the medical community itself are divided on the issue, although those divisions often seem traceable to the speakers' respective ideological positions on the issue of abortion itself (particularly late term abortion) or on the issue of governmental regulation of the practice of medicine.

Dr. Pamela Smith, the Director of Medical Education in Obstetrics and Gynecology at Mt. Sinai Hospital in Chicago and also, at the time, President-Elect of the American Association of Pro-Life Obstetricians and Gynecologists, conceded in her testimony before the House Subcommittee on the Constitution<sup>158</sup> that "[t]here is no uniformly accepted medical terminology for the method that is the subject of this legislation."<sup>159</sup> However she went on to note that, "[t]he term you have chosen, partial-birth abortion, is straightforward. Your definition is straightforward, and in my opinion, covers this procedure and no other."<sup>160</sup>

On the other hand, Dr. Mary Campbell, a board-certified obstetrician/gynecologist and Medical Director of Planned Parenthood of Metropolitan Washington, told the Senate Committee on the Judiciary that her opposition to the bill was based in large part on its vagueness.<sup>161</sup> Dr. Campbell stated that "[t]his bill is intolerably vague. It attempts to pro-

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156. *Colautti*, 439 U.S. at 394.

157. See, e.g., *Village of Hoffman Estates v. The Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 501 (1982) (measuring the challenged language by the understanding of "[a] business person of ordinary intelligence").

158. See *House Hearing*, *supra* note 23, at 38-44 (testimony and prepared statement of Pamela Smith, M.D.).

159. *Id.* at 42 (testimony of Pamela Smith, M.D.); see also *id.* at 44 (prepared statement of Pamela Smith, M.D.).

160. *Id.* at 42 (testimony of Pamela Smith, M.D.); see also *id.* at 44 (prepared statement of Pamela Smith, M.D.). In her appearances both before the House Subcommittee and the Senate Committee on the Judiciary, Dr. Smith also remarked on the similarities between the abortion procedure at issue and standard obstetrical practice for a breech delivery and demonstrated her point with "a model of a 19- to 20-week-old infant." *Id.* at 39-40 (testimony of Pamela Smith, M.D.); see also *Senate Hearing*, *supra* note 23, at 76-78 (testimony of Pamela Smith, M.D.); *id.* at 80 (prepared statement of Pamela Smith, M.D.). Note that a fetus of 19 to 20 weeks is still nonviable. See *id.* at 99 (statement of Dr. Mary Campbell noting that viability is "about 25 weeks"); see also *HERN*, *supra* note 46, at 255-57 (citing cases and stating that the Supreme Court has repeatedly held that viability cannot be fixed at a specific time period in a statute).

161. See *Senate Hearing*, *supra* note 23, at 103 (statement of Dr. Mary Campbell).

hibit a medical procedure without adequately describing the procedure in terms that doctors understand. . . . The bill's vagueness will have a chilling effect on the availability of abortion services. Physicians are unwilling to do things that might be illegal."<sup>162</sup> Even more forcefully, Dr. J. Courtland Robinson, Associate Professor in the Department of Gynecology and Obstetrics at Johns Hopkins University School of Medicine, with a joint appointment to the Johns Hopkins School of Hygiene and Public Health, who appeared before both the House and Senate Committees,<sup>163</sup> stated:

This legislation appears to be about something you are referring to as partial-birth abortion. I now am beginning to learn a little about what you think it means, but I did not know it until a few days ago. Never in my career have I heard a physician who provides abortions refer to any technique as a partial-birth abortion. That, I suspect, is because the name did not exist until someone who wanted to ban abortions made it up. Medically, we do not do partial-birth abortion. There is no such thing.<sup>164</sup>

Dr. Robinson went on to testify:

For many physicians, this law would amount to a ban on D&E entirely, because they would not undertake a surgery if they were legally prohibited from completing it in the best way they saw fit at the time the procedure was being done. Because the law itself is so vague and bizarre, leaving them to wonder whether they are open to prosecution or not.

This means that by banning this very rare technique, you end up banning D&E, essentially recognized as the safest method of performing secondary trimester abortions. That means that women will probably die. I know. I have seen it happen.<sup>165</sup>

Dr. Robinson also pointed out in his testimony that during any surgical procedure, the physician may begin anticipating things to go one way,

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162. *Id.*; see also *infra* note 378 and accompanying text (noting Dr. Campbell's third reason for opposition—that the bill would outlaw “the safest way of ending a third trimester pregnancy”).

163. See *House Hearing*, *supra* note 23, at 63-67 (statement and prepared statement of J. Courtland Robinson, M.D.); see also *Senate Hearing*, *supra* note 23, at 103-06 (same). In his testimony before the House Subcommittee, Dr. Robinson identified himself as “here on behalf of the National Abortion Federation, the national professional association of abortion providers.” *House Hearing*, *supra* note 23, at 63 (statement of J. Courtland Robinson, M.D.); see also *id.* at 65 (prepared statement of J. Courtland Robinson, M.D.).

164. *House Hearing*, *supra* note 23, at 64 (prepared statement of J. Courtland Robinson, M.D.); see also *Senate Hearing*, *supra* note 23, at 104 (statement of J. Courtland Robinson, M.D.).

165. *House Hearing*, *supra* note 23, at 65; see also *Senate Hearing*, *supra* note 23, at 104-05. Dr. Robinson's testimony is buttressed by the finding of the United States Court of Appeals for the Sixth Circuit in *Voinovich* that the language of the Ohio statute necessarily included D&E within its purview. See *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 200 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

but unexpected events may create a "unique demand" requiring a different course of action.<sup>166</sup> At that point, "[t]elling a physician that it's illegal for him or her to adapt a certain surgical method for the safety of the patient is absolutely criminal and flies in the face of the standards for the quality of medical care."<sup>167</sup> The federal scienter requirement added by the Senate amendment might help to dispel this particular concern; however, almost all currently existing state legislation leaves the issue wide open.<sup>168</sup>

Perhaps the most objective medical viewpoint came from a statement submitted for the record to the Senate Committee by Warren M. Hern, M.D., Director of the Boulder, Colorado, Abortion Clinic and a Clinical Professor in the Obstetrics and Gynecology Department at the University of Colorado Health Sciences Center in Denver.<sup>169</sup> Dr. Hern is the author of *Abortion Practice*, the principal medical textbook on abortion procedures, and a well-known authority on the subject.<sup>170</sup> He specializes in difficult, late term abortions.<sup>171</sup> While Dr. Hern does not himself

166. *House Hearing*, *supra* note 23, at 65.

167. *Id.*; *see also Senate Hearing*, *supra* note 23, at 104 (testimony of J. Courtland Robinson, M.D.); *id.* at 106 (statement of J. Courtland Robinson, M.D.).

168. *See supra* notes 39-41 and accompanying text. Judge Rosen, in *Evans v. Kelley*, was particularly concerned that the vague wording of the Michigan law necessarily amounted to a ban on the D&E technique, one of the most frequently used abortion procedures in Michigan and the only feasible one between 13 and 16 weeks of pregnancy. *See Evans v. Kelley*, 977 F. Supp. 1283, 1317 (E.D. Mich. 1997). In his view, this fact was decisive on the undue burden question. *See id.* The affiliate court in *Voinovich* reached the same conclusion with respect to Ohio's law. *See Voinovich*, 130 F.3d at 200.

169. *See Senate Hearing*, *supra* note 23, at 242-55 (statement of Warren M. Hern, M.D.).

170. *See id.* at 244; *see also HERN*, *supra* note 46, at back cover (Lawrence A. Reich, who wrote in *The New England Journal of Medicine*, stated of Hern's text that "it is the first comprehensive work offering a clear and concise treatise on one of the most frequently performed procedures in the United States today. . . . [T]his book will serve as the yardstick by which all other information on abortion must be measured."). Reich also noted that the National Abortion Federation and Planned Parenthood Federation of America called the book "the authoritative medical treatise on abortion practice" in their *amici curiae* briefs in *Reproductive Health Services v. Webster*, 662 F. Supp. 407 (W.D. Mo. 1987), *aff'd in part, rev'd in part*, 851 F.2d 1071 (8th Cir. 1988), *rev'd*, 492 U.S. 490 (1989), and *Ragsdale v. Turnock*, 734 F. Supp. 1457 (N.D. Ill. 1990), *aff'd*, 941 F.2d 501 (7th Cir. 1991). *Id.*; *see also Bonavoglia*, *supra* note 33, at 59 (describing Hern as "the author of a major textbook on abortion, who does late abortions using a combination of techniques"); Diane M. Gianelli, *Outlawing Abortion Method: Veto-Proof Majority in House Votes to Prohibit Late-Term Procedure*, AM. MED. NEWS, Nov. 20, 1995, at 3 (describing Hern as "the author of *Abortion Practice*, the nation's most widely used textbook on abortion standards and procedures, [who] specializes in late-term procedures").

171. *See, e.g., Senate Hearing*, *supra* note 23, at 242-55 (statement of Warren M. Hern, M.D.) (stating that fewer than 500 abortions per year are performed after 26 weeks). Dr. Hern noted that "[t]he majority of these are now performed by me or one of my medical colleagues." *Id.* at 249. Dr. Hern's statement goes on to describe three cases of particular danger to maternal health which he

perform the dilation and extraction or the intact dilation and evacuation procedure,<sup>172</sup> he stoutly maintains that "there is no such thing as 'partial birth abortion,'"<sup>173</sup> and goes on to note that, although the contemplated "specific operation . . . is quite rare as a routine matter," nevertheless, "[i]t is my understanding that the maneuvers described by the sponsors of [the bill] are followed by attending physicians throughout the nation when the safety of the woman having the abortion is at issue."<sup>174</sup>

The two legal academicians who appeared before the Senate Committee, specifically to address issues of constitutionality, also offered conflicting views on the vagueness issue.<sup>175</sup> Douglas W. Kmiec, Professor of Law at the University of Notre Dame, dismissed the vagueness question as a non-issue:

[E]ven though there has been some concern raised here this morning about vagueness, under the constitutional due process standards and under the medical testimony that has been given, I think there is little question but that there is fair warning to doctors and others who would perform this procedure as to exactly what conduct is being prohibited.<sup>176</sup>

In his prepared statement, Professor Kmiec dealt more specifically with the definitions of vagueness found in *Colautti* and other cases cited herein<sup>177</sup> to elaborate upon his view that, despite the fact that the language of the bill did not use medical terminology, nonetheless it provided the specific class of persons affected by the legislation with "fair warning" of the prohibited behavior.<sup>178</sup>

Professor Louis Michael Seidman, Professor of Law at the Georgetown Law Center, on the other hand, expressed his view that "this bill makes doctors guess, at the pain of criminal punishment, whether the

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handled successfully. See *id.* at 249-52; see also Painter, *supra* note 24 (citing Dr. Warren Hern as one who "routinely performs late abortions").

172. See *Senate Hearing*, *supra* note 23, at 245-48 (statement of Warren M. Hern, M.D.); see also Painter, *supra* note 24.

173. *Senate Hearing*, *supra* note 23, at 245 (statement of Warren M. Hern, M.D.).

174. *Id.* at 245, 247.

175. Compare *id.* at 169-87 (statement of Douglas W. Kmiec, Prof. of Law, Univ. of Notre Dame) (supporting the bill), with *id.* at 188-208 (statement of Louis Michael Seidman, Prof. of Law, Georgetown Univ. Law Center) (opposing the bill). The only legal academician to appear before the House Subcommittee did not discuss the issue of vagueness. See *House Hearing*, *supra* note 23, at 97-102 (prepared statement of David M. Smolin, Prof. of Law, Cumberland Law School, Samford Univ.) (supporting the bill).

176. *Senate Hearing*, *supra* note 23, at 171 (statement of Prof. Douglas W. Kmiec).

177. See *supra* notes 154-57 and *infra* notes 192-94 and accompanying text.

178. *Senate Hearing*, *supra* note 23, at 184-85 (prepared statement of Prof. Douglas W. Kmiec).

procedure that they are engaged in is covered or not."<sup>179</sup> In his prepared statement, Professor Seidman made a particular point of the potential chilling effect upon the exercise by women of their constitutional rights, cited in *Colautti*<sup>180</sup> as a cause for invalidation of an abortion regulation pertaining to the behavior of the women's physicians.<sup>181</sup> He also singled out for criticism on vagueness grounds other wording of the bill that no one else had mentioned:

[T]he exception that allows abortions to "save the life of the mother" is itself unconstitutionally vague. The bill fails to recognize that risk to life is inherently probabilistic. Suppose, for example, that if the abortion is not performed, there is a 10 percent chance that the woman will die. Physicians are forced to guess on the pain of criminal penalty whether this risk is large enough to come within the statutory exception.<sup>182</sup>

It is true that the 1995 bill referred to by these constitutional scholars differed from the 1997 version in that the former criminalized any so-called "partial-birth abortion" in absolute terms, and then permitted an affirmative defense. Under the 1995 bill, the physician could escape criminal or civil liability only by proving by a preponderance of the evidence that he or she had reasonably believed that the procedure was "necessary to save the life of the mother" and that "no other [form of abortion] would suffice for that purpose."<sup>183</sup> The harsh (and constitutionally questionable) specific effects of both the burden-shifting provision and the "reasonable belief" language have been ameliorated at least to some extent<sup>184</sup> by their omission in the current federal proposal, as well as by the Senate's addition of a scienter requirement. However, some state laws retain these affirmative defense or "reasonable belief" provisions,<sup>185</sup> and, in any event, the questions revolving around the basic non-

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179. *Id.* at 189 (statement of Prof. Louis Michael Seidman).

180. *Colautti v. Franklin*, 439 U.S. 379, 399-95 (1979); see also *supra* notes 154-56 and accompanying text.

181. See *Senate Hearing*, *supra* note 23, at 192 (prepared statement of Prof. Louis Michael Seidman).

182. *Id.*

183. H.R. 1833, 104th Cong. § 2(e)(1), (2) (1995).

184. It is worth noting that the 1997 bill does not refer to the physician's "best medical judgment." Instead, it provides that the penalty "shall not apply to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury." H.R. 1122, 105th Cong. § 2(a) (1997). Even if the prosecutor (or the civil litigant) has the burden of proof, one can imagine beives of medical experts appearing as witnesses on each side of the questions raised by the language; sending such questions to juries is problematic, and the prospect seems likely to be chilling to any physician's behavior.

185. Four states have passed laws that contain "reasonable belief" provisions alone or with

medical "partial-birth abortion" terminology remain troublesome.

In *Voinovich*, the federal trial judge engaged in an extensive examination of the vagueness questions raised by Ohio's ban against the "dilation and extraction" abortion procedure.<sup>186</sup> After describing in detail various medical procedures used to perform abortions at different stages of pregnancy, Judge Rice found:

The testimony indicates that the D & X procedure may be considered to be a variant of the D & E technique. Indeed, doctors who use the procedure may not know which procedure they will perform until they encounter particular surgical variables and circumstances after they begin the procedure to terminate the pregnancy. . . .

