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## Overcoming Barriers to the Protection of Viable Fetuses

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# Overcoming Barriers to the Protection of Viable Fetuses

Randy Beck\*

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## *I. Introduction*

The Supreme Court’s abortion jurisprudence has recognized a compelling state interest in preserving the lives of viable fetuses.<sup>1</sup> When acting to protect a “viable” fetus—one “potentially able to live outside the mother’s womb, albeit with artificial

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\* Justice Thomas O. Marshall Chair of Constitutional Law, University of Georgia School of Law. I would like to thank the other participants in this conference and the editors of the Washington and Lee Law Review for their helpful comments on my Article. Thank you as well to Raqketa Williams for her research assistance. I join the editors in mourning the tragic loss of Lara Gass, a gracious and remarkable young woman who played a central role in organizing the conference and making the participants feel welcome.

1. See *Roe v. Wade*, 410 U.S. 113, 163 (1973) (“With respect to the State’s important and legitimate interest in potential life, the ‘compelling’ point is at viability.”).

aid”<sup>2</sup>—the state “may go so far as to proscribe abortion . . . except when it is necessary to preserve the life or health of the mother.”<sup>3</sup> Allowing relatively unrestricted abortion until fetal viability represents an extremely broad recognition of abortion rights by international standards.<sup>4</sup> Only a handful of countries join the United States in permitting abortion for any reason until fetal viability or beyond.<sup>5</sup> As Justice Blackmun recognized in a memorandum to Justice Powell, “[b]y that time [viability], the state’s interest [in protecting fetal life] has grown large indeed.”<sup>6</sup>

In prior articles, I have critiqued the Court’s failure to offer a plausible constitutional or moral justification for treating viability as the earliest point at which a state may significantly limit abortions.<sup>7</sup> Viability varies from one fetus to the next based on factors that should be legally and morally irrelevant, including the progress and availability of neonatal treatment techniques, the race and gender of the fetus, the mother’s altitude during gestation, and whether the mother smokes during pregnancy.<sup>8</sup> It

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2. *Id.* at 160.

3. *Id.* at 163–64.

4. See Randy Beck, *State Interests and the Duration of Abortion Rights*, 44 MCGEORGE L. REV. 31, 40–41 (2013) [hereinafter Beck, *State Interests*] (showing that the viability rule is extreme when compared to abortion laws of other countries).

5. See *id.* (noting that most countries require a “legally permissible reason” for seeking an abortion or only recognize the right to abort within the first twelve weeks of pregnancy (citing Randy Beck, Gonzales, Casey and the Viability Rule, 103 NW. U. L. REV. 249, 264 (2009))).

6. See Randy Beck, *Self-Conscious Dicta: The Origins of Roe v. Wade’s Trimester Framework*, 51 AM. J. LEGAL HIST. 505, 523 (2011) [hereinafter Beck, *Self-Conscious Dicta*] (discussing private correspondence between Justices Powell and Blackmun, in which Blackmun indicated his lack of commitment to the point marking the end of the first trimester versus another point, such as viability).

7. See, e.g., Randy Beck, Gonzales, Casey, and the Viability Rule, 103 NW. U. L. REV. 249, 271–76 (2009) [hereinafter Beck, Gonzales, Casey and the Viability Rule] (noting that the Roe Court failed to provide a constitutional principle to support its conclusion that a state may only prohibit abortions of viable fetuses and considering whether this omission was rectified in Casey); Randy Beck, *Transtemporal Separation of Powers in the Law of Precedent*, 87 NOTRE DAME L. REV. 1405, 1462–63 (2012) (discussing scholars’ analysis of the Roe Court’s lack of constitutional justification).

8. See Beck, *State Interests*, *supra* note 4, at 37–40 (explaining the various factors physicians often consider when determining viability of a fetus, but noting that viability is arbitrary because many of these factors are “morally and

therefore seems difficult to explain why the state's interest in protecting fetal life would become significantly greater after the fetus crosses the viability threshold than before.<sup>9</sup> Nor does fetal viability reduce the burden of pregnancy on the mother.<sup>10</sup>

Setting those questions to the side, however, I start this Article from the premise that the Court was correct in *Roe v. Wade*<sup>11</sup> concerning the significance of fetal viability. I assume for the sake of argument that viability is a momentous point in pregnancy and that "logical and biological justifications" support a compelling state interest in protecting the lives of fetuses that have crossed the viability threshold.<sup>12</sup> The goal of this Article is to highlight factors that individually and in concert significantly hinder legislative attempts to preserve the lives of viable fetuses, and to identify measures that, if permitted by the courts, could facilitate the pursuit of this state interest.

Part II of the Article argues that Supreme Court case law virtually guarantees that some viable fetuses will be aborted even though they could in fact survive outside the womb with proper care. The Court has required some level of deference to debatable viability predictions made by treating physicians, even if those predictions may be unduly pessimistic about the prospects for fetal survival.<sup>13</sup> Part III notes that most abortions take place in private facilities operated by abortion providers, making it difficult to monitor the provider's compliance with a state law prohibiting postviability abortions.<sup>14</sup> By way of illustration, I consider the investigation and prosecution of Philadelphia's Dr. Kermit Gosnell, which disclosed a number of techniques Gosnell employed to cover up the deaths of hundreds of viable fetuses and

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constitutionally irrelevant").