Based on the testimony of various physicians, this Court further finds that in both the D & E and D & X procedures, a suction device may be purposely inserted into the skull in order to remove the skull contents, to accomplish the goal of decompressing the fetal head, thereby facilitating its removal from the woman's body. Because the statutory definition of the prohibited "Dilation and Extraction Procedure" thereby appears to encompass the purportedly allowable D & E procedure as well, Plaintiff has demonstrated a substantial likelihood of success of showing that this definition is unconstitutionally vague, as it does not provide physicians with fair warning as to what conduct is permitted, and as to what conduct will expose them to criminal and civil liability.<sup>187</sup>

Judge Rice's conclusions contain obvious similarities to points made by various witnesses at the congressional hearings, particularly the state-

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affirmative defense provisions. See MICH. COMP. LAWS ANN. § 333.17016 (West Supp. 1997) ("A physician . . . may perform a partial-birth abortion if the physician or other individual reasonably believes that performing the partial-birth abortion is necessary to save the life of a pregnant woman whose life is endangered by a physical disorder, physical illness, or physical injury and that no other medical procedure will accomplish that purpose."); OHIO REV. CODE ANN. § 2919.15(C)(1) (West 1997) ("It is an affirmative defense to a charge under division (B) of this section that all other available abortion procedures would pose a greater risk to the health of the pregnant woman than the risk posed by the dilation and extraction procedure."); Partial-Birth Abortion Ban Act of 1997, 1997 Ark. Acts 984 ("It is an affirmative defense to a prosecution under this section, which must be proved by a preponderance of the evidence, that the partial-birth abortion was performed by a physician who reasonably believed: 1) the partial-birth abortion was necessary to save the life of the woman upon whom it was performed; and 2) no other form of abortion would suffice for that purpose."); Act effective July 1, 1997, 1997 Ind. Legis. Serv. 1185 (Michie) ("A person may not knowingly or intentionally perform a partial birth abortion unless a physician reasonably believes that: 1) performing the partial birth abortion is necessary to save the mother's life; and 2) no other medical procedure is sufficient to save the mother's life."). Of course, as of this writing, both the Michigan and Ohio statutes have been enjoined as unconstitutional. See *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 201 (6th Cir. 1997), cert. denied, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934); *Evans v. Kelley*, 977 F. Supp. 1283, 1319 (E.D. Mich. 1997).

186. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1063-87 (S.D. Ohio 1995), aff'd, 130 F.3d 187 (6th Cir. 1997), cert. denied, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

187. *Id.* at 1066-67 (footnotes omitted).



ments of Dr. Robinson and Professor Seidman.<sup>188</sup> Affirming *Voinovich*, the United States Court of Appeals for the Sixth Circuit stated its agreement with Judge Rice that the Ohio law encompassed the D&E procedure, as well as D&X.<sup>189</sup>

A review of the salient testimony and of the two federal court cases on this issue suggests that these bans are invariably unconstitutionally vague. On the other hand, virtually everyone (medical and non-medical) who has addressed the question seems to have a clear picture of the procedure under discussion.<sup>190</sup> At the same time, medical experts have testified, both before Congress and in two trial courts, that the presence of the contemplated prohibition would leave them uncertain as to where the line might be drawn between legal and illegal conduct. This fact, they argue, would necessarily have a chilling effect upon their willingness to perform abortion procedures that are now deemed completely acceptable and even routine. The Senate's scienter requirement may help to alleviate these concerns. However, of the states enacting these prohibitions, only Nebraska and New Jersey have included such language,<sup>191</sup> and the effects of these requirements are largely uncertain. Under all these circumstances, the criteria for vagueness singled out by the Supreme Court in *Colautti* certainly seem to be met: those subjected to these bans lack fair warning of the line between permissible and impermissible conduct;<sup>192</sup> a similar confusion among prosecutors seems likely to result in " 'arbitrary and erratic arrests and convictions' ";<sup>193</sup> and "the uncertainty induced by the statute threatens to inhibit the exercise of constitutionally protected rights."<sup>194</sup>

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188. See *supra* notes 163-67 and 179-82 and accompanying text; see also *Evans*, 977 F. Supp. at 1304-11 (discussing vagueness issue and concluding Michigan statute was void for vagueness); *Planned Parenthood of S. Ariz., Inc. v. Woods*, 982 F. Supp. 1369, 1378-79 (D. Ariz. 1997) (same).

189. See *Voinovich*, 130 F.3d at 200.

190. Even the two appellate judges responsible for affirming *Voinovich* recognized that a difference exists between D&E and D&X; they simply thought that Ohio's statutory language failed to delineate precisely the necessary distinction. See *id.* at 200. But see *id.* at 214 (Boggs, J., dissenting) (expressing view that "the words chosen clearly define a procedure understood by doctors and laymen alike").

191. See *supra* note 40 and accompanying text.

192. See *Colautti v. Franklin*, 439 U.S. 370, 390 (1979) (citing *United States v. Harriss*, 347 U.S. 612, 617 (1954)).

193. *Id.* (quoting *Papachristou v. Jacksonville*, 405 U.S. 156, 162 (1972)).

194. *Id.* at 391 (citing *Smith v. Goguen*, 415 U.S. 566, 573 (1974); *Grayned v. City of Rockford*, 408 U.S. 104, 109 (1972); *Keyishian v. Board of Regents*, 385 U.S. 589, 603-04 (1967)).

## B. *Validity of the Bans Under the Roe/Casey Framework*

In addition to potential vagueness problems, the statutory prohibitions under consideration raise substantial constitutional questions under the abortion rights standards established by the Supreme Court in *Roe v. Wade*<sup>195</sup> and its progeny, as modified in 1992 by *Planned Parenthood of Southeastern Pennsylvania v. Casey*.<sup>196</sup> Objections stem from two sources: the virtually uniform failure of enacted or proposed legislation to provide for an exception to the ban against using the D&X procedure for a post-viability abortion when, in the professional judgment of the attending physician, the woman's health interests are at stake (as opposed to her life); and arguments that the ban as applied to a pre-viability abortion may impose an "undue burden" on the woman's right, as that standard was delineated in *Casey*.

### 1. *Post-Viability Abortions*

In establishing constitutional protection for a woman's right to choose to have an abortion, *Roe* was very clear with respect to the validity of regulations of post-viability situations. *Roe* held that, "[f]or the stage subsequent to viability, the 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."<sup>197</sup> *Roe*'s companion case, *Doe v. Bolton*,<sup>198</sup> clarified the Court's reference to the "health of the mother":

Whether, in the words of the Georgia statute, "an abortion is necessary" is a professional judgment that the Georgia physician will be called upon to make routinely.

. . . [T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman.<sup>199</sup>

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195. 410 U.S. 113 (1973).

196. 505 U.S. 833 (1992).

197. *Roe*, 410 U.S. at 164-65.

198. 410 U.S. 179 (1973).

199. *Id.* at 192.

This definition of "health" has continued to be recognized as the governing standard and was in no way modified by *Casey*, where the Joint Opinion stated explicitly:

. . . We also reaffirm *Roe's* holding that "subsequent to viability, the 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."<sup>200</sup>

The federal bill provides an exception to its prohibition, either pre-viability or post-viability, "to a partial-birth abortion that is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury."<sup>201</sup> The bill's failure to provide a health exception was the primary flaw cited by President Clinton and the basis for his promise to veto the 1997 legislation.<sup>202</sup> Of the nineteen state laws that have been passed so far, only two include an exception where the abortion is necessary to preserve the health of the pregnant woman.<sup>203</sup> The trial judge in *Voinovich* enjoined Ohio's prohibition partly on the ground that the health exception provided by the legislature encompassed only the woman's *physical* health and therefore was not as broad as constitutionally required by *Bolton*.<sup>204</sup> Although the United States Court of Appeals for

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200. *Casey*, 505 U.S. at 879 (Joint Op. of Justices O'Connor, Kennedy and Souter) (quoting *Roe*, 410 U.S. at 164-65). Although the cited portion of *Casey* appeared in the plurality opinion, the statement would, of course, have found agreement in the views of Justices Stevens and Blackmun. See *Casey*, 505 U.S. at 911 (Stevens, J., concurring in part and dissenting in part); *id.* at 922 (Blackmun, J., concurring in part and dissenting in part); see also, e.g., Bonavoglia, *supra* note 33, at 62 (recounting the broad definition of health the Supreme Court introduced in *Doe v. Bolton* and assuming it is still the governing definition); John E. Yang, *House Overrides Abortion Bill Veto; Senate Unlikely to Follow On Highly Charged Issue*, WASH. POST, Sept. 20, 1996, at A1 (stating that proponents of the ban do not want to include a health exception because "health" is interpreted so broadly by the Supreme Court).

201. H.R. 1122, 105th Cong. § 2(a) (1997).

202. See *Clinton Vetoes*, *supra* note 119 (reporting Clinton's veto); Yang, *supra* note 119 (noting latest House vote and Clinton's reaffirmation of his vow to veto the bill); see also Yang, *supra* note 200 (stating that Clinton vetoed the ban in April 1996 because it lacked a health exception for the woman); John E. Yang, *House Passes 'Partial-Birth' Abortion Ban; Fight Looms*, WASH. POST, Mar. 21, 1997, at A12 (stating that Clinton's administration reported that he will veto the bill if it does not contain an exception to protect the woman's health).

203. See OHIO REV. CODE ANN. § 2919.15(C)(1) (Banks-Baldwin 1997) ("It is an affirmative defense . . . that all other available abortion procedures would pose a greater risk to the health of the pregnant woman than the risk posed by the dilation and extraction procedure."); UTAH CODE ANN. § 76-7-310.5(2)(A) (Supp. 1996) ("After viability . . . no person may knowingly perform a partial birth abortion or dilation and extraction procedure, or a saline abortion procedure, unless all other available abortion procedures would pose a risk to the life or the health of the pregnant woman.").

204. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1080-81 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No.

the Sixth Circuit did not need to reach this issue to affirm the trial court's ruling, the two-judge majority addressed the mental health question and, like Judge Rice, concluded that the Ohio ban "unconstitutionally limits the performance of post-viability abortions to those cases in which a pregnant woman's physical health is threatened."<sup>205</sup>

Because *Casey* had no occasion to consider post-viability abortion regulations, it is impossible to say that the Court would not tolerate more severe restrictions on abortions performed at this stage than it has previously countenanced. However, the Joint Opinion's specific reference to the language of *Roe* on this point indicates that so far, the law established by that case and *Bolton* remains intact.<sup>206</sup> Thus, even if the general regulation of a particular abortion procedure were to pass constitutional muster, allowable exceptions would surely have to include both pre-viability and post-viability abortions undertaken to preserve the woman's health, as well as her life. These prohibitions are surely constitutionally flawed, therefore, in their failure to include such provisions.

## 2. Pre-Viability Abortions: The "Undue Burden" Standard

In 1992, *Casey* revamped *Roe*'s familiar trimester framework that had governed abortion jurisprudence for almost twenty years.<sup>207</sup> Although *Roe*'s central holding was left intact,<sup>208</sup> the plurality opinion found that

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97-934); see also *Voinovich*, 130 F.3d at 208 (discussing the same issue); *Planned Parenthood of S. Ariz., Inc. v. Woods*, 982 F. Supp. 1369, 1378 (D. Ariz. 1997) (holding Arizona's ban unconstitutional partly on the ground that "it fails to provide an exception from banned procedures where such a procedure is necessary for a woman's health.").

205. *Voinovich*, 130 F.3d at 207.

206. See *Casey*, 505 U.S. at 879 (Joint Op. of Justices O'Connor, Kennedy and Souter).

207. See *id.* at 872 (Joint Op. of Justices O'Connor, Kennedy and Souter) (summarizing *Roe*'s trimester framework and noting that, "[m]ost of our cases since *Roe* have involved the application of rules derived from the trimester framework"); *Roe v. Wade*, 410 U.S. 113, 163-65 (1973). *Roe* held that a woman's right of privacy was sufficiently broad to encompass a qualified right to have an abortion. See *id.* at 154. Because during approximately the first trimester of pregnancy abortion was actually safer than carrying the fetus to term, the state's legitimate interest in the woman's health meant that "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." *Id.* at 164. During approximately the second trimester, the state's compelling interest in maternal health would support regulations reasonably related to that interest. See *id.* Once the fetus reached viability—i.e., had the "capability of meaningful life outside the mother's womb"—the state's interest in the potentiality of human life became compelling, and it could proscribe abortion except when necessary to preserve the woman's life or health. *Id.* at 163-65.

208. See *Casey*, 505 U.S. at 846 (Joint Op. of Justices O'Connor, Kennedy and Souter).

It must be stated at the outset and with clarity that *Roe*'s essential holding, the holding we reaffirm, has three parts. First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. . . . Second is a confirmation of the State's power to restrict abortions after fetal viability, if

"[t]he trimester framework . . . does not fulfill *Roe's* own promise that the State has an interest in protecting fetal life or potential life."<sup>209</sup> The case therefore held that "[n]ot all burdens on the right to decide whether to terminate a pregnancy will be undue. In our view, the undue burden standard is the appropriate means of reconciling the State's interest with the woman's constitutionally protected liberty."<sup>210</sup> To elaborate:

A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. A statute with this purpose is invalid because the means chosen by the State to further the interest in potential life must be calculated to inform the woman's free choice, not hinder it. And a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice cannot be considered a permissible means of serving its legitimate ends. . . . In our considered judgment, an undue burden is an unconstitutional burden. Understood another way, we answer the question, left open in previous opinions discussing the undue burden formulation, whether a law designed to further the State's interest in fetal life which imposes an undue burden on the woman's decision before fetal viability could be constitutional. The answer is no.<sup>211</sup>

Does a legislative ban against use of the D&X or intact D&E abortion procedure impose an "undue burden" on a pregnant woman's choice to have an abortion of a nonviable fetus? Examination of this question logically begins with the only Supreme Court case to consider a state's prohibition against a specific abortion technique. In 1976, *Planned Parenthood of Central Missouri v. Danforth*<sup>212</sup> invalidated Missouri's statutory prohibition of saline amniocentesis as a method of abortion after the first twelve weeks of pregnancy.<sup>213</sup> Based on its findings that roughly 70% of all abortions performed in the country after the first trimester used the prohibited method, that the alternative techniques of hysterotomy and hysterectomy were "significantly more dangerous and critical

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the law contains exceptions for pregnancies which endanger the woman's life or health. And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child.

*Id.* The first two of these three parts derive from *Roe*. See *supra* note 207.

209. *Id.* (Joint Op. of Justices O'Connor, Kennedy and Souter).

210. *Id.* (Joint Op. of Justices O'Connor, Kennedy and Souter). Justices Stevens and Blackmun would have left the holding of *Roe* unchanged. See *id.* at 911 (Stevens, J., concurring in part and dissenting in part); *id.* at 922 (Blackmun, J., concurring in part and dissenting in part). Chief Justice Rehnquist and Justices White, Scalia, and Thomas would have overruled *Roe*. See *id.* at 944 (Rehnquist, J., concurring in part and dissenting in part).

211. *Id.* at 877 (Joint Op. of Justices O'Connor, Kennedy and Souter) (citations omitted).

212. 428 U.S. 52 (1976).