9. *See id.* at 40 (critiquing the Court's selection of viability as the controlling line because crossing the viability threshold does not increase a state's interest in protecting human life).

10. *See id.* (explaining that viable fetuses impose no less of a burden on the mother than pre-viable fetuses).

11. 410 U.S. 113 (1973).

12. *Id.* at 163.

13. *See infra* note 46 (explaining *Roe v. Wade*'s deference to medical judgment); *infra* notes 59–61 and accompanying text (discussing the uncertainty of determining fetal viability, which causes disagreement among physicians).

14. *Infra* Part III.

newborn infants over an extended period.<sup>15</sup> Part IV points out that Dr. Gosnell's violations of Pennsylvania law were facilitated by the unwillingness of public officials to provide oversight and ensure regulatory compliance, notwithstanding numerous reports of serious problems at Gosnell's clinic.<sup>16</sup> Part V suggests that the Supreme Court could facilitate state protection of viable fetuses by allowing prohibition of elective abortions at a time shortly before viability, such as twenty weeks gestation, a line that would be easier to enforce than viability itself.<sup>17</sup> Additional protection could be afforded to viable fetuses by allowing states to require hospitalization at some point in the second trimester, so that abortions near the viability threshold would take place in an environment that was both safer and less isolated from the broader medical community.

## *II. The Requirement of Deference to Abortion Providers Virtually Ensures the Abortion of Some Viable Fetuses*

The Supreme Court has attributed considerable significance to the point in pregnancy described as "viability," treating the fetus potentially able to live outside the womb as categorically distinct from the same fetus a few weeks or a few days before viability.<sup>18</sup> At the same time, the importance of viability in the Supreme Court's case law has diminished over the years.<sup>19</sup> Dicta in *Roe*—part of the opinion's "trimester framework"—identified viability as the earliest point at which a state's interest in fetal life becomes "compelling," justifying a prohibition on abortion.<sup>20</sup>

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15. See *infra* note 89 and accompanying text (discussing the prosecution of Dr. Kermit Gosnell).

16. *Infra* Part IV.

17. *Infra* Part V.

18. See *Roe v. Wade*, 410 U.S. 113, 163 (1973) (concluding that the "compelling point" for a state's interest in protecting potential life is at viability).

19. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878–79 (1992) (rejecting *Roe*'s "trimester framework" and stressing the state's "profound interest in protecting potential life").

20. See *Roe*, 410 U.S. at 163–64 ("With respect to the State's important and legitimate interest in potential life, the 'compelling' point is at viability . . . . [The State] may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother."); Beck, *Self-*

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*,<sup>21</sup> the controlling plurality opinion rejected *Roe*'s trimester framework and concluded that states could legislate to protect fetal life from the outset of pregnancy, so long as the regulation did not place an "undue burden" on abortion rights.<sup>22</sup> However, the *Casey* plurality, again in dicta, deferred to *Roe*'s conclusion that abortion may only be proscribed after fetal viability.<sup>23</sup> More recently, in *Gonzales v. Carhart*,<sup>24</sup> the Court upheld a ban on the intact dilation and evacuation abortion technique, even prior to viability,<sup>25</sup> notwithstanding the dissent's claim that the majority had "blur[red] the line, firmly drawn in *Casey*, between previability and postviability abortions."<sup>26</sup>

Forty years after *Roe*, the Court's rationale for selecting viability as a controlling line in pregnancy remains obscure.<sup>27</sup> In neither *Roe* nor *Casey* did the Court offer a plausible moral or constitutional reason for concluding that the state interest in fetal life justifies substantial limits on abortion only after the fetus might be able to survive outside the womb.<sup>28</sup> But notwithstanding the absence of legal or philosophical justification, one might think that the viability rule at least has the virtue of clarity.<sup>29</sup> The *Casey* plurality highlighted this

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*Conscious Dicta*, *supra* note 6, at 516 (noting that evidence from case files shows Justices in the *Roe* majority knew they were creating dicta in drawing a line at viability).

21. 505 U.S. 833 (1992).

22. *See id.* at 878–79 (recognizing the central right of *Roe* but rejecting its "trimester framework," thereby allowing states to impose regulations on abortion services that satisfy an "undue burden" analysis).

23. *See id.* at 879 (reaffirming the conclusion of *Roe* that states may regulate and prohibit abortion after viability).

24. 550 U.S. 124 (2007).

25. *See id.* at 147 (concluding that the Act prohibiting the dilation and evacuation abortion techniques is not void for vagueness, does not impose an undue burden, and is not invalid on its face).

26. *Id.* at 171 (Ginsburg, J., dissenting).

27. *See Beck, Gonzales, Casey, and the Viability Rule*, *supra* note 7, at 279 ("In the post-*Gonzales* world, the task of establishing the legitimacy of the viability rule has become significantly more demanding.")