213. See *id.* at 79.

for the woman," that a third, arguably safer, alternative technique was not yet widely used (and indeed, there was no evidence of the availability of this technique in Missouri), and that the maternal mortality rate in childbirth exceeded the mortality rate of abortions performed by saline amniocentesis, the Court held that the regulation did not serve the state's interest in maternal health—the only cognizable interest at this stage of pregnancy under *Roe*.<sup>214</sup>

There are, of course, notable differences between the bans at issue here and the situation in *Danforth*. First, unlike the saline amniocentesis technique in the 1976 case, D&X is not a widely used abortion method at this time; in fact, it is apparently quite rare.<sup>215</sup> Second, *Casey* now requires greater attention to the state's interest in nonviable fetal life, so that the regulation must be upheld unless it imposes an undue burden on the woman's choice.<sup>216</sup> Nonetheless, the trial judge in *Voinovich* stayed Ohio's prohibition partly on the ground that "Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on the D & X procedure is unconstitutional under *Danforth* and *Casey*."<sup>217</sup> The United States Court of Appeals for the Sixth Circuit went even further. Finding that Ohio's statutory prohibition encompassed the D&E procedure as well as D&X, the appellate court reasoned that the law's effect was to ban the abortion method most commonly used during the second trimester.<sup>218</sup> Therefore, *Danforth* provided a perfect parallel and necessarily dictated that the act be permanently enjoined as an undue burden. The judge in *Evans v. Kelley* issued a permanent injunction against Michigan's ban, partly on the ground that it violated *Casey*'s undue burden standard in a number of respects.<sup>219</sup> Assuming, *arguendo*, that a legislature could frame a definition of D&X sufficiently narrow to escape a finding such as that made by the Sixth Circuit in *Voinovich*, or to survive any vagueness ob-

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214. See *id.* at 76-79.

215. See *supra* notes 65-76 and accompanying text.

216. See *supra* notes 209-11 and accompanying text.

217. *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1071 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

218. See *Voinovich*, 130 F.3d at 200-01.

219. See *Evans v. Kelley*, 977 F. Supp. 1283, 1315-20 (E.D. Mich. 1997) (analyzing the law under *Casey*). Interestingly, Judge Rosen thought that "the reasoning of the Court in *Danforth* fore-shadows and substantially tracks the *Casey* 'undue burden' analysis." *Id.* at 1315; see also *Planned Parenthood of S. Ariz., Inc. v. Woods*, 982 F. Supp. 1369, 1377-78 (D. Ariz. 1997) (holding Arizona's ban posed an undue burden on women seeking abortion); *Carhart v. Stenberg*, 972 F. Supp. 507, 523 (D. Neb. 1997) (finding that Nebraska's ban posed an undue burden on the choice of women consulting one particular physician plaintiff).

jection whatsoever, were the federal trial judges correct that such a law would nonetheless impose an undue burden on a women's abortion right?

a. *The Casey "Purpose" Prong*

As *Casey* specifically prohibits any abortion regulation which "has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus,"<sup>220</sup> the first question is whether the *purpose* of the ban is invalid. *Casey* suggests that its purpose prong can be met in either of two ways: by "[r]egulations which do no more than create a structural mechanism by which the State, or the parent or guardian of a minor, may express profound respect for the life of the unborn . . . if they are not a substantial obstacle to the woman's exercise of the right to choose";<sup>221</sup> or "[r]egulations designed to foster the health of a woman seeking an abortion . . . if they do not constitute an undue burden"<sup>222</sup> (i.e., the same maternal health interest recognized in *Roe* and in *Danforth*).

As *Casey* revealed, the primary purpose behind Pennsylvania's regulations was to create the kind of "structural mechanism" referred to by the Court.<sup>223</sup> The legislature sought to serve the state's interest in preferring live birth over abortion by taking several steps to ensure that the woman's choice was a thoughtful, reflective, and informed one: thus, barring medical emergency, the laws required a twenty-four-hour waiting period between the woman's receipt of certain information and the performance of the abortion; specified that the information must be supplied by a physician or qualified nonphysician; and provided that the information must include the health risks to the woman of abortion and of live birth, the probable gestational age of the fetus, and the availability of materials published by the state concerning fetal development and information about abortion alternatives—such as paternal or state-supplied support or adoption.<sup>224</sup> All of these were upheld because they either served maternal health interests or simply constituted reasonable measures "to ensure an informed choice."<sup>225</sup> So long as the requirement did not pose a substan-

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220. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (Joint Op. of Justices O'Connor, Kennedy and Souter); see also *supra* notes 210-11 and accompanying text.

221. *Casey*, 505 U.S. at 877 (Joint Op. of Justices O'Connor, Kennedy and Souter).

222. *Id.* at 878 (Joint Op. of Justices O'Connor, Kennedy and Souter).

223. See *id.* at 881 (Joint Op. of Justices O'Connor, Kennedy and Souter).

224. See *id.* (Joint Op. of Justices O'Connor, Kennedy and Souter).

225. *Id.* at 883 (Joint Op. of Justices O'Connor, Kennedy and Souter) (referring specifically to the availability of materials relating the consequences to the fetus). Compare the Court's statement, quoted above in text, that "the means chosen by the State to further the interest in potential life

tial obstacle to the woman's right to exercise her choice, the fact that the measure was directed towards convincing her to choose live birth over abortion was not disqualifying.<sup>226</sup>

The question left unanswered by *Casey* (because there was no occasion to consider it) is whether a law regulating abortion of a nonviable fetus may validly serve any other purpose than the state's interests in maternal health or in influencing the woman's choice towards a preference for live birth. Certainly, the case is framed in terms of recognizing those two legitimate purposes, so long as their implementation does not have the effect of an undue burden. Does a prohibition against D&X serve either of these two aims?

There is no evidence to date that the availability or nonavailability of the D&X procedure as an abortion technique has had or is likely to have any effect on the number of women who choose to have an abortion.<sup>227</sup> The rarity of the procedure tends to bear out this conclusion,<sup>228</sup> as does the fact that alternative methods for late term abortions have existed for many years.<sup>229</sup> While members of the medical community themselves differ on the question of the relationship between use of the technique

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must be calculated to *inform the woman's free choice*, not hinder it." *Id.* at 877 (Joint Op. of Justices O'Connor, Kennedy and Souter) (emphasis added).

226. See *id.* at 878 (Joint Op. of Justices O'Connor, Kennedy and Souter).

227. See, e.g., *Senate Hearing*, *supra* note 23, at 235 (letter from Prof. Louis Michael Seidman of Georgetown Univ. Law Center to Sen. Orrin G. Hatch in response to questions posed by Sen. Leahy) ("The net effect of the bill is . . . likely to be no reduction in the number of abortions, but only a shift from methods that are less risky to methods that are more risky, to the mother's health."); 143 CONG. REC. S4715 (daily ed. May 20, 1997) (statement of Sen. Daschle) (After voting for the ban, Daschle said, "My own decision was not easy, in part, because this bill may have no practical effect on abortions in this country. It is likely that doctors wishing to perform later-term abortions will simply choose another option."); 143 CONG. REC. S4701 (daily ed. May 20, 1997) (statement of Sen. Mikulski) ("The bill before us [H.R. 1122] bans one procedure. It does not ban one single abortion. It bans a method of abortion. It enables a doctor to choose any other abortion procedure—even ones that might cause a greater health risk to the woman."); Garrow, Editorial, *supra* note 24 ("And, even if the law somehow did briefly take effect, it wouldn't prohibit a single abortion; doctors would simply have to employ different procedures, albeit ones that are potentially more dangerous to pregnant women. Santorum's hollow endeavor, no matter how successful it has been as self-promotion, is not intended to reduce the number of abortions."); Page, *supra* note 111 ("Abortion opponents in Congress could have had a major victory, a complete ban on almost all late-term abortions. Instead, they passed a bill that would ban only one grisly sounding procedure. . . . Sen. Rick Santorum, R-Pa., who led the fight for the ban, admitted his bill would not stop any abortions. Doctors have alternatives to the so-called 'partial birth' method. So why ban it? Politics.").

228. See *supra* notes 65-75 and accompanying text (discussing frequency of use of the procedure).

229. See *supra* notes 58-60 and accompanying text (concerning the techniques of instillation and hysterotomy).



and maternal health—with some expressing doubt about the performance of such a procedure outside a hospital, while others hail it as preservative of both maternal health and future fertility<sup>230</sup>—a primary actual purpose underlying these legislative bans appears to be the prevention of unnecessary cruelty to the fetus.<sup>231</sup>

In *Voinovich*, where the Ohio ban's stated purpose was the prevention of unnecessary cruelty to the fetus,<sup>232</sup> the trial court considered plaintiff's argument that *Casey* had delineated the only two permissible purposes for regulating pre-viability abortions, and that any other interest was "neither proper nor legitimate."<sup>233</sup> Defendant, on the other hand, argued that the named interest in cruelty prevention was "justified by the 'State's profound interest in potential life throughout pregnancy.'"<sup>234</sup> Observing that the issue appeared to be one of first impression before any court, the judge concluded that *Casey* nowhere characterized its two stated purposes in regulating pre-viability abortions as exclusive, and further, that the state interest in potential fetal life recognized by *Casey* could vindicate "interests other than those of persuading the woman to choose childbirth over abortion, or of protecting her health and safety."<sup>235</sup> Specifically, the court agreed with defendants "that it would be contrary to all logic and common sense, to hold that a state has no interest in preventing unnecessary cruelty to fetuses."<sup>236</sup> Judge Rice was therefore willing—as a matter of public interest—to examine evidence on the question of whether the D&X procedure causes pain to the fetus, even though he considered other factors to be dispositive of the case.<sup>237</sup> Because of the potential importance of the fetal pain question to the general issue of whether bans against D&X are either justifiable or wise, it is appropriate to consider the pain question more specifically.

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230. See *infra* notes 357-80 and accompanying text.

231. See H.R. REP. NO. 104-267, at 2-3 (1995) (explaining the "Background and Need for the Legislation" with respect to the "Partial-Birth Abortion Ban Act of 1995") ("The physician, traditionally trained to do everything in his power to assist and protect both mother and child during the birth process, deliberately kills the child in the birth canal. H.R. 1833 would end this cruel practice. . . . This method is particularly brutal and inhuman."); *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1071 (S.D. Ohio, 1995) (quoting the Ohio General Assembly), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934); see also *infra* notes 238-88 and accompanying text (discussing potential pain to the fetus).

232. See *Voinovich*, 911 F. Supp. at 1071.

233. *Id.* at 1072. Although referring to the ban's stated purpose in a footnote, the appellate court did not consider this question. See *Voinovich*, 130 F.3d at 98 n.6.

234. *Voinovich*, 911 F. Supp. at 1072 (quoting *Casey*).

235. *Id.*

236. *Id.*

237. See *id.*

### The Issue of Fetal Pain

As is true of virtually every aspect of the D&X issue, the perspectives available on the question of whether the procedure is painful to the fetus seem to reflect the political biases of the respective speakers more than they do any scientific data on the matter.<sup>238</sup> Thus, the 1995 House Report advocating adoption of that year's bill stated that "[i]t is well documented that a baby is highly sensitive to pain stimuli during this period and even earlier."<sup>239</sup> Yet not all those who testified before the House Subcommittee were in agreement with this statement or supplied clear-cut evidence to back it up.

Two witnesses opposed to the use of D&X offered their views that fetal pain was an inevitable concomitant. Mary Ellen Morton, R.N., a neonatal specialist, told the Subcommittee that she was there "to dispel the notion that unborn babies would not feel agonizing pain" during a D&X procedure.<sup>240</sup> Her evidence was based on her experience with extremely premature neonates—some born as early as twenty-three or twenty-four weeks' gestation—and consisted of the fact that anesthesia would be administered to one of these babies during any surgery, followed by analgesic and amnesiac drugs afterwards, in order to relieve pain.<sup>241</sup> She also related her observations of the reactions of very young babies to noxious stimuli (such as punctures and injections), noting their changing facial expressions and their differing vocalizations.<sup>242</sup>

Robert J. White, M.D., Professor of Surgery at Case Western Reserve University, testified that "[b]y the 20th week of gestation and beyond, the fetus has in place the neurocircuitry to appreciate pain. . . . As a matter of fact, there are studies that demonstrate even at 8 weeks through 13 weeks, there's enough neurocircuitry present so that pain and noxious stimuli could be perceived."<sup>243</sup> However, under questioning by Representative Barney Frank, Dr. White conceded that he was opposed to all abortion.<sup>244</sup> Furthermore, when Dr. White testified as an expert wit-

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238. See, e.g., *supra* notes 158-74 and accompanying text (noting that physicians' views on the vagueness issue often seem traceable to their respective opinions about abortion).

239. H.R. REP. NO. 104-267, at 4 (1995); see also *id.* at 4 n.5 (citing published sources supporting the statement).

240. *House Hearing, supra* note 23, at 76 (statement of Mary Ellen Morton, R.N., Neonatal Specialist and Flight Nurse).

241. See *id.* at 76-77.

242. See *id.*

243. *House Hearing, supra* note 23, at 67 (statement of Robert J. White, M.D., Prof. of Surgery, Case Western Reserve Univ.).

244. See *id.* at 90 (statement of Robert J. White, M.D.). Dr. White stated in his testimony that

ness at the *Voinovich* trial, the judge made a point of the fact that, under questioning with regard to whether a fetus at twenty-four weeks can consciously experience pain, Dr. White "noted that the problem is 'what we consider consciousness,'" and admitted "that he did not know 'at what particular stage in the gestational [age] . . . that an infant is conscious.'"<sup>245</sup>

On the other hand, Dr. J. Courtland Robinson, of the Department of Gynecology and Obstetrics at Johns Hopkins University, who opposed the ban against D&X on behalf of the National Abortion Federation, offered a view that cast doubt on the value of Nurse Morton's and Dr. White's evidence. While Dr. Robinson conceded that he was "not a neuroscientist," he also characterized Nurse Morton's views as "[i]nstitutively . . . learned," and observed that "[i]nstitutes, of course, are not the way we learn."<sup>246</sup> While hedging in response to a direct question by stating, "I'm not sure I know what pain is,"<sup>247</sup> Dr. Robinson went on to say:

I am sure that if you had the fetus outside and had it sophisticated, you would see EKG changes, you would see certain reactions. But this [sic] simply the passage of information from a no-susceptive sensor up to the brain. Whether that is pain or not pain, I do not know the answer to that.<sup>248</sup>

Dr. Robinson's credibility was not itself free from doubt. His earlier testimony had suggested that fetal pain is a moot question, not for reasons related to immature neurological development, but rather for reasons pertaining to the timing and agency of fetal death.<sup>249</sup> In his formal statement, Dr. Robinson told the Subcommittee that fetal demise occurs early in any abortion procedure, "either by an artificial medical means or through the combination of steps taken as the procedure is begun. Thus, in no case is pain induced to the fetus."<sup>250</sup> He also stated that even if neurological development would permit pain to the fetus (which he doubted), "analgesia and anesthesia given to the woman neutralizes any

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he goes "back to a time in American medicine when abortion was abhorred by the medical profession." *Id.* at 67 (statement of Robert J. White, M.D.).

245. *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1073 (S.D. Ohio 1995) (alterations in original), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

246. *House Hearing*, *supra* note 23, at 94 (testimony of J. Courtland Robinson, M.D.).

247. *Id.*

248. *Id.*

249. *See id.* at 64 (statement of J. Courtland Robinson, M.D.).

250. *Id.*

pain that may be perceived by the fetus.”<sup>251</sup>

Dr. Robinson's statement apparently echoed a letter to the House Subcommittee from Dr. James McMahon, who, prior to his death, performed abortions using the method of intact D&E in California.<sup>252</sup> Although Dr. McMahon's letter itself does not appear in the record, it is quoted as stating that anesthesia given to the woman would induce a “‘medical coma’” in the fetus which, in Dr. McMahon's view, evidently amounted to “‘neurological fetal demise.’”<sup>253</sup> This notion was vehemently contradicted in another letter to the Subcommittee from Watson A. Bowes, Jr., M.D., Professor at the University of North Carolina.<sup>254</sup> Cited as “an internationally recognized authority on maternal and fetal medicine,”<sup>255</sup> Dr. Bowes maintained in his letter that “[h]aving cared for pregnant women who for one reason or another required surgical procedures in the second trimester, I know that they were often heavily sedated or anesthetized for the procedures, and the fetuses did not die.”<sup>256</sup> With regard to the specific pain issue, Dr. Bowes' letter states:

Although it is true that analgesic medications given to the mother will reach in the fetus and presumably provide some degree of pain relief, the extent to which this renders this procedure pain free would be very difficult to document. I have performed in-utero procedures on fetuses in the second trimester, and in these situations the response of the fetuses to painful stimuli, such as needle sticks, suggest that they are capable of experiencing pain. Further evidence that the fetus is capable of feeling fetal pain is the response of extremely preterm infants to painful stimuli.<sup>257</sup>

The controversy over fetal pain that arose during the House Subcommittee hearings recurred in the Senate Committee hearings five months later. A registered nurse, Brenda Pratt Shafer, who characterized herself as “at that time very pro-choice,” described her experiences

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251. *Id.*

252. *See supra* notes 48-49 and accompanying text (describing Dr. McMahon's work).

253. *House Hearing, supra* note 23, at 105 (Letter from Watson A. Bowes, Jr., M.D., Prof., Univ. of North Carolina at Chapel Hill to Chairman Canady) (July 11, 1995) (quoting from “a document entitled ‘Testimony Before the House Subcommittee on the Constitution,’ June 23, 1995,” by Dr. James McMahon). It should be noted that Dr. McMahon died of cancer on Oct. 28, 1995. *See* 142 CONG. REC. H2921 (daily ed. Mar. 27, 1996). His death occurred between the House Hearing and the Senate Hearing; presumably, his failure to attend the former was attributable to failing health.

254. *See House Hearing, supra* note 23, at 104-07.

255. *Id.* at 107 (parenthetical injected in the Appendix, apparently by the House Subcommittee, next to Dr. Bowes' signature).

256. *Id.* at 105.

257. *Id.* at 106.

working with Dr. Haskell for three days.<sup>258</sup> She related her horror at what she saw, and described movements of the visible fetus prior to completion of the D&X procedure that in her mind suggested reactions of suffering.<sup>259</sup> Her testimony was directly contradicted by a letter read to the Committee by Senator Kennedy from Christie Gallivan, Dr. Haskell's head nurse, who claimed to have supervised Nurse Shafer at the clinic. Nurse Gallivan's letter maintained that "at no point during a dilation and extraction or intact D&E is there any fetal movement or response that would indicate awareness of pain and struggle. Ms. Pratt absolutely cannot have witnessed fetal movements as she described."<sup>260</sup>

Also at the Senate hearings, Dr. J. Courtland Robinson repeated the testimony he had given to the House Subcommittee,<sup>261</sup> including his statements about the "neutralizing effect" on any pain to the fetus induced by the anesthesia given to the woman.<sup>262</sup> On this point, Senator Orrin Hatch had already read to the Committee the refutation contained in a letter to him from Dr. Watson Bowes of the University of North Carolina Medical School<sup>263</sup>—the same letter that Dr. Bowes had sent to the House Subcommittee.<sup>264</sup> Dr. Bowes' views received substantial support from the testimony of Dr. Norig Ellison, Professor of Anesthesia and Vice Chair of the Department at the University of Pennsylvania School of Medicine, Clinical Director of the Anesthesia Department at the University hospital, and President of the American Society of Anesthesiologists (the organization which he was representing at the hearing).<sup>265</sup> Referring to Dr. McMahon's purported statements about the effects on the fetus of anesthesia given to the pregnant woman, Dr. Ellison told the Committee:

According to his written testimony . . . Dr. McMahon stated that anesthesia given the mother as part of the procedure eliminates any pain to the fetus, and that a medical coma is inducted [sic] in the fetus, causing a "neurological fetal demise," or—in lay terms—brain death.

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258. *Senate Hearing, supra* note 23, at 17-18 (statement of Brenda Pratt Shafer).

259. *See id.*

260. *Id.* at 19 (Sen. Kennedy, reading letter from Christie Gallivan dated July 17, 1995); *see also id.* at 336 (a copy of Ms. Gallivan's letter appended to the hearings).

261. *See id.* at 103 (statement of J. Courtland Robinson, M.D.); *id.* at 105 (prepared statement of J. Courtland Robinson, M.D.).

262. *Id.* at 104, 106; *see also supra* notes 250-51 and accompanying text.

263. *See Senate Hearing, supra* note 23, at 52-53 (Letter from Prof. Watson A. Bowes, Jr., M.D. to Sen. Orrin Hatch (Nov. 9, 1995)).

264. *See supra* notes 255-57 and accompanying text.

265. *See Senate Hearing, supra* note 23, at 107-08 (statement of Dr. Norig Ellison).

I believe this statement to be entirely inaccurate. I am deeply concerned, moreover, that the widespread publicity given to Dr. McMahon's testimony may cause pregnant women to delay necessary and perhaps even life-saving medical procedures, totally unrelated to the birthing process, due to misinformation regarding the effect of anesthetics on the fetus.

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Although it is certainly true that some general anesthetic medications given to the mother will reach the fetus and perhaps provide some pain relief, it is equally true that pregnant woman [sic] are routinely heavily sedated during the second or third trimester for the performance of a variety of necessary surgical procedures with absolutely no adverse effect on the fetus, let alone brain death. In my medical judgment, it would be necessary in order to achieve McMahon's neurological demise of the fetus in a partial-birth abortion, to anesthetize the mother to such a degree as to place her own health in serious jeopardy.<sup>266</sup>

Dr. Ellison offered no views on fetal neurological development and made it clear that the American Society of Anesthesiologists had taken no position on the appropriateness of any abortion procedure; its sole desire was to contradict any statements indicating that anesthesia administered to a pregnant woman might kill or harm her fetus.<sup>267</sup>

Perhaps the most reliable evidence on the fetal pain issue from the standpoint of neurological development came from Warren M. Hern, M.D., the author of the standard medical text on abortion and a highly respected physician who does not use either the D&X or intact D&E procedure.<sup>268</sup> In a written statement dated November 17, 1995, appended to the Senate hearings as a Submission to the Record, Dr. Hern cited another authority as follows:

According to biologist Clifford Grobstein and others, fetal neurological development well into the early part of the third trimester is insufficient for the fetus to experience what we regard as "pain." In Professor Grobstein's book, *Science and the Unborn* (1988, Basic Books, New York), "... an adequate neural substrate for experienced pain does not exist until about the seventh month of pregnancy (thirty weeks), well into the period when prematurely born fetuses are viable with intensive life support." Like any other mammalian organism, fetuses have enough neurological development to permit certain reflexes, but this is not the same as pain. Interpretation of these reflexes as "pain" is highly misleading.<sup>269</sup>

*Voinovich* considered the testimony of two expert witnesses called

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266. *Id.* at 107 (statement of Norig Ellison, M.D.); *see also id.* at 108 (prepared statement of Norig Ellison, M.D.); *see also supra* notes 252-53 and accompanying text (concerning Dr. McMahon's statements).

267. *See Senate Hearing, supra* note 23, at 108-09 (statement and prepared statement of Dr. Norig Ellison).

268. *See supra* notes 169-74 and accompanying text.

269. *Senate Hearing, supra* note 23, at 248-49 (statement of Warren M. Hern, M.D.).

by the defendant on the issue of fetal pain.<sup>270</sup> The perspective of Dr. Robert White, who appeared before the House Subcommittee, has already been referred to. At this point, suffice it to recall that Dr. White is opposed to abortion in general; that he testified both before the House Subcommittee and in the *Voinovich* trial that by the time of the abortion procedure, the neurocircuitry to experience pain was already in place; and that, nonetheless, at the trial he was able to answer a direct question as to whether the fetus "consciously experiences pain" only by noting the problem of "what we consider consciousness" and admitting that he did not know at what point in gestation the fetus could be characterized as "conscious."<sup>271</sup>

The other expert witness on fetal pain at the *Voinovich* trial was Dr. Joseph Conomy, a professor of clinical neurology at Case Western Reserve University. Dr. Conomy testified that "at the age of twenty to twenty-four weeks, many of the neural pathways which transmit pain to the brain are established, although the corticocol projections from the lower level of the brain, the thalamus, are not yet established."<sup>272</sup> It was therefore his opinion that "pain can be transmitted to at least the lower levels of the brain at that age."<sup>273</sup> Dr. Conomy also attested to the fact that fetuses at that stage respond to both nurturing and noxious stimuli in different ways.<sup>274</sup> However, although this neurologist was willing to state

270. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1072-75 (S.D. Ohio 1995) (considering testimony of Dr. Robert White and Dr. Joseph Conomy), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

271. See *supra* notes 243-45 and accompanying text. At the trial, Dr. White first testified that in his opinion, "the fetus *may* feel pain during the D & X procedure"—an answer stricken from the record "because it did not indicate an opinion within reasonable medical *probability*. Later . . . after viewing a videotape of the procedure being performed on a dead fetus, Dr. White amended his opinion to state that the fetus *can* feel pain." *Voinovich*, 911 F. Supp. at 1073 (citations omitted). Dr. White based his opinion in part on the fact that at the relevant stage of fetal development, chemicals in the brain that suppress pain are not yet established in fetuses, even though the chemicals to experience pain are. See *id.*; cf. *House Hearing, supra* note 23, at 67 (statement of Robert J. White, M.D.).

272. *Voinovich*, 911 F. Supp. at 1072.

273. *Id.*

274. See *id.* at 1073; cf., e.g., *supra* notes 248, 257 and accompanying text; see also *House Hearing, supra* note 23, at 77 (statement of Mary Ellen Morton, R.N.):

Well, this just kind of sums it up for you. But basically, we see differences in their vocalizations. There's different kinds of cries. Even your small babies can actually moan, just like an adult would. The facial expressions. We see chin quivering, eye squeezing, we see eye rolling, all kinds of brow bulge, a square chin when they are experiencing pain activity. We see differences in their sleep-wake cycles. We see a lack of consolability. Their sucking ability changes when they are in pain. Their general appearance, their color actually deteriorates because they deoxygenate their blood when they are in severe pain. We also see posture motor

that the D&X procedure would "prompt an unpleasurable stimulus to the fetus," he nonetheless said that it would be "'speculative' to try to 'get inside the mind of a fetus, if there is one.'" <sup>275</sup> In the end, in the words of the *Voinovich* district court opinion, "Dr. Conomy specifically refused to testify that a fetus can feel pain"; his reluctance was based on the fact that the reflex responses exhibited do not tell us anything about the fetus's actual perception. <sup>276</sup>

Of extreme interest to this important issue is the last bit of Dr. Conomy's testimony summarized by Judge Rice: "Finally, Dr. Conomy testified that a fetus who is aborted by the D & E procedure, which involves dismemberment, might experience as much discomfort as a fetus who is aborted by the D & X procedure." <sup>277</sup> In summarizing Dr. White's testimony, the court noted that Dr. White agreed with Dr. Conomy that "the D & E procedure would also be painful for the fetus, although the nervous system is more formed at twenty to twenty-four weeks when the D & E procedure is used on a less frequent basis." <sup>278</sup> The trial judge himself, in a footnote to his opinion, stated his own view that if the fetus does feel pain, the D&E procedure—dismemberment—might well be *more* painful than D&X because of the relative speed of each as a surgical procedure (D&X involving a "relatively quick incision and suctioning process"). <sup>279</sup> This would be true, in the judge's view, unless the nervous system was sufficiently less developed at the stages where D&E is performed than at those where D&X is performed. <sup>280</sup> One problem, of course, is that at some point, these stages merge, as borne out, *inter alia*, by testimony before the congressional hearings that a physician might begin expecting to perform one procedure, and end up having to proceed with another. <sup>281</sup>

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responses, such as jitteriness and arching, when they are exhibiting a pain stimulus.

*Id.* Similarly, Dr. White stated:

If one examines the biochemical data, i.e., the concentrations of corticoid and betaendorphin in fetal plasma immediately following the introduction of a needle which passes through the fetal abdomen (between the 20 [sic] and 34 [sic] week of gestation), one documents marked increases in the values of these substances strongly suggesting a painful experience. The classical cardiovascular responses associated with stress and pain can be easily elicited in fetuses of this age.

*Id.* at 69-70 (statement of Robert J. White, M.D.).

275. *Voinovich*, 911 F. Supp. at 1073.

276. *Id.*

277. *Id.*

278. *Id.*

279. *See id.* at 1074 n.29.

280. *See id.*

281. *See supra* notes 161-74 and accompanying text (concerning vagueness issues occasioned



Yet, D&E—dilation and evacuation—is the abortion technique routinely used for fetuses of thirteen to nineteen weeks' gestation, and never questioned by anyone, except as someone might object to abortion in general!<sup>282</sup>

In *Voinovich*, Judge Rice concluded that the evidence available on the fetal pain issue is insufficient to justify regulation of any given abortion procedure on those grounds:

Until medical science advances to a point at which the determination of when a fetus becomes "conscious" can be made within a reasonable degree of certainty, neither doctors nor judges nor legislators can definitively state when an abortion procedure becomes "cruel," in the sense of when the fetus becomes aware of pain. That judgment must be made by each individual member of society.

Given that there is no reliable evidence that the D & X procedure is more cruel than other methods of abortion, this Court is unable to conclude that the ban on the use of the D & X procedure serves the stated interest of preventing unnecessary cruelty to the fetus. As in *Danforth*, the ban on the D & X procedure therefore "comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting," second-trimester abortions prior to viability.<sup>283</sup>

An evaluation of scientific data is far beyond the scope of this article. However, an examination of the evidence available to Congress after the 1995 hearings and to the court in *Voinovich* suggests that surely Judge Rice's conclusions on this point are correct. The language of *Casey* may well be broad enough to include state interests beyond the two legitimate purposes identified in the case—maternal health and ensuring a thoughtful and informed choice on the woman's part.<sup>284</sup> The Joint Opinion does, after all, talk in terms of "a substantial state interest in potential life throughout pregnancy."<sup>285</sup> While its references to this interest are invariably linked to the two identified purposes—particularly influencing the woman's choice in favor of live birth by providing her with information designed to achieve that purpose, so long as the effect

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in part by the uncertainties that can surround the surgical procedure).