28. *See id.* at 267–76 (discussing the Supreme Court's failure to justify the viability rule).

29. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 869–70 (1992) (arguing right to abortion should be governed by "a line that is clear" and

rationale in explaining its decision to adhere to viability as a controlling line in pregnancy: “Liberty must not be extinguished for want of a line that is clear.”<sup>30</sup>

In the abstract arena of legal discourse, viability seems to offer a clear conceptual line that distinguishes two classes of fetuses: those that can survive outside the womb and are subject to legal protection, and those that cannot survive outside the womb and may not be effectively protected by the state.<sup>31</sup> Regrettably, though, the seeming clarity of the viability rule evaporates when one understands how viability determinations are made in medical practice. The viability of a fetus is not an objective description of a readily observable set of characteristics.<sup>32</sup> It is instead a medical prognosis, a prediction about what would happen if you removed the fetus from the nurturing environment of the womb and instead employed whatever neonatal treatment techniques were at hand.<sup>33</sup> In *Colautti v. Franklin*,<sup>34</sup> the Supreme Court emphasized “the uncertainty of the viability determination”<sup>35</sup>:

As the record in this case indicates, a physician determines whether or not a fetus is viable after considering a number of variables: the gestational age of the fetus, derived from the reported menstrual history of the woman; fetal weight, based on an inexact estimate of the size and condition of the uterus; the woman’s general health and nutrition; the quality of the available medical facilities; and other factors. Because of the number and the imprecision of these variables, the probability of any particular fetus’ obtaining meaningful life outside the womb can be determined only with difficulty. Moreover, the record indicates that even if agreement may be reached on the

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then drawing the line at viability).

30. *Id.* at 869.

31. *See id.* (explaining the Court’s insistence on “drawing the line” at viability).

32. *See Beck, Gonzales, Casey, and the Viability Rule, supra* note 7, at 257 (explaining that doctors determining viability must predict the likely consequences of premature delivery, often with the assistance of medical research on the survival rates of premature infants).

33. *Id.*

34. 439 U.S. 379 (1979).

35. *See id.* at 395–96 (concluding that the “uncertainty of the viability determination” makes it problematic to impose strict civil or criminal liability against physicians performing abortions near the viability threshold).

probability of survival, different physicians equate viability with different probabilities of survival, and some physicians refuse to equate viability with any numerical probability at all. In the face of these uncertainties, it is not unlikely that experts will disagree over whether a particular fetus in the second trimester has advanced to the stage of viability.<sup>36</sup>

Once it is recognized that viability represents an uncertain medical prediction, it is understandable that doctors might disagree about which fetuses have arrived at that stage of development.<sup>37</sup> In some circumstances, all competent doctors should reach the same conclusion about the viability or nonviability of a particular fetus.<sup>38</sup> In cases nearer to the margin, however, two doctors might reasonably disagree about viability, just as they might disagree about the likely consequences of a particular medical treatment or the length of time a particular patient has to live.<sup>39</sup>

Given that viability determinations are uncertain and debatable, it follows that some of them will almost certainly be wrong.<sup>40</sup> On the one hand, a physician might reach a mistaken conclusion that a fetus can survive outside the womb. If a doctor performs a Caesarian section to deliver what he believes to be a viable fetus, the infant might nevertheless fail to survive, notwithstanding the best efforts of a neonatal intensive care unit. Conversely, a doctor might mistakenly declare nonviable a fetus that could, in reality, survive with proper care. Errors in this direction are less likely to be detected if the viable fetus perishes in the course of an abortion.

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36. *Id.*

37. *See id.* at 396 (“[D]ifferent physicians equate viability with different probabilities of survival . . . .”); Beck, Gonzales, Casey, and the *Viability Rule*, *supra* note 7, at 271 (noting that viability causes disagreement among medical professionals because it involves predictions made on a case-by-case basis using various factors that change over time (citations omitted)).

38. *But see Colautti*, 439 U.S. at 395–96 (explaining the uncertainty of determining viability, which may lead experts to disagree over whether a particular fetus is viable).

39. *See id.* (“[I]t is not unlikely that experts will disagree over whether a particular fetus in the second trimester has advanced to the stage of viability.”).

40. *See Beck, State Interests, supra* note 4, at 37 (noting that different doctors might classify the same fetus as viable or nonviable, due to differences in skill and treatment philosophy) (citing Beck, Gonzales, Casey, and the *Viability Rule, supra* note 7, at 260).



The Supreme Court's abortion jurisprudence seems to clearly support two propositions: (1) by the time a fetus can potentially survive outside the womb, the state has a compelling interest in protecting the life of that fetus;<sup>41</sup> and (2) a doctor may mistakenly classify a viable fetus as nonviable.<sup>42</sup> From those two propositions, it would seem to follow that the state needs a regulatory means to protect viable fetuses against the effects of such medical errors.<sup>43</sup> After all, compelling state interests are interests of the highest magnitude.<sup>44</sup> They are so important that they justify qualification of constitutional rights.<sup>45</sup> If the *Roe* Court was correct about the significance of fetal viability, the state should seemingly have some means by which it can vindicate its compelling interest in protecting a viable fetus at risk of death due to a mistaken medical conclusion that it is not viable.

Contrary to these expectations, the Supreme Court's case law has instead stressed deference to a doctor's potentially mistaken viability determinations, making it difficult for states to protect viable fetuses in cases near the margin. As commentators have noted, *Roe* and its early progeny seem to focus on the interests of doctors as much as their patients,<sup>46</sup> perhaps a result of Justice

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41. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 837 (1992) (reaffirming *Roe*'s conclusion that after viability, a state's interest in protecting potential human life allows it to regulate and proscribe abortion, except where it is necessary to preserve the life or health of the mother (citing *Roe v. Wade*, 410 U.S. 113, 164–65 (1973))); *Roe*, 410 U.S. at 163–64 (concluding that the state's interest in protecting potential life becomes "compelling" at viability).

42. See, e.g., *Colautti v. Franklin*, 439 U.S. 379, 395–96 (1979) (explaining the various and uncertain factors used to predict viability, which may lead to disagreement among professionals).

43. See *infra* Part V (discussing the author's proposed regulations).

44. Cf. *Wisconsin v. Yoder*, 406 U.S. 205, 215 (1972) (noting that "only those interests of the highest order" could justify restrictions on free exercise of religion).

45. See *City of Akron v. Akron Ctr. for Reprod. Rts.*, 462 U.S. 416, 428 (1983) ("At viability this interest in protecting the potential life of the unborn child is so important that the State may proscribe abortions altogether, 'except when it is necessary to preserve the life or health of the mother.'" (quoting *Roe v. Wade*, 410 U.S. 113, 164 (1973)), *overruled on other grounds by Casey*, 505 U.S. 833).

46. See, e.g., Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L.J. 385, 393 (2013) ("In *Roe v.*

Blackmun's years representing the Mayo Clinic before he became a judge.<sup>47</sup> The *Roe* opinion sometimes framed its discussion in terms of doctors' rights: in the first trimester, for instance, the Court said "the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."<sup>48</sup> This physician-centered view of abortion remains apparent in later opinions dealing with state regulations relating to fetal viability.<sup>49</sup> In *Planned Parenthood of Central Missouri v. Danforth*,<sup>50</sup> for instance, the Court noted that in *Roe*, "[t]he participation by the attending physician in the abortion decision, and his responsibility in that decision . . . were emphasized."<sup>51</sup> In keeping with this emphasis on empowering medical practitioners, *Danforth* described viability as "a point purposefully left flexible for professional determination, and dependent upon developing

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*Wade* the Court framed the right of abortion as the right of doctors to practice medicine according to their professional judgment rather than recognizing abortion as a right of women's health that necessarily included access to abortion services." (citations omitted)). The Court's insistence on deference to the judgments of the treating physician traces back to *Doe v. Bolton*, 410 U.S. 179 (1973), the companion case to *Roe v. Wade*, 410 U.S. 179 (1973). In *Doe*, the Court struck down a Georgia provision for review by a hospital review committee of the treating physician's abortion recommendation, which it viewed as "basically redundant." *Id.* at 195–98. It also rejected a separate requirement that two physicians examine the woman and concur in the treating physician's recommendation of an abortion: "Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice." *Id.* at 198–99.

47. See Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 147 (2006)

The most common explanation of how this modest man came to produce such an immodest decision [*Roe*] draws on Blackmun's background as resident counsel for the Mayo Clinic and his admiration of the medical profession. Justice Blackmun had wanted to become a doctor; later in life he became a lawyer for doctors, and he brought to the Court a deep attitude of protectiveness toward physicians.

48. *Roe v. Wade*, 410 U.S. 113, 163 (1973).

49. See, e.g., *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 61 (1976) (relying on *Roe* to explain the role of the medical professional in determining viability).

50. 428 U.S. 52 (1976).

51. *Id.* at 61.

medical skill and technical ability.”<sup>52</sup> The Court upheld the definition of “viability” in a Missouri statute only because it left determination of viability to the judgment of the treating physician:

[W]e agree with the District Court that it is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician. The [Missouri] definition of viability . . . merely reflects this fact.<sup>53</sup>

*Danforth* therefore rejected the contention that “a specified number of weeks in pregnancy must be fixed by statute as the point of viability.”<sup>54</sup>

The Court revisited viability determinations a few terms later in *Colautti*, again emphasizing the primacy of the judgment of the doctor performing the abortion:

Viability is reached when, in the judgment of the attending physician on the particular facts of the case before him, there is a reasonable likelihood of the fetus’ sustained survival outside the womb, with or without artificial support. Because this point may differ with each pregnancy, neither the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or fetal weight or any other single factor—as the determinant of when the State has a compelling interest in the life or health of the fetus. Viability is the critical point. And we have recognized no attempt to stretch the point of viability one way or the other.<sup>55</sup>

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52. *See id.* (“Finally, for the stage subsequent to viability, a point purposefully left flexible for professional determination, and dependent upon developing medical skill and technical ability, the State may regulate an abortion to protect the life of the fetus and even may proscribe abortion except where it is necessary . . .”).