282. See *supra* notes 101-03 and accompanying text. Recall that Dr. White testified before the House Subcommittee that there was evidence that the neurological circuitry for sensations of pain was in place in fetuses as young as 8-13 weeks' gestation. See *supra* notes 243-45 and accompanying text.

283. *Voinovich*, 911 F. Supp. at 1074-75 (footnote omitted) (quoting *Planned Parenthood of Missouri v. Danforth*, 428 U.S. 52, 79 (1976)).

284. See *supra* notes 220-22 and accompanying text (identifying the purposes specifically recognized by the Joint Opinion in *Casey*).

285. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 876 (1992) (Joint Op. of Justices O'Connor, Kennedy and Souter).

is not one of posing a substantial obstacle to her decision making power<sup>286</sup>—recognition of “the State’s profound interest in potential life”<sup>287</sup> could be read to support other kinds of measures aimed towards promoting fetal welfare *in the abortion decision making context*.<sup>288</sup> If so, Judge Rice is certainly correct that the prevention of unnecessary cruelty to the fetus during the abortion process would constitute a cognizable state interest, so long as the measures serving that interest did not in any way jeopardize maternal health or pose a substantial obstacle to the woman’s exercise of her right to have an abortion of a nonviable fetus.

Assuming, *arguendo*, that the purpose of preventing unnecessary cruelty to a nonviable fetus is a legitimate state interest under *Casey*, the means of prohibiting an abortion technique that could be shown to be unnecessarily painful would appear to be a reasonable way to serve the purpose, *if* (and *only if*) the prohibited *effect* of an undue burden did not follow. However, current evidence suggests that at the present time we simply cannot establish with any degree of certainty the presence of pain in the fetus that might occur as the result of any particular abortion procedure. If such a link could be established with a degree of scientific reliability, then surely it would have to be a factor in the evaluation of *any* abortion technique, not just D&X. Because the regulation would have to meet the criteria of *Casey*’s effect prong, as well as its purpose prong, it is necessary to evaluate potential problems related to that standard.

### *b. The Casey “Effect” Prong*

The Joint Opinion states that “a statute which, while furthering the interest in potential life or some other valid state interest, has the effect of placing a substantial obstacle in the path of a woman’s choice cannot be considered a permissible means of serving its legitimate ends.”<sup>289</sup> In the context of a pre-viability abortion, the most likely “undue burden”—besides that bearing on the decision making process itself, as already discussed<sup>290</sup>—is one which, while “furthering the interest in potential life or

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286. See *id.* at 882-83 (Joint Op. of Justices O’Connor, Kennedy and Souter).

287. *Id.* at 878 (Joint Op. of Justices O’Connor, Kennedy and Souter).

288. Any other context conjures up questions of maternal/fetal conflicts and the potential for state regulation of a variety of behaviors during pregnancy, such as alcohol ingestion or smoking. Commentators have long presented arguments against the dangers of allowing that much power to government in the regulation of the behavior of pregnant women. See, e.g., Janet Gallagher, *Prenatal Invasions and Interventions: What’s Wrong With Fetal Rights*, 10 HARV. WOMEN’S L.J. 9, 31-32 (1987).

289. *Casey*, 505 U.S. at 877 (Joint Op. of Justices O’Connor, Kennedy and Souter).

290. See *supra* notes 224-26 and accompanying text.

some other valid state interest,"<sup>291</sup> would nonetheless have the *effect* of undermining the woman's interest in her own health and welfare.<sup>292</sup> For that matter, the Court has in every case emphasized that in any contemplated abortion at any stage of pregnancy—pre-viability or post-viability—the woman's health interests are paramount to all other considerations.<sup>293</sup> Thus, medical necessity where the life or health of the woman is at stake is the only valid reason for trumping the state's interest in the potential life of a viable fetus;<sup>294</sup> her well-being is certainly an overriding factor in the pre-viability context.

In interpreting what it means to consider the woman's health interests as paramount, the Court has made it clear that whenever more than one abortion technique is possible or feasible, the woman is entitled to the use of the method which is most beneficial to *her*, even though another technique might be both generally safe for her and more beneficial to the fetus.<sup>295</sup> Thus, *Planned Parenthood of Central Missouri v. Danforth*<sup>296</sup> invalidated a prohibition against the use of saline amniocentesis as an abortion technique after the first twelve weeks of pregnancy partly because "it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed."<sup>297</sup> Similarly, a portion of *Thornburgh v. American College of Obstetricians and Gynecologists*<sup>298</sup> which was not overruled by *Casey*<sup>299</sup> invalidated a statutory provision relevant to post-viability abortions that, in the eyes of the Court, "required a 'trade-off' between the woman's health and fetal survival, and failed to require that maternal health be the

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291. *Casey*, 505 U.S. at 877 (Joint Op. of Justices O'Connor, Kennedy and Souter).

292. Maternal health interests—along with an interest in the potential life of the fetus—have, of course, been of primary concern throughout the history of abortion jurisprudence. See *supra* notes 195-200, 206-11 and accompanying text (discussing the holdings of *Roe*, *Casey*, and Supreme Court decision making in general on the abortion question).

293. See, e.g., *Casey*, 505 U.S. at 880 (Joint Op. of Justices O'Connor, Kennedy and Souter).

294. See *supra* notes 200-06 and accompanying text (discussing regulation of post-viability abortions and the failure of D&X bans to pass constitutional muster on the ground that they fail to provide an exception to their prohibitions when the woman's health—though not her life—is at stake).

295. See *infra* notes 296-301 and accompanying text.

296. 428 U.S. 52 (1976).

297. *Id.* at 79; see also *supra* notes 212-13 and accompanying text (discussing *Danforth*).

298. 476 U.S. 747 (1986).

299. *Casey* overruled *Thornburgh's* specific holdings invalidating certain "informed consent" requirements specifying that particular information must be given to the woman; that the physician must be the person to convey it; and that, *inter alia*, she must be notified of the availability of state-supplied printed materials concerning her rights and options. See *Thornburgh*, 476 U.S. at 759-65 (invalidating such provisions); cf. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 881-87 (1992) (Joint Op. of Justices O'Connor, Kennedy and Souter) (upholding similar provisions).

physician's paramount consideration. . . . In *Colautti*, this Court recognized the undesirability of any 'trade-off' between the woman's health and additional percentage points of fetal survival."<sup>300</sup> In other words, the woman's health interests must never be subordinated to the state's interest in the potential life of the fetus. This means that, given a variety of available techniques for performing the procedure, the woman is entitled to the method most beneficial to her.<sup>301</sup>

It is true, of course, that alternative procedures are available for abortions at twenty to twenty-four weeks' gestation, and have been for some time.<sup>302</sup> As described by Dr. Warren Hern in his standard medical textbook, *Abortion Practice*, these may include D&E or a variation thereof.<sup>303</sup> In week twenty, according to the text, D&E is still a possibility, particularly when accompanied by urea amniocentesis several hours prior to the procedure.<sup>304</sup> By this time, delivery of the fetus is difficult

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300. *Thornburgh*, 476 U.S. at 768-69 (citations omitted). The statute in *Thornburgh* required that a physician performing a post-viability abortion must use " 'the abortion technique . . . which would provide the best opportunity for the unborn child to be aborted alive unless,' in the physician's good-faith judgment, that technique 'would present a significantly greater medical risk to the life or health of the pregnant woman.' " *Id.* at 768.

301. Compare this reasoning to the following language in *Voinovich*:

The reasoning in *Danforth* suggests that a state may act to prohibit a method of abortion, if there are safe and available alternatives. . . . The issue . . . therefore, is whether . . . there are safe and available alternatives to the D & X procedure, which is typically performed during the twentieth to twenty-fourth weeks of pregnancy, such that there would be no undue burden if the procedure were banned.

*Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1067 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934). The trial court went on to find that D&X may actually be an improvement over existing methods of late-term abortion and concluded, therefore, that a ban on the procedure was an undue burden on the woman's abortion right. *See id.* at 1070; *see also infra* notes 315-26 and accompanying text. The appellate court did not directly address the "trade-off" issue. However, it did note that some abortions between twenty and twenty-four weeks' gestation would involve viable fetuses, and "[t]he undue burden standard applies only to pre-viability abortion regulations." *Voinovich*, 130 F.3d at 201. With respect to the issue of the validity of a D&X ban for post-viability abortions, the Court of Appeals made assumptions that appear to be at some variance with aspects of the district court's reasoning: "Because a state can proscribe all abortions post-viability, when not required for the life and health of the mother, we will assume *arguendo* that a state could restrict the abortion procedures performed post-viability, as long as abortions were still available to protect the life and health of the mother." *Id.* at 202.

302. *See supra* notes 58-60 and accompanying text.

303. HERN, *supra* note 46, at 154. This book is the standard medical text on abortion. *See supra* note 170 and accompanying text.

304. *See* HERN, *supra* note 46, at 153-54. Urea amniocentesis consists of infusion by gravity or direct injection into the amniotic cavity of a salt solution to stimulate dilation; it will induce labor. *See id.* at 123. Multiple laminaria, used for dilation, will have been inserted over a two-to-three-day period, prior to urea amniocentesis. *See id.* at 153-54.

due to size and the increasing cohesiveness of fetal bones.<sup>305</sup> However, so long as the bones are not too hard, dismemberment is still likely to take place; a part of that procedure will include collapsing the skull, very much as Dr. Haskell has described in the D&X procedure.<sup>306</sup>

In weeks twenty-one through twenty-four, "[t]he procedure changes significantly."<sup>307</sup> At this stage, Dr. Hern calls for the induction of actual labor, although he still recommends instrument use as part of the process.<sup>308</sup> Patients with a history of cesarean sections "are not permitted to go into hard labor as are other patients."<sup>309</sup> Rather, once contractions reach a specified stage, such patients should be taken to the procedure room for completion of the abortion by a D&E technique.<sup>310</sup> The only alternative, the surgical technique of hysterotomy, "has been almost completely abandoned because of its associated high morbidity."<sup>311</sup>

Complications cited by Dr. Hern as sometimes associated with D&E include trapped calvaria (skull); fragmented placenta (causes delay in emptying the uterus and thus "contributes to the bleeding");<sup>312</sup> placenta previa;<sup>313</sup> hemorrhage; ruptured membranes; cervical laceration; perforation; and infection.<sup>314</sup> The rulings of *Danforth*, *Colautti*, and *Thornburgh* suggest that if any abortion technique were developed that were more effective in avoiding or overcoming these problems, women's right of access to that method would receive a higher degree of constitutional protection than would any state interest in the potential life of the fetus, as a state may not require a "trade-off"<sup>315</sup> between the health interests of a pregnant woman and those of her fetus.

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305. See *id.* at 154 (Hern mentions the difficulties of increasing bone hardness, particularly with respect to weeks 21-24).

306. See *id.* Dr. Hern's statement to the Senate Committee stated "[i]t is my understanding that the maneuvers described by the sponsors of [the 1995 bill] are followed by attending physicians throughout the nation when the safety of the woman having the abortion is at issue." *Senate Hearing*, *supra* note 23, at 247 (statement of Warren M. Hern, M.D.). Describing his own approach (which includes inducing fetal death on the first or second day), he added, "[i]n the case of a breech presentation of a dead fetus, the procedure described by sponsors of [the 1995 bill] is routinely followed." *Id.*

307. HERN, *supra* note 46, at 154.

308. See *id.*

309. *Id.* at 146.

310. See *id.*

311. *Id.* at 123.

312. *Id.* at 194-95.

313. Placenta previa is defined as "an abnormal implantation of the placenta at or near the internal opening of the uterine cervix so that it tends to precede the child at birth usu[ally] causing severe maternal hemorrhage." WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1728 (1976).

314. See HERN, *supra* note 46, at 195-206.

315. See *supra* notes 298-300 and accompanying text (citing cases using this language).

Does D&X or intact D&E as a late abortion technique constitute an actual improvement over current methods in terms of protection of the woman's health? Medical opinion is sharply divided on this question.<sup>316</sup> But in *Voinovich*, the trial court heard evidence on this issue and concluded that in fact such might be the case.<sup>317</sup> For example, Dr. George Goler, the Ohio Section Chief of ACOG, testified to his view that D&X represents an improvement over D&E "because it causes less trauma to the maternal tissues (by avoiding the break up of bones, and the possible laceration caused by their raw edges), less blood loss, and results in an intact fetus that can be studied for genetic reasons."<sup>318</sup> Although an intact fetus also results from techniques using induced labor, Judge Rice noted that "the use of various substances to induce labor can cause autolysis, or the breaking down of tissue, which may make the fetus tissue less useful for [genetic] studies."<sup>319</sup> Additionally, D&X requires less time than techniques which induce labor,<sup>320</sup> and may well be characterized as more available to patients, in that it can be performed on an outpatient basis and, unlike at least some induction and instillation methods, does not require hospitalization (thereby entailing less expense and inconvenience to the patient).<sup>321</sup> Judge Rice was not persuaded by defendant's arguments that D&X was "not within the accepted medical standards," because the procedure was too new and controversial to measure in that way.<sup>322</sup> He cited the testimony of Dr. Haskell, the developer of the procedure, to the effect that in approximately a thousand D&E procedures that Dr. Haskell had performed after the twentieth week of pregnancy, two patients had serious complications.<sup>323</sup> But after the same number of D&X procedures at that stage, Dr. Haskell's patients had *no* serious complications.<sup>324</sup>

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316. See *infra* notes 364-80 and accompanying text.

317. See *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. at 1051, 1069-70 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

318. *Id.* at 1069.

319. *Id.*

320. See *id.*

321. See *id.* at 1070.

322. *Id.* at 1069 n.23.

323. See *id.* at 1069.

324. See *id.* The court went on to note that "[a]lthough this is anecdotal, not statistical, evidence, this Court finds that it is both uncontradicted and plausible." *Id.*; see also *Carhart v. Stenberg*, 972 F. Supp. 507, 515-16 (D. Neb. 1997) (citing benefits of the banned procedure, with particular reference to *Voinovich*).

Although the *Voinovich* court heard counter evidence as well,<sup>325</sup> the district court's opinion in essence maintains that the important factor here is that the issue of whether D&X might actually represent an improvement over existing methods is an open one. Therefore, this potentially promising new development should not be stymied by the law prior to having an opportunity to prove itself one way or the other:

Because the D & X procedure appears to have the potential of being a safer procedure than all other available abortion procedures, this Court holds that the Plaintiff has demonstrated a substantial likelihood of success of showing that the state is not constitutionally permitted to ban the procedure. If this abortion procedure, which appears to pose less of a risk to maternal health than any other alternative, were banned, and women were forced to use riskier and more deleterious abortion procedures, the ban could have the effect of placing a substantial obstacle in the path of women seeking pre-viability abortions, which would be an undue burden and thus unconstitutional under *Casey*.<sup>326</sup>

### *C. Other Voices, Other Views: The Fuzziness of Casey and the Inconclusiveness of the Constitutional Question*

In attempting to analyze the constitutional issues raised under *Casey* by legislative prohibitions against D&X, it is important to take note of the testimony proffered by three constitutional law professors at the congressional hearings.<sup>327</sup> Of these, two took the position that the ban was constitutional and one agreed with the conclusions reached by Judge Rice in *Voinovich* and Judge Rosen in *Evans v. Kelley*. The House Subcommittee on the Judiciary heard only from Professor David M. Smolin, of Cumberland Law School, Samford University.<sup>328</sup> Professor Smolin pointed out that, "as a practical matter, given current preferences for

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325. See *Voinovich*, 911 F. Supp. at 1069. For example, one expert witness, who had performed D&E procedures but not D&X, testified that "the D & X procedure would have greater complications than the induction methods, because there is an increased possibility of perforating the patient's uterus when the abortion is performed in the late second trimester." *Id.*; see also *infra* notes 366, 371-76 and accompanying text (discussing the arguments against the safety of D&X). Although noting the district court's finding that "the D & X procedure is potentially safer than other available abortion procedures," the court of appeals did not specifically address that issue. *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 197 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

326. *Voinovich*, 911 F. Supp. at 1070.