53. *Id.* at 64. The Missouri statute defined “viability” as “that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life-supportive systems.” *Id.* at 63.

54. *See id.* at 65 (“We thus do not accept appellants’ contention that a specified number of weeks in pregnancy must be fixed by statute as the point of viability.”).

55. *Colautti v. Franklin*, 439 U.S. 379, 388–89 (1979).

The *Colautti* Court deemed a Pennsylvania statute unconstitutionally vague where it imposed duties on a doctor who determined that a fetus “is viable or if there is sufficient reason to believe that the fetus may be viable.”<sup>56</sup> One concern was whether the “sufficient reason” language referred to a purely subjective evaluation by the attending physician, or whether it contemplated an objective second-guessing of the physician’s determination:

[I]t is ambiguous whether there must be “sufficient reason” from the perspective of the judgment, skill, and training of the attending physician, or “sufficient reason” from the perspective of a cross section of the medical community or a panel of experts. The latter, obviously, portends not an inconsequential hazard for the typical private practitioner who may not have the skills and technology that are readily available at a teaching hospital or large medical center.<sup>57</sup>

A second ambiguity flowed from the statutory identification of two separate points in gestation—when the fetus “is viable” and when it “may be viable”—either of which would impose heightened duties on the doctor.<sup>58</sup> The Court reinforced its vagueness analysis by pointing to the absence of a scienter requirement with respect to the treating physician’s determination of fetal viability:

The prospect of . . . disagreement [among doctors about viability], in conjunction with a statute imposing strict civil and criminal liability for an erroneous determination of viability, could have a profound chilling effect on the willingness of physicians to perform abortions near the point of viability in the manner indicated by their best medical judgment.<sup>59</sup>

The precise implications of *Danforth* and *Colautti* are open to debate. The Court did not accord complete deference to the doctor

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56. See *id.* at 380 n.1. (reciting relevant portions of the Pennsylvania statute).

57. *Id.* at 391–92.

58. See *id.* at 393 (explaining that “may be viable” could mean there is a remote possibility that the fetus can survive outside the womb, yet it has not attained the reasonable likelihood of survival usually associated with viability, or it could refer to viability “as physicians understand it”).

59. *Id.* at 396.

performing the abortion in either case.<sup>60</sup> *Roe* itself indicated that, as in other medical contexts, the doctor's medical judgments with respect to abortion are subject to oversight by the state:

The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician. If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available.<sup>61</sup>

*Colautti* referred to this portion of *Roe*, suggesting that an abuse of proper medical judgment in the context of a viability determination would be subject to “judicial and intra-professional” remedies.<sup>62</sup>

At the same time, *Danforth* and *Colautti* do seem to give primacy to physicians' viability determinations when they cannot be viewed as abuses of medical judgment, even if other doctors would reach contrary conclusions.<sup>63</sup> It is ironic that *Colautti* accepts as a given that abortion practitioners “may not have the skills and technology” of a teaching hospital or large medical center, and then makes the medical judgments of such practitioners the standard for determining the legal rights of potentially viable fetuses.<sup>64</sup> The irony grows more troubling when

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60. *See id.* at 387 (noting the availability of judicial and professional remedies if the doctor abused the privilege of making medical judgments); *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52, 64–65 (1976) (noting that the determination of fetal viability is to be made using the exercise of “professional judgment”).

61. *Roe v. Wade*, 410 U.S. 113, 165–66 (1973).

62. *See Colautti v. Franklin*, 439 U.S. 379, 387 (1979) (explaining the Court's past emphasis on affording the physician the discretion to determine viability (citing *Roe*, 410 U.S. at 166)).

63. *See id.* at 387–88 (explaining the Court's deference to medical judgment in *Roe*, *Doe*, and *Danforth* and reaffirming the principle (citations omitted)); *Danforth*, 428 U.S. at 64 (recognizing that “viability was a matter of medical judgment, skill, and technical ability”).

64. *Compare Colautti*, 439 U.S. at 391–92 (explaining that the statute at issue is unclear as to whether there must be sufficient reason to believe a fetus is viable from the perspective of the medical community or the attending

one recognizes that the doctors making these decisions about the legal status of another human being may operate under a conflict of interest.<sup>65</sup> Doctors willing to perform late-term abortions can earn significant fees.<sup>66</sup> Most abortion providers will not perform abortions after twenty weeks because of the increased risk of complications.<sup>67</sup> Consequently, providers willing to perform abortions near the margin of viability, or after viability, may be able to charge higher rates.<sup>68</sup> The potential revenue from near-

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physician, who may be a private practitioner without the skills and technology of larger facilities), *with id.* at 396 (“We reaffirm, however, that ‘the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician.’” (quoting *Danforth*, 428 U.S. at 64)).

65. *Cf.* THE FEDERALIST NO. 80 (Alexander Hamilton) (“No man ought certainly to be a judge in his own cause, or in any cause in respect to which he has the least interest or bias.”).

66. *See* ABORTION AFTER THE FIRST TRIMESTER IN THE UNITED STATES 2 (2013), [http://www.plannedparenthood.org/files/PPFA/Abortion\\_After\\_First\\_Tri\\_mester.pdf](http://www.plannedparenthood.org/files/PPFA/Abortion_After_First_Tri_mester.pdf) [hereinafter ABORTION AFTER THE FIRST TRIMESTER] (“[I]n 2009, non-hospital facilities charged an average of \$1500 for abortion at 20 weeks.” (citations omitted)).

67. REPORT OF THE GRAND JURY at 3, *In re County Investigating Grand Jury XXIII* (2011) (Misc. No. 0009901-2008) [hereinafter GRAND JURY REPORT] (“Most doctors won’t perform late second-trimester abortions, from approximately the 20th week of pregnancy, because of the risks involved.”); *id.* at 27 (reporting that Dr. Gosnell “had many late-term Philadelphia patients because most other local clinics would not perform procedures past 20 weeks”); Rachel K. Jones, Mia R. S. Zolna, Stanley K. Henshaw & Lawrence B. Finer, *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSP. ON SEXUAL & REPROD. HEALTH 6, 14 (2008) (noting that only 20% of abortion providers offered services at twenty weeks and only eight percent offered services at twenty-four weeks); *Abortion Care*, UNM CTR. FOR REPROD. HEALTH, <http://www.unmcrh.org/abortion-care/> (last visited Nov. 23, 2013) (“We offer abortion care up to 22 weeks gestational age (time since last menstrual period).”) (on file with the Washington and Lee Law Review). One study of abortion mortality found 3.4 deaths per 100,000 abortions performed between sixteen and twenty weeks, compared to 8.9 deaths per 100,000 for abortions performed at twenty-one weeks or above. Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 733 (2004).

68. *See* GRAND JURY REPORT, *supra* note 67, at app. C (2005 price list showing price of \$1625 for abortion performed at or between twenty-three and twenty-four weeks). For some particularly late abortions, Dr. Kermit Gosnell of Philadelphia reportedly charged \$2500–\$3000. *See id.* at 81 (noting a sliding scale of charges “with late-term abortions sometimes costing \$2,500 or more”); *id.* at 88 (noting testimony from employees and patients who said Gosnell charged anywhere from \$2,500–\$3,000 for late-term abortions).

viability abortions may provide a powerful incentive for finding a marginal fetus nonviable so the abortion may be performed.<sup>69</sup> Other nonmedical factors, such as a strong commitment to women's reproductive autonomy, might also incline a doctor to declare a fetus nonviable in situations open to debate.<sup>70</sup>

*Colautti* seemed to accept as normal the idea that different physicians might agree on the probability of fetal survival and yet reach different conclusions as to fetal viability.<sup>71</sup> This goes a long way toward putting doctors' viability determinations on the honor system, rather than treating viability as a serious regulatory line with weighty state interests at stake. The Court's requirement of deference to the treating physician would seem to shield a doctor who performs an abortion on a fetus declared "nonviable" even if other doctors with different financial and professional incentives would reach the opposite conclusion.<sup>72</sup> This requirement of deference to the attending physician's viability determinations virtually guarantees that some fetuses will be aborted in cases near the margin even though they could in fact survive outside the womb with proper care.<sup>73</sup> In such situations, the Court's case law requiring deference to a doctor desiring to perform an abortion undermines the state's acknowledged and compelling interest in protecting viable unborn human life.<sup>74</sup>

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69. See Jones, *supra* note 67, at 14 (noting that the average cost of an abortion at ten weeks is \$523 but the average cost at twenty weeks is three times this amount).

70. Cf. Moore v. Regents of Univ. of Cal., 793 P.2d 479, 485 (Cal. 1990) (recognizing that a doctor's medical judgment may be influenced by personal interests).

71. See *Colautti v. Franklin*, 439 U.S. 379, 396 (1979) (explaining that physicians may agree on a fetus' probability of survival, but their opinions may differ on whether to associate viability with that level of survival).

72. See Beck, Gonzales, Casey, and the Viability Rule, *supra* note 7, at 260 (explaining that deference to medical judgments may prove problematic where the doctor has financial, legal, or ideological interests at stake (citing *Moore*, 793 P.2d at 485)).

73. See Beck, *State's Interest*, *supra* note 4, at 57 ("The imprecision of the viability line will make it very difficult in some cases to prove beyond a reasonable doubt that a particular doctor knew he or she was aborting a viable fetus.").

74. See *id.* (noting that the viability rule defers to the judgment of the physician to such a degree that it "undermines the goal of regulating the physician's conduct").