327. The legal experts' views on the vagueness question have already been discussed. See *supra* notes 176-82 and accompanying text (Prof. Douglas W. Kmiec dismissing vagueness as a non-issue; Prof. Seidman's argument that the federal bill was unconstitutionally vague; Prof. Smolin, testifying before the House Subcommittee, did not discuss the vagueness question).

328. See *House Hearing*, *supra* note 23, at 97-102 (prepared statement of Prof. David M. Smolin).

other methods, the law would probably have some influence in the choice of method in less than five thousand abortions annually."<sup>329</sup> Contrasting that statistic with the situation in *Danforth*, where the prohibited method was used in "68% to 80% of all post-first-trimester abortions,"<sup>330</sup> Professor Smolin also characterized the sections of Dr. Hern's text, *Abortion Practice*, that have been summarized in this article,<sup>331</sup> as describing "an effective method for these late term abortions."<sup>332</sup> Applying *Casey*, Professor Smolin concluded:

Thus, it is clear that a prohibition of partial-birth abortions would leave in place the currently standard and dominant methods of abortion during the second half of pregnancy. Thus, the current law cannot be viewed, as was the law in *Danforth*, as having the propose [sic] or effect of inhibiting the majority of abortions during a certain period. The proposed ban on partial-birth abortions is a true regulation, and not in any way a prohibition of abortion.<sup>333</sup>

Professor Smolin went on to dissect *Casey* more particularly, and to discuss its criteria for pre-viability and then post-viability abortions (noting that the time period of twenty to twenty-four weeks' gestation was "at the periphery of viability").<sup>334</sup> With respect to pre-viability abortions, Professor Smolin's analysis differed from that of Judge Rice. Whereas the latter took the position in *Voinovich* that prohibition of a new, possibly safer, technique would constitute an "undue burden" because it would force a "trade-off" between maternal health interests and the potential life of the fetus,<sup>335</sup> Professor Smolin's reading of *Casey* provided for much more legislative leeway:

To gain the burden of the undue burden standard, a physician would have to demonstrate that there was no medically-viable alternative method of abortion, during this short period from twenty weeks to viability at twenty-three to twenty-four weeks. Yet, even Dr. Haskell's paper documents the alternatives of induction methods, and of Dr. Hern's technique for softening the fetal tissues prior to D&E abortion.<sup>336</sup>

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329. *Id.* at 98 (prepared statement of Prof. David M. Smolin). Although Prof. Smolin's statement was written before it was known that use of the D&X technique, or something very like it, was more widespread than first thought, these numbers still appear to be realistic. *See supra* notes 65-76 and accompanying text (discussing how often the D&X procedure is used).

330. *House Hearing, supra* note 23, at 98 (prepared statement of Prof. David M. Smolin); *see also supra* notes 212-14 and accompanying text (discussing *Danforth*).

331. *See supra* note 170 and accompanying text.

332. *House Hearing, supra* note 23, at 98 (prepared statement of Prof. David M. Smolin).

333. *Id.*

334. *Id.* at 99.

335. *See supra* notes 317-26 and accompanying text.

336. *House Hearing, supra* note 23, at 99 (prepared statement of Prof. David M. Smolin).



Post-viability abortions are subject to much greater state control, Professor Smolin pointed out, and "[t]he proposed ban on partial-birth abortions is merely a regulation of abortion, and therefore is, in its application to the abortion of viable fetuses, well within constitutional limits."<sup>337</sup> Reading *Casey* and the ban together, Professor Smolin concluded that rational basis review was appropriate at all stages,<sup>338</sup> and that the ban served the legitimate purposes of public morality, preservation of the disparity between the physician's roles in childbirth on the one hand and abortion on the other, and "protecting respect for human life, and for constitutional persons, by not permitting a fetus present in the birth canal to be deliberately assaulted and killed."<sup>339</sup>

Similarly, Professor Douglas W. Kmiec, of Notre Dame University, told the Senate Judiciary Committee that "there are no constitutional concerns."<sup>340</sup> Professor Kmiec described the fetuses undergoing the procedure as "partially-born child[ren],"<sup>341</sup> and accordingly did not consider the entire process as coming within the definition of "abortion."<sup>342</sup> However, should it be viewed that way, "the *Casey* standards are well met";<sup>343</sup> the health exception requirement has been fulfilled because

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337. *Id.* Indications are that the United States Court of Appeals for the Sixth Circuit would agree with Prof. Smolin on this point. See *Women's Med. Prof'l Corp. v. Voinovich*, 130 F.3d 187, 201-02 (6th Cir. 1997) (Assuming, for purposes of the severability analysis, that abortion procedures for post-viability abortions could be regulated. See *supra* note 301 and accompanying text.), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934).

338. See *House Hearing, supra* note 23, at 99 (prepared statement of Prof. David M. Smolin).

339. *Id.* at 100. A number of the ban's adherents have been heavily influenced by the visual image of a fetus whose body is visible before completion of the abortion process. See, e.g., *House Hearing, supra* note 23, at 1 (opening statement of Chairman Canady) ("This hearing focuses on partial-birth abortion because while every abortion sadly takes a human life, this method takes that life as the baby emerges from the mother's womb while the baby is in the birth canal."); *id.* at 4 (letter from Rep. Canady and Rep. Vucanovich to fellow Congresspersons) ("We have included diagrams of the procedure on the back of this letter. The diagrams clearly show how unthinkable this procedure is for those who value the dignity of human life and believe in common decency."); Gianneli, *supra* note 33, at 3 ("In an attempt to derail an abortion-rights bill . . . opponents have launched a full-scale campaign against late-term abortions. The centerpieces of the effort are newspaper advertisements and brochures that graphically illustrate a [dilation and extraction procedure.]"). Professor Smolin also explored the issue of Congressional authority under the Commerce Clause and found no difficulty in justifying the federal bill. See *House Hearing, supra* note 23, at 101-02 (prepared statement of Prof. David M. Smolin). As already mentioned, this article focuses on the substance of the prohibition itself on both state and federal levels; the Commerce Clause issue is beyond the scope of this examination. See *supra* note 142.

340. *Senate Hearing, supra* note 23, at 169 (statement of Prof. Douglas W. Kmiec).

341. *Id.* Prof. Kmiec was among those who were quite disturbed by the description of the process and saw it as essentially a birth. See *supra* note 103.

342. *Senate Hearing, supra* note 23, at 170 (statement of Prof. Douglas W. Kmiec).

343. *Id.*

"[t]here are both alternative birth procedures and alternative abortion procedures that are untouched."<sup>344</sup> Professor Kmiec was not convinced that D&X might constitute a safer procedure for the woman, because it "is really a manipulated breech birth—one of the most maternally risky procedures that there is."<sup>345</sup>

Taking a contrary view, Professor Louis Michael Seidman, of the Georgetown University Law Center,<sup>346</sup> told the Senate Judiciary Committee that the 1995 bill was "riddled with unconstitutional provisions."<sup>347</sup> With respect to the purpose and effect questions arising under *Casey*, Professor Seidman first found no legitimate purpose served by the bill, as it "does nothing to discourage abortion, per se" and "does nothing to protect the rights of fetuses" or "to protect potential life."<sup>348</sup> Not only is any alternative procedure "every bit as deadly to the fetus," but "[g]raphic descriptions of it are every bit as disturbing."<sup>349</sup> Furthermore, in Professor Seidman's view, the effect of the prohibition is unconstitutional under *Casey*, because "what is outlawed is safer for the woman," so that requiring an alternative is deleterious to her health interests.<sup>350</sup> The lack of a health exception violates the ruling of *Casey* even in the post-viability phase.

What conclusions are possible at this point with respect to the application of the standards of *Casey* to statutory prohibitions against D&X or intact D&E? An evaluation of this question is difficult partly because the phraseology of "undue burden" or "substantial obstacle" is not self-explanatory, and no guidance on defining *Casey*'s criteria has issued from the Court since the decision was rendered in 1992. Furthermore, it is both possible and plausible to give either a narrow or a broad interpretation to each *Casey* prong, and that choice may itself be decisive in arriving at an answer.

Thus, with respect to the "purpose" prong, the question remains unresolved as to whether *Casey*'s two identified permissible purposes of influencing the woman's choice and preserving her health are exclusive or whether they are merely examples of the most likely legitimate purposes a government might seek to serve with its abortion policy. If they are indeed exclusive categories, a law restricting a particular abortion tech-

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344. *Id.*

345. *Id.*

346. See *supra* notes 179-82 and accompanying text (discussing Prof. Seidman's testimony).

347. *Senate Hearing, supra* note 23, at 188 (statement of Prof. Louis Michael Seidman).

348. *Id.*

349. *Id.*

350. *Id.*

nique would appear unlikely to influence the woman's choice whether to have an abortion at all, and the issue would then come down to a resolution of the second question, the medical question—how would her health interests be affected?

If, on the other hand, these purposes are not exclusive, a governmental interest in preventing unnecessary fetal pain might well be legitimate. The answer here, however, once again comes down to a medical issue—does the fetus in fact experience pain that governmental policy should be directed at preventing? Assuming, for a moment, that the medical questions could be answered and that the answers to both were positive—i.e., that the fetus does experience pain during the relevant gestational stage of the abortion process, and that the D&X procedure is in some circumstances the most beneficial to the woman's health and future fertility—what is the appropriate relationship between these two answers? Is the state required to defer to the woman's health interests every time, even if the additional advantage to her well-being is marginal and the pain experienced by the fetus is severe? *Casey* does not provide the answers to these questions. There may be valid arguments that the two purposes identified in the case are not necessarily exclusive and that the state has a legitimate interest in requiring respectful and humane treatment of all fetuses, whenever feasible.<sup>351</sup> Like all abortion jurisprudence, *Casey* does suggest that the woman's health interests should always prevail whenever there is a conflict;<sup>352</sup> however, the case is incapable of answering either of the two medical questions about fetal pain and maternal welfare which in turn give rise to the issue of how to weight those interests.

With respect to *Casey*'s "effect" prong, one interpretation of "undue burden" suggests that a woman choosing abortion must be entitled in every instance to the technique that she and her physician think is optimal for the preservation of her health interests, reading "health" broadly to include her psychological and emotional well-being, as well as her physical condition. Another arguably plausible view is that any given abortion technique can be restricted in the service of a legitimate state interest, so long as safe and effective alternatives exist for the pregnant woman to exercise her legal choice. In other words—according to this line of reasoning—given the existence of alternative methods for late

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351. See, e.g., *Planned Parenthood of Minnesota v. Minnesota*, 910 F.2d 479, 488 (8th Cir. 1990) (upholding a Minnesota statute regulating disposal of fetal remains and finding it rationally related to the legitimate state interest of "protecting public sensibilities").

352. See *supra* notes 292-301 and accompanying text.

term abortion that have existed for some time, the prohibition against one, rarely-used method (which may still be legally employed if necessary to save the woman's life) should not pose a constitutional problem so long as the restriction serves a legitimate interest. The fact that the woman might prefer the prohibited technique because it would take less time, cost less, or cause her less pain or stress may not be a constitutionally sufficient reason to invalidate the restriction.<sup>353</sup>

To recap the constitutional issues arising from bans against the D&X procedure: the failure to provide an exception when medical necessity would dictate use of the procedure for the sake of a woman's health (not just her life) is surely unconstitutional. That exception must apply throughout pregnancy, including post-viability abortions. Abortion jurisprudence has been consistent on this point.<sup>354</sup> This constitutional problem is obviously susceptible to easy linguistic remedy, although both Congress and state legislatures have so far been unwilling to add the needed phraseology.

There is a very substantial vagueness problem in the legislative definitions of the prohibited behavior.<sup>355</sup> The scienter requirement added by the Senate amendment to the federal bill may (or may not) resolve this problem on the federal level; even if it does, only two states' laws have injected a similar requirement.<sup>356</sup> This problem may be more difficult to resolve than the health exception requirement. However—particularly given the fact that everyone referring to the procedure appears to understand the topic under discussion—this defect may be subject to remedy, with careful re-drafting.

The questions raised by application of both the purpose prong and the effect prong of *Casey* are more difficult to answer at this time, given the lack of specificity inherent in the "undue burden" test and the fact that the Court has provided no further guidance since the case was decided. Strong arguments—persuasive to many, including this author—suggest that if D&X does represent an improvement over current methods of late abortion, and thus the woman's health interests are served by use of the new technique, the constitutional jurisprudence of the abortion

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353. See *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 874 (1992) (Joint Op. of Justices O'Connor, Kennedy and Souter) ("The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it.").

354. See *supra* notes 197-200 and accompanying text.

355. See *supra* notes 161-94 and accompanying text.

356. See *supra* note 40 and accompanying text.

cases requires that physicians be permitted to use D&X as a procedure in any abortion situation where they find it appropriate.

Yet there remains the nagging concern of fetal pain; if indeed the problem exists, compassion dictates that we not dismiss it out-of-hand. This is a question that can only be answered by the medical experts, if at all—not by the legal system. If fetal pain is real, however, surely any requirements that the law might validly impose in order to alleviate the problem would necessarily have to apply to *all* abortion procedures that might cause fetal pain, not just to one of them. As with all abortion regulations, there would have to be an exception for situations of medical necessity where contrary action was needed to preserve the life or health of the pregnant woman.

Another medical problem remains to which there appears to be no definitive answer: the issue of whether D&X or intact D&E is preferable to alternatives, at least in some cases, as best serving the woman's interests in her health and future fertility. Again, only the medical community can provide the answer to this question—not the legal system.

## V. VIEWS OF THE MEDICAL PROFESSION

### A. *With Respect to the D&X Procedure*

The views of the medical community on the D&X abortion method encompass the issues of both fetal pain and maternal health. The sharp disagreement with respect to fetal pain<sup>357</sup> may militate, as a matter of medical practice, in favor of trying to avoid or alleviate the possibility of any such problem whenever feasible. Dr. Hern, for example (who did not think fetal pain was an issue at this stage of pregnancy<sup>358</sup> and who also thought the fetus was usually dead before the commencement of the intact D&E procedure<sup>359</sup>), nonetheless told the Senate Judiciary Committee:

[An] approach, which I favor and which is followed by some other physicians, is to induce fetal death on the first or second day of treatment of the cervix. This requires an injection of a medication into the fetus under (usually) ultrasound guidance. This is the procedure which I and one or two other physicians follow. It is accompanied by other forms of treatment, but these vary according to the physician. In the case of a breech presentation of a dead fetus, the procedure described by sponsors of [the 1995 bill]<sup>360</sup> is routinely followed.<sup>361</sup>

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357. See *supra* notes 240-88 and accompanying text.