*III. Providers Sometimes Conceal Performance of Postviability Abortions*

A second barrier to state protection of viable fetuses results from the fact that abortions typically take place in private clinics and doctors' offices operated by a small number of personnel.<sup>75</sup> In *Doe v. Bolton*,<sup>76</sup> the Supreme Court struck down a requirement that all abortions be performed in an accredited hospital.<sup>77</sup> In *City of Akron v. Akron Center for Reproductive Health*,<sup>78</sup> the Court invalidated an ordinance requiring hospitalization for any abortion in the second trimester.<sup>79</sup> These decisions have fostered the proliferation of medical facilities dedicated to performance of abortions as their primary activity.<sup>80</sup> The Guttmacher Institute reports that “[n]early all U.S. abortions take place in nonhospital settings.”<sup>81</sup>

According to Guttmacher Institute researchers, as of 2005, only twenty percent of abortion clinics performed abortions at twenty weeks gestation, and only eight percent reported that they did so at twenty-four weeks.<sup>82</sup> If these figures remain accurate, many abortion clinics would not seem to present a high risk of

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75. Cf. *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 435 (1983) (noting that second-trimester abortions rarely took place in hospitals), *overruled on other grounds by* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); see also Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—And the Women They Serve—Pay the Price*, 16 GUTTMACHER POLICY REV. 7, 7 (2013) (noting that nearly all abortions in the United States take place in non-hospital settings) (citation omitted).

76. 410 U.S. 179 (1973).

77. See *id.* at 194–95 (concluding that the provision in question requiring hospitalization for second trimester abortions was invalid because the state failed to prove that only hospitals could satisfy the state's health interest).

78. 462 U.S. 416 (1983), *overruled on other grounds by* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

79. See *id.* at 434–39 (arguing an Akron ordinance imposed a burden on access to abortion procedures because requiring hospitalization may result in additional and unnecessary expenses).

80. David M. Smolin, *Cultural and Technological Obstacles to the Mainstreaming of Abortion*, 13 ST. LOUIS U. PUB. L. REV. 261, 261 (1993) (“Most abortions are performed in specialized abortion clinics, rather than in hospitals or physicians' offices.”).

81. Gold & Nash, *supra* note 75, at 7.

82. Jones et al., *supra* note 67, at 14.



performing postviability abortions.<sup>83</sup> Because most abortions do not occur in hospital settings, however, when a clinic does perform abortions near the viability threshold, much of the information relevant to the viability determination—fetal weight, mother’s health, race and gender of the fetus, ultrasound images, last reported menstrual period and the like—will be in the possession of the doctor and his staff.<sup>84</sup> A doctor willing to violate a state law prohibiting abortion after viability would presumably screen employees to ensure loyalty.<sup>85</sup> While most states ask doctors to submit information about each abortion, including the gestational age of the fetus (California being a notable exception),<sup>86</sup> one would not expect a doctor desiring to perform postviability abortions to accurately comply with such reporting rules.<sup>87</sup>

The prosecution of Philadelphia’s Dr. Kermit Gosnell highlights steps taken by one profit-motivated abortion provider to conceal the performance of postviability abortions.<sup>88</sup> Gosnell was convicted in 2013 on hundreds of charges, including three counts of first-degree murder for killing infants born alive at his

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83. *But see infra* notes 165–66 and accompanying text (noting that Gosnell falsified records and failed to report numerous late-term abortions).

84. *See, e.g.*, GRAND JURY REPORT, *supra* note 67, at 247 (noting the difficulty in obtaining evidence for criminal prosecution because the illegal activity took place inside Gosnell’s clinic).

85. *But see* Wendy Saltzman, *Delaware Abortion Clinic Facing Charges of Unsafe and Unsanitary Conditions*, ABC ACTION NEWS, WPVI-TV (July 24, 2013), <http://abclocal.go.com/wpvi/story?id=9059172> (last visited Jan. 10, 2014) (reporting recent cases of abortion clinic staff disclosing violations of the law by their employers) (on file with the Washington and Lee Law Review).

86. *See* STATE POLICIES IN BRIEF: ABORTION REPORTING REQUIREMENTS (2013), [http://www.guttmacher.org/statecenter/spibs/spib\\_ARR.pdf](http://www.guttmacher.org/statecenter/spibs/spib_ARR.pdf) (charting the forty-seven states requiring reporting).

87. *See* GRAND JURY REPORT, *supra* note 67, at 156 (detailing inaccuracies in reports filed by Gosnell).