358. See *supra* note 269 and accompanying text.

359. See *Senate Hearing, supra* note 23, at 246 (statement of Warren M. Hern, M.D.).

360. See *supra* notes 50-52 and accompanying text (referring to the insertion of a suction device into the skull and evacuation of its contents).

Dr. Hern's approach may turn out to be the better norm for defining the medical standard of care, whatever surgical technique the physician plans for the actual abortion. However, only the medical community can decide this.<sup>362</sup> So long as the issue of fetal pain is as debatable as is currently the case, it lacks the factual foundation necessary to serve as a legitimate state interest justifying legal restrictions on the surgical technique of a physician trying to perform an abortion at twenty to twenty-four weeks' gestation in a manner that will best preserve the health interests of the woman (including her future fertility). That would be to require the "trade-off" between maternal health and potential life so frequently invalidated by the Court.<sup>363</sup>

With respect to the second medical question—whether the use of the D&X or intact D&E procedure (or a variation thereof) actually is at times the best technique for preserving the woman's health and future fertility—the claimed medical advantages have already been briefly reviewed,<sup>364</sup> as has the conflicting evidence presented to the trial court in *Voinovich*, along with that factfinder's eventual conclusion that "the D & X procedure appears to have the potential of being a safer procedure than all other available abortion procedures."<sup>365</sup> It remains the case, however, that the opinions of the medical professionals who have come forward to date are just as sharply divided on the maternal health issue as on that of

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361. *Senate Hearing*, *supra* note 23, at 247 (statement of Warren M. Hern, M.D.).

362. *See infra* notes 397-402 and accompanying text (discussing the concept of the "medical standard of care" and the fact that its definition, even for legal purposes, must necessarily come from the medical community). Militating against this possibility, Judge Rosen in *Evans v. Kelley* noted the high level of expertise (not possessed by many physicians in the country) required to administer such an injection. *See Evans v. Kelley*, 977 F. Supp. 1283, 1301 (E.D. Mich. 1997). He further found:

With the injection comes increased risk of hemorrhage, infection, and even uterine necrosis. There is also the risk of missing the fetus and hitting instead the mother's bowel or a blood vessel, thereby increasing the risk of life-threatening infection or internal bleeding. Indeed, Dr. Johnson [the court's appointed expert witness] opined that where there is no independent medical reason to attempt to ensure fetal demise by injection, "the risks are not justified medically."

*Id.* at 1318. Judge Rosen therefore concluded that "attempting to ensure fetal demise . . . would operate as an additional undue burden because it would impose additional medical risks on women seeking abortions." *Id.*; *see also Carhart v. Stenberg*, 972 F. Supp. 507, 514-15 (D. Neb. 1997) (noting difficulties of the injection procedure and the fact that the woman's medical condition may preclude the use of any injected substance).

363. *See supra* notes 294-301 and accompanying text.

364. *See supra* notes 58-64 and accompanying text.

365. *Women's Med. Prof'l Corp. v. Voinovich*, 911 F. Supp. 1051, 1070 (S.D. Ohio 1995), *aff'd*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 1998 WL 124649 (U.S. Mar. 23, 1998) (No. 97-934); *see also Carhart*, 972 F. Supp. at 524-27 (detailing the advantages of the new procedure).

fetal pain. Once again, their opinions are often difficult to assess, because they are obviously linked to the respective physicians' views on the moral questions inherent in any discussion of abortion.

Thus, Pamela Smith, M.D., Director of Medical Education at Mt. Sinai Hospital in Chicago, and also President-Elect of the American Association of Pro-life Obstetricians and Gynecologists, did not actually address the maternal health question head-on, but told the House Judiciary Subcommittee on the Constitution:

I have practiced obstetrics and gynecology for 15 years. I work with many indigent women. I have never encountered a case in which it would be necessary to deliberately kill the fetus in this manner in order to save the life of the mother. There are cases in which some acute emergency occurs during the second half of the pregnancy that makes it necessary to get the baby out fast—even if the baby is too premature to survive. This would include, for example, HELLP syndrome, a severe form of pre-eclampsia that can develop quite suddenly. But no doctor would employ the partial-birth method of abortion, which—as Dr. Haskell carefully describes—takes three days!<sup>366</sup>

Dr. Smith also expressed her personal opinion with respect to D&E (the dismemberment technique used predominantly from weeks thirteen through nineteen or twenty):<sup>367</sup> "It is cruel and violent, but is quite distinct in some important respects from the partial-birth method."<sup>368</sup> She later added:

Today, partial-birth abortions are being heralded by some as safer alternatives to D&E. But "advances" in this type of technology do not solve the problem . . . they only compound it. In part because of its similarity to obstetrical techniques that are designed to save a baby's life and not to destroy it, this procedure produces a moral dilemma that is even more acute than that encountered in dismemberment techniques. The baby is literally inches from being declared a legal person by every state in the union. The urgency and seriousness of these matters therefore require appropriate legislative action.<sup>369</sup>

On the other hand, Dru Elaine Carlson, M.D., Director of Reproductive Genetics and a perinatologist and geneticist at Cedars-Sinai Medical

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366. *House Hearing*, *supra* note 23, at 44 (prepared statement of Pamela Smith, M.D.); *see also supra* notes 158-60 and accompanying text (concerning Dr. Smith's testimony, generally).

367. *See supra* notes 158-60 and accompanying text.

368. *House Hearing*, *supra* note 23, at 42 (statement of Pamela Smith, M.D.). According to her testimony, Dr. Smith was specifically countering a point in a letter from the National Abortion Federation dated June 12, 1995, maintaining that D&E and the procedure at issue were not surgically different. *See id.* Note that her characterization of D&E supports the notion that any restriction enacted in the interest of preventing unnecessary fetal pain would have to apply to *all* late term abortion techniques, not just D&X. *See id.* at 41-42.

369. *Id.* at 44.

Center in Los Angeles, expressed an entirely different view in a letter to Congresswoman Patricia Schroeder, which is appended to the Dissenting Views that became part of the House Report. Speaking of Dr. James McMahon's intact D&E procedure, she stated:

One concept that seems to be lost on the general public is that these pregnancies can have a significant health risk to the mother. Often fetuses that have physical abnormalities will have increased amniotic fluid that can cause uterine atony and severe maternal bleeding at birth. Fetuses that have fluid in their lungs and bodies can cause mothers to experience the "mirror syndrome," where they themselves become bloated and dangerously hypertensive. Abnormal fetuses often require operative deliveries, and this puts the mother at increased risk of infection and death. The usual type of termination of pregnancy is a traumatic stretching of the cervix that then increases a woman's chance for infertility in the future. The procedure that is up for "banning" allows very passive dilatation of the cervix and allows gentle manipulation to preserve the very much desired fertility of these distraught women. To put it mildly, this is not just a "fetal issue," it is a health care issue for the mother as well.<sup>370</sup>

The Senate Judiciary Committee also heard witnesses of diametrically opposing views on the question of the relationship between maternal health interests and the use of D&X. Dr. Pamela Smith offered basically the same testimony she had presented to the House Subcommittee hearing.<sup>371</sup> Her opinion was substantiated by that of Nancy Romer, M.D., also a board-certified obstetrician/gynecologist, and a fellow of ACOG.<sup>372</sup> Dr. Romer practices in Dayton, Ohio, where Dr. Haskell operates an abortion clinic.<sup>373</sup> Dr. Romer testified that "I have never had a patient who required the partial-birth abortion procedure for maternal illness or fetal malformations."<sup>374</sup> She also stated that "[o]ur hospital . . . [has] found alternatives that we feel have been proven to be efficacious and safe."<sup>375</sup> Dr. Romer went on to criticize Dr. Haskell for performing delicate procedures at risky stages of pregnancy in outpatient facilities and told the Subcommittee, "[w]ithout this legislation, we are protecting a procedure whose safety and efficacy are highly suspect."<sup>376</sup>

On the other hand, Dr. Mary Campbell, Medical Director of Planned Parenthood of Metropolitan Washington and a board-certified obstetri-

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370. H.R. REP. NO. 104-267, at 31 (1995).

371. See *Senate Hearing*, *supra* note 23, at 75-79 (statement of Pamela Smith, M.D.); *id.* at 79-83 (prepared statement of Pamela Smith, M.D.).

372. See *id.* at 109 (statement of Nancy Romer).

373. See *id.*

374. *Id.*

375. *Id.*

376. *Id.* at 110.



cian/gynecologist who had spent time observing at Dr. James McMahon's clinic, told the Senate Committee that "[b]ecause the fetal head is decompressed, only two-thirds of the dilation necessary for spontaneous vaginal delivery is necessary for intact D&E. This markedly decreases the chance of cervical lacerations during the procedure and cervical incompetence in future pregnancies."<sup>377</sup> She concluded by stating that she opposed the bill for three medically-based reasons: (1) vagueness; (2) the consequent chilling effect on a woman's right to have an abortion; and (3) "[t]his bill outlaws the safest way of ending a third trimester pregnancy . . . safer than induction, far safer than hysterotomy."<sup>378</sup>

As was true with the fetal pain issue, perhaps the most objective and expert testimony in the congressional hearings on the issue of maternal health came from Dr. Warren Hern, who does not use the D&X or intact D&E procedure himself but who was familiar with the technique, particularly the work of Dr. James McMahon.<sup>379</sup> Dr. Hern told the Senate Committee:

The possible advantages of Intact D & E procedure include a reduction of the risk of perforation of the uterus. Since most women seeking abortions are young women who hope to reproduce in the future, having a safe abortion technique for late abortion is of paramount importance, aside from the prevention of complications.

Another advantage of the Intact D & E is that it eliminates the risk of embolism of cerebral tissue into the woman's blood stream. This catastrophe can be almost immediately fatal.<sup>380</sup>

Thus, currently available medical evidence on the issue of maternal health is inconclusive, yet at least some relevant data suggest the possibility that D&X or intact D&E may actually represent an improvement over older late term abortion techniques. If that is the case, to prohibit use of the new procedure would violate the constitutionally protected prohibition against forcing a "trade-off" between the woman's health interests and the state's interest in potential life. Therefore, like the fetal pain question, the maternal health debate also fails to provide the factual foundation necessary for restricting a woman's right of access to this particular abortion method, if she and her physician should determine that it

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377. *Id.* at 101 (statement of Dr. Mary Campbell); *see also id.* at 102 (prepared statement of Dr. Mary Campbell). Dr. Campbell defined "cervical incompetence" as referring to "a cervix so weakened by trauma that it opens too early in [subsequent] pregnancy." *Id.*

378. *Id.* at 101, 103; *see also supra* notes 33, 160-61 and accompanying text (concerning the testimony of Dr. Mary Campbell).

379. *See Senate Hearing, supra* note 23, at 245 (statement of Warren M. Hern, M.D.).

380. *Id.* at 248 (statement of Warren M. Hern, M.D.).

is the best procedure for preserving her physical, emotional, and psychological health.

### *B. With Respect to Legislative Intervention*

In addition to their professional evaluations of the specific procedure at issue, many members of the medical community have also spoken out on the appropriateness of this particular kind of legislative intervention into the exercise of their professional judgment. While it is easy to dismiss their protests on the grounds that no one, after all, likes to be regulated, and furthermore, that the medical profession has long been regulated—often over its registered protest—others have joined them in this instance, recognizing that this is a different kind of regulation from any others enacted to date. While other laws have, for example, established mechanisms for licensing members of the medical profession, for disciplinary procedures, for the prevention of fraud on the part of medical professionals, or to provide guidelines as to how the public fisc shall be expended for medical care,<sup>381</sup> the law has not heretofore attempted to tell qualified physicians what surgical procedures they may or may not engage in for the purpose of achieving valid medical objectives (in this case, abortions that would definitely be legal if carried out in any other established manner comporting with the medical standard of care—a standard traditionally defined by the medical profession<sup>382</sup>).

Thus, Dr. J. Courtland Robinson, of the Johns Hopkins University School of Medicine, stated at the congressional hearings:

When a woman is faced with a need to terminate a pregnancy, the physician has a number of different techniques available in selecting according to the total medical situation: hypertonic glucose, saline, urea, suction D&C, suction D&E. We have used different techniques over the years in our practice. As in all of medicine, we develop and select techniques which are most appropriate, study the long-term impacts, and determine which is safer. The physician needs to be able to decide, in consultation with the patient and based upon her specific physical and emotional needs, what is the appropriate method. The practice of medicine by committee or legislature is not good for patients or for medicine in general.<sup>383</sup>

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381. See *supra* notes 26-30 and accompanying text.

382. See *Senate Hearing, supra* note 23, at 14 (statement of Sen. Kennedy) (stating that "[t]he Senate should oppose this bill because its enactment would be the first time in American history that Congress has outlawed a specific medical procedure"); H.R. REP. NO. 104-267, at 22 (1995) (Dis-senting Views) ("There is no other example in Federal law of Congress prescribing which of a series of valid medical procedures a licensed doctor may or may not undertake."); see also *supra* note 97 and accompanying text.

383. *Senate Hearing, supra* note 23, at 103-04 (statement of J. Courtland Robinson, M.D.); see also *id.* at 105-06 (prepared statement of J. Courtland Robinson, M.D.).

Similarly, Dr. Warren Hern emphasized the importance of according physicians the right to make professional judgments based on their expertise, particularly in on-the-spot situations:

While I may choose a different method of performing a late abortion, I support the right of my medical colleagues to use whatever methods they deem appropriate to protect the woman's safety during this difficult procedure. It is simply not possible for others to second guess the surgeon's judgment in the operating room. That would be dangerous and unacceptable.<sup>384</sup>

Later, after describing three particularly harrowing situations in which he had to act quickly to perform abortions in order to save the women's lives,<sup>385</sup> Dr. Hern stated even more dramatically: "Mr. Chairman, I did not have time with any of these cases to consult the United States Senate on the proper method of performing the abortions."<sup>386</sup> In a similar vein, ACOG reacted to H.R. 1122 with a policy statement that summarizes a number of the points made in this article:

Terminating a pregnancy is performed in some circumstances to save the life or preserve the health of the mother. Intact D & X is one of the methods available in some of these situations. A select panel convened by ACOG could identify no circumstances under which this procedure . . . would be the *only* option to save the life or preserve the health of the woman. An intact D & X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based upon the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D & X, may outlaw techniques that are critical to the lives and health of American women. The intervention of legislative bodies into medical decision making is inappropriate, ill advised, and dangerous.<sup>387</sup>

The medical opinions cited have been buttressed by some of the policymakers involved in the congressional hearings, although obviously not by a majority. For example, in the 1995 House Subcommittee hearing on H.R. 1833 ("The Partial-Birth Abortion Ban Act of 1995"), the Hon. Sheila Jackson Lee expressed her view that "[t]o criminalize a physician for concluding a surgical procedure in the way he or she deems to be safest for the patient—the woman—is tantamount to legislating malpractice."<sup>388</sup> The fourteen representatives who joined in the Dissenting Views

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384. *Id.* at 248 (statement of Warren M. Hern, M.D., M.P.H., Ph.D.).