88. Joseph A. Slobodzian, *Gosnell Guilty of Three Murder Counts*, PHILA. INQUIRER (May 15, 2013), [http://articles.philly.com/2013-05-15/news/39258185\\_1\\_verdict-jury-gosnell-case](http://articles.philly.com/2013-05-15/news/39258185_1_verdict-jury-gosnell-case) (last visited Jan. 10, 2014) (reporting the outcome of Dr. Kermit Gosnell’s murder trial) (on file with the Washington and Lee Law Review); Sarah Hoye & Sunny Hostin, *Doctor Found Guilty of First-Degree Murder in Philadelphia Abortion Case*, CNN (May 14, 2013) <http://www.cnn.com/2013/05/13/justice/pennsylvania-abortion-doctor-trial/> (last visited Jan. 10, 2014) (reporting Dr. Kermit Gosnell’s murder convictions) (on file with the Washington and Lee Law Review).

clinic, involuntary manslaughter in the death of an adult patient, and twenty-one counts of performing abortions on women more than twenty-four weeks pregnant.<sup>89</sup> The grand jury that investigated Gosnell's clinic produced a lengthy report, suggesting that the counts recommended for prosecution represented just the tip of the iceberg.<sup>90</sup> According to the grand jury, Gosnell attracted business from surrounding states because he "was known as a doctor who would perform abortions at any stage, without regard for legal limits."<sup>91</sup> The grand jury estimated that Gosnell performed at least four or five illegal abortions a week.<sup>92</sup> In addition to performing abortions on viable fetuses *in utero*,<sup>93</sup> Gosnell's clinic often induced delivery of live babies at the clinic, at which point Gosnell or another staff member would "[e]nsur[e] fetal demise" by "sticking scissors into the back of the baby's neck and cutting the spinal cord. He called that 'snipping.'"<sup>94</sup> The grand jury reported that "[o]ver the years, there were hundreds of 'snippings,'" but "[m]ost of these acts cannot be

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89. Slobodzian, *supra* note 88; Hoye & Hostin, *supra* note 88.

90. See GRAND JURY REPORT, *supra* note 67, at 219–47 (suggesting various criminal charges against Dr. Kermit Gosnell).

91. *Id.* at 27.

92. *Id.* at 79.

93. See *id.* ("Steven Massof estimated that in 40 percent of the second-trimester abortions performed by Gosnell, the fetuses were beyond 24 weeks gestational age. Latosha Lewis testified that Gosnell performed procedures over 24 weeks 'too much to count,' and ones up to 26 weeks 'very often.'"); *id.* at 78

Several of the clinic's former staff told the Grand Jury that Gosnell performed many, many abortions beyond the legal limit in Pennsylvania—a gestational age of 24 weeks. Their testimony is confirmed by clinic files, by fetal remains found at the facility, by photographs of babies that Gosnell delivered and then killed, and by a 30-plus-weeks baby girl born dead at a hospital after Gosnell had inserted laminaria to begin a third trimester abortion.

94. *Id.* at 4; see also *id.* at 99–100 ("Gosnell's staff testified about scores of gruesome killings of such born-alive infants carried out mainly by Gosnell, but also by employees Steve Massof, Lynda Williams, and Adrienne Moton. These killings became so routine that no one could put an exact number on them. They were considered 'standard procedure.'"). One of Gosnell's employees indicated that the doctor preferred it when the baby was delivered because it involved less work for him and reduced the risk that he would perforate the uterus, something that had resulted in a number of malpractice suits. *Id.* at 31. Therefore, he would sometimes have his staff press on patients' abdomens to bring about delivery. *Id.*

prosecuted, because Gosnell destroyed the files.”<sup>95</sup> “It was Gosnell’s standard business practice,” they concluded, “to slay viable babies.”<sup>96</sup>

The grand jury’s report noted a variety of steps Dr. Gosnell took that helped hide his performance of illegal postviability abortions:

- Gosnell regularly falsified reports submitted to the state Department of Health to vastly underreport the number of second- and third-trimester abortions he performed.<sup>97</sup> His final quarterly report indicated that he had performed 118 first-trimester abortions and two second-trimester abortions. However, in reviewing just a few files, state officials found evidence of at least six second-trimester abortions performed in the last two months of the quarter.<sup>98</sup>
- The reports Gosnell filed between 2000 and 2010 apparently indicated that there were no complications from abortions performed at his clinic,<sup>99</sup> even though two

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95. *Id.* at 5; *see also id.* at 114 (noting that an unlicensed doctor at the clinic, Steven Massof, “admitted that there were about 100 instances in which he severed the spinal cord after seeing a breath or some sign of life”).

96. *See id.* at 25 (“It was Gosnell’s standard business practice, to slay viable babies. The women who died, or whose health he recklessly endangered or irreparably harmed, were simply collateral damage for the doctor’s corrupt and criminal enterprise.”).

97. *See id.* at 156 (detailing failure by Dr. Gosnell to file accurate reports required by the Department of Health).

98. *Id.* Testimony heard by the grand jury indicated that as of 2000, Gosnell was performing between five and six second-trimester abortions each week, but that as referrals of first-trimester abortions diminished, Gosnell came to rely more on referrals for late-term abortions. *See id.* at 26–28 (relating testimony about how Dr. Gosnell ran his clinic and how it changed over time to allow for more late-term abortions).

99. *See id.* at 171 (noting that the forms the Department of Health relied on to compile data for its reports were falsified by Gosnell and therefore “worthless”). It is not clear how to reconcile the grand jury’s statement on page 171 that the forms filed by Gosnell between 2000 and 2010 recorded only one second-trimester abortion with the statement on page 156 that the report for the last quarter of 2009 recorded two second-trimester abortions; however, both references are consistent in that they show Gosnell