385. *See id.* at 249-52.

386. *Id.* at 252.

387. ACOG, *Statement on Intact D&X*, *supra* note 8, at 2.

388. *House Hearing*, *supra* note 23, at 103 (Appendix 1) (Statement of Hon. Sheila Jackson Lee).

to the House Report stated as follows:

The legislation outlaws a valid medical procedure used when other methods of late term abortion may be more dangerous to the health or life of the woman who has decided to undergo an abortion. There is no other example in Federal law of Congress prescribing which of a series of valid medical procedures a licensed doctor may or may not undertake. It is inappropriate for Members to substitute their judgment for the professional opinion of doctors, and we oppose the effort to do it. The decision to perform one form of abortion over another is a difficult one, often made during a complicated, premature labor, which requires expert, professional judgment of a doctor. This legislation indefensibly interferes with the medical judgment of licensed doctors.<sup>389</sup>

These policymakers express legitimate concerns that should be weighed carefully before any legislature, on any level, attempts to address questions with respect to appropriate medical procedures for specific medical situations.

Does this mean that medical practitioners should be left free to perform potentially dangerous and insufficiently proven procedures on unsuspecting patients whose lives and health could thereby be negatively affected? Of course not. Nor does it mean that the legal system has no part to play in safeguarding patients' interests. Rather, the contention here is that effective mechanisms for dealing with the appropriateness of any given non-experimental medical procedure, such as D&X,<sup>390</sup> are already in place, and further, that those mechanisms are sufficient to protect patients whose physicians might recommend or perform that particular procedure.

## VI. ALTERNATIVES FOR APPROPRIATE REGULATION: SELF-POLICING AND THE TORT SYSTEM

Despite the many federal and state laws which have some bearing on the medical profession,<sup>391</sup> basic governance of the practice of medicine, like that of other professions, has been self-governance.<sup>392</sup> Thus, licensing requirements are established by state law, but implementation—including both access to entry and disciplinary actions—is left to

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389. H.R. REP. NO. 104-267, at 22 (1995); *cf. Senate Hearing, supra* note 23, at 14; *see also supra* note 382.

390. No contention has been made in any of the materials examined here that D&X is an experimental technique and thus should be subjected to any regulations involving experimental procedures.

391. *See supra* notes 26-30 and accompanying text.

392. *See generally* 1 FURROW ET AL., *supra* note 13, § 3-1, at 86 (discussing licensing requirements for the health professions). The section also discusses arguments *contra* this position. *See id.*

"boards dominated by the regulated professions."<sup>393</sup> Credentialing for staff hospital privileges and disciplinary actions taken with regard to those already on staff constitute other forms of peer control that physicians exercise over each other.<sup>394</sup>

To licensing and credentialing procedures for hospital staff may now be added review for admission as providers to managed care systems.<sup>395</sup> Again, there is an interplay between law, which provides the framework for the systems of evaluation, and physician-administered peer review, which provides the evaluations themselves of whether accepted medical practice standards have been met. Thus, both federally qualified and state regulated health maintenance organizations generally "must establish ongoing internal quality assurance programs, including procedures for problem identification, corrective action, and interpretation and analysis of patterns of care rendered to individual patients by individual providers."<sup>396</sup>

The leading treatise on health law states the traditional justification for the extensive degree of self-policing among doctors: "Allocation of substantial power to the medical professions furthers the public interest, it is argued, because the lay public is incapable of adequately evaluating the quality of medical services."<sup>397</sup> Although some commentators have taken issue with this hypothesis,<sup>398</sup> the general policy of physician self-policing remains the norm.<sup>399</sup>

Added to the licensing and peer review systems is the tort system itself, provided by the law. A patient whose physician (or other health care professional) has breached the duty of meeting the medical standard of care in the provision of health care services is entitled to a civil recovery, when that breach has resulted in compensable damages to the patient.<sup>400</sup> The medical standard of care consists of that degree of care that a reasonable physician (or other health care professional) would have

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393. *Id.* § 3-1, at 85.

394. *See id.* § 3-1, at 86.

395. *See, e.g.,* 2 FURROW ET AL., *supra* note 13, § 11-11, at 53-60 (discussing regulation of health maintenance organizations).

396. *Id.* § 11-11, at 56; *see also id.* § 11-12, at 60 (noting that preferred provider programs also frequently include quality assurance programs); *id.* § 8-3 (noting that managed care organizations are increasingly held liable for the malpractice of their physicians, on the grounds of failure to select medical staff properly or to provide continuing supervision and control of medical staff).

397. 1 FURROW ET AL., *supra* note 13, § 3-1, at 86.

398. *See id.*

399. *See generally id.* § 6-2.

400. *See id.*

provided under the circumstances.<sup>401</sup> As noted earlier, this standard of care can only be defined by medical professionals themselves; hence, expert witnesses are routinely necessary in the trial of a medical malpractice case.<sup>402</sup> When this fact is added to the mechanisms of licensure and peer review, the clear picture that emerges is that the law, traditionally and still today, depends upon the medical profession itself to determine those situations in which a health care provider has overstepped legal bounds in providing medical care and should suffer appropriate legal consequences. This is certainly true of actual medical procedures, particularly surgical procedures.

Why should the situation be any different with respect to the abortion procedure known as D&X or intact D&E? Unlike the case with most instances of medical decision making, the right of a woman to decide to have an abortion of a nonviable fetus is a constitutionally protected right.<sup>403</sup> Her right to have an abortion of even a viable fetus is also constitutionally protected, if the abortion is necessary to preserve her life or health.<sup>404</sup> One would think, then, that legislatures should be especially chary about stepping in to tell physicians how to perform this particular kind of medical treatment. At the very least, there should be clear evidence of failure on the part of the usual means of protecting society from questionable medical practices before any legislature, federal or state, would attempt to tell physicians how they must (or must not) behave with respect to the performance of an otherwise legal abortion.

Yet where is this evidence? It appears to be altogether lacking. All the research that forms the basis for this article failed to yield a single example of a malpractice suit brought against a physician because of an adverse patient outcome following performance of an abortion using the method of D&X or intact D&E. On the contrary, there were many heartfelt statements of gratitude and relief by women who had undergone the procedure.<sup>405</sup>

To those who would counter that it is not the women but the fetuses whose welfare is primarily harmed by this procedure, the answer must be that no regulation may require a "trade-off" between the woman's health interests and the state's interest in potential life. So far, there is no factual foundation to justify prohibiting any particular abortion procedure

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401. See *supra* note 32 and accompanying text.

402. See *supra* note 32 and accompanying text.

403. See *supra* notes 207-11 and accompanying text.

404. See *supra* notes 195-206 and accompanying text.

405. See *supra* notes 62, 64, 83-92 and accompanying text.

based on the state's interest in preventing unnecessary fetal pain. If that foundation can ever be established, surely any resulting regulation would have to address the fetal pain issue as it might arise in relation to any abortion technique (including the now routine dismemberment technique of D&E), not just D&X.<sup>406</sup>

Others may point out that the normal peer review mechanisms cannot always be counted on here, because a physician working at an abortion clinic does not necessarily need, and may not have, staff privileges at any hospital. Such is, in fact, the case with Dr. Martin Haskell, the developer of D&X.<sup>407</sup> Furthermore, a physician whose sole work is in an abortion clinic may not be a member of any managed care organization—although that would not universally be the case. Dr. Haskell testified at the *Voinovich* trial that "[r]oughly twenty five percent of patients have insurance to cover the procedure."<sup>408</sup> Thus, although Medicare covers no abortions, and Medicaid does not cover abortions in many states (including Ohio<sup>409</sup>), some health insurance plans—and therefore, presumably, some managed care plans—do.<sup>410</sup> One would expect this to be particularly true of medically necessary or therapeutic abortions, which would characterize a significant percentage of D&X procedures, including those performed on the women who testified at the congressional hearings and those who stood with President Clinton when he announced his veto of the 1995 federal bill.<sup>411</sup>

It may be, then, that the usual credentialing systems would not apply to a given physician whose practice was confined to work in an abortion clinic; there may be no one "looking over his or her shoulder," so to speak. Yet, there remains the licensing system. State medical boards are empowered not only to license medical professionals and to take dis-

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406. For example, Dr. Hern's practice of a lethal injection to the fetus prior to the abortion might even become part of the medically defined standard of care, if fetal pain should be scientifically established. See *supra* notes 283-88 and accompanying text. But note also the degree of expertise involved, and the necessity of using ultrasound to guide the physician's injection. See *supra* notes 283-88 and accompanying text.

407. See *Senate Hearing, supra* note 23, at 45 (containing portions of the trial transcript introduced into the record by Sen. Orrin G. Hatch, Chairman of the Senate Judiciary Committee). In addition to being asked whether he had staff privileges at any hospital (the answer to which was, "No, [I do] not"), Dr. Haskell was also questioned about his board certification. See *id.* at 31, 45. He responded that he was at one time certified in family practice, but did not re-certify. See *id.* at 32.

408. *Senate Hearing, supra* note 23, at 43 (transcript of the *Voinovich* trial, cross-examination of Martin Haskell, M.D.).

409. See *id.*

410. See *id.*

411. See *supra* notes 79-94 and accompanying text.

ciplinary action against them (including suspension, revocation, probation, reprimand, or other kind of censure), but also to set standards by which to evaluate their conduct, in terms of appropriate medical care and patient safety.<sup>412</sup> Certainly, the medical board in Ohio knows what Dr. Martin Haskell is doing and could take steps to curtail his activities, if board members thought them medically unacceptable. While other physicians may be more circumspect in publicizing their abortion methods, any method of self-policing—or, for that matter, any policing of behavior at all—rests on the notion that those who are not obeying valid rules will be found out and subjected to appropriate consequences. Yet, the research upon which this article is based disclosed no instance of disciplinary action taken against a physician by a state medical board based upon an evaluation that the physician's performance of D&X or intact D&E violated the norms of medically acceptable conduct. Thus, while there is clearly disagreement among members of the medical profession about this procedure, there appears to be no consensus among responsible physicians that the practice should be stopped. Under these circumstances, legislation that would achieve that effect seems particularly foundationless and ill-advised.

## VII. CONCLUSION

Abortion, particularly late term abortion, is never a pretty process. In the section of his text, *Abortion Practice*, dealing with "Second-Trimester Abortion," Dr. Warren Hern points to D&E as "an emotionally stressful experience"<sup>413</sup> for those who participate in providing the procedure and makes the following observation:

It is of utmost importance to keep in mind the advantages that the procedure offers for patients and that the professional responsibilities of genuinely helping other people with difficult problems are frequently stressful. Those providing D & E procedures must be keenly aware of their level of commitment to the availability of choice for women in this stage of pregnancy. A strong commitment is as important here as is excellence in surgical technique.<sup>414</sup>

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412. See, e.g., VA. CODE ANN. § 54.1-2912.1 (Michie Supp. 1997) (empowering the State Board of Medicine to "prescribe by regulation such requirements as may be necessary to ensure continued practitioner competence," and providing further that "[i]n promulgating such regulations, the Board shall consider (i) the need to promote ethical practice, (ii) an appropriate standard of care, (iii) patient safety, (iv) application of new medical technology, (v) appropriate communication with patients, and (vi) knowledge of the changing health care systems"); see also *id.* § 54.1-2915 (authorizing disciplinary actions). See generally 1 FURROW ET AL., *supra* note 13, § 3-1.

413. HERN, *supra* note 46, at 134.

414. *Id.* at 134-35.



The same is surely true of any abortion procedure at this or a later stage of pregnancy and must be especially true of D&X. In fact, it is the shock value of the physical description of the procedure upon which its opponents often seem to rely in garnering support for their position.<sup>415</sup> Yet, the dismemberment techniques of D&E are certainly just as shocking, at least to this writer.

In resolving what has become a highly emotional debate over the D&X procedure (a debate that has rekindled the larger social policy debate over abortion itself), we must not lose sight of the constitutional protection accorded to women choosing abortion—certainly where the fetus is nonviable, but even, under appropriate conditions, where the stage of viability has been reached. A review of relevant Supreme Court precedent shows these laws to be unconstitutional in some respects: in their failure to provide an exception to their terms where the health of the woman (not just her life) may be endangered; and in the vagueness of their language, especially where no scienter requirement has been included in the criminal statute. Beyond those two specific points, these legislative

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415. See, e.g., *Senate Hearing, supra* note 23, at 116 (prepared statement of Helen M. Alvare, Esq.) ("Call it natural law, call it human instinct, or call it a basic sense of fairness, the partial-birth abortion violates everything that is good, everything held dear in the human person and the human community. When a practitioner uses a sharp scissor to stab a hole in a baby's skull and vacuum out its brains, and calls it a 'medical procedure,' words have lost their meaning."); *House Hearing, supra* note 23, at 4 (letter of Canady and Vucanovich):

This type of abortion, performed in the second and third trimester of pregnancy, is particularly brutal and inhuman because the baby is delivered except for the head before the abortionist kills the baby. . . .

During the partial-birth procedure, the abortionist uses forceps to pull a living baby feet-first through the birth canal until the baby's body is exposed, leaving only the head just within the uterus. The abortionist then forces surgical scissors into the base of the baby's skull creating an incision through which he inserts a suction tube to evacuate the brain tissue from the baby's skull. The evacuation of this tissue causes the skull to collapse, allowing the baby's head to be pulled from the birth canal.

*Id.*; Gianelli, *supra* note 33, at 3 ("By depicting a procedure expected to make most readers squeamish, campaign sponsors hope to convince voters and elected officials that a proposed federal abortion-rights bill is so extreme that states would have no authority to limit abortions—even on potentially viable fetuses."); Barbara Vobejda & David Brown, *Harsh Details Shift Tenor of Abortion Fight; Both Sides Bend Facts On Late-Term Procedure*, WASH. POST, Sept. 17, 1996, at A1 (referring to Haskell's paper describing the procedure):

It provided what abortion foes had long believed was crucial in turning public opinion their way: a graphic description of one type of abortion they felt would offend many, perhaps most, Americans. . . .

The activists believed that publicizing the details of the procedure would fuel a national debate, pull many abortion rights liberals to their side and prompt Congress for the first time to ban a specific abortion procedure.

They were right.

*Id.*

prohibitions are highly constitutionally suspect under both the purpose and effect prongs of the "undue burden" standard enunciated by the Supreme Court in *Casey*.

Even if the constitutional defects could be remedied, strong social policy considerations militate heavily against legislative intervention into a medical judgment call about the appropriate surgical technique to use in performing an otherwise legal abortion. If D&X turns out to be "bad medicine" in the eyes of the medical profession, the procedures for its regulation are already in place—peer review mechanisms, state medical board licensing decisions, and the medical malpractice system. Unless and until these procedures prove unequal to their task of protecting patient welfare while ensuring responsible and ethical medical decision making, it is constitutionally questionable and represents unsound social policy for Congress to define an "accepted medical procedure." That standard can come only from the medical community, and in this respect, abortion is no different from any other medical procedure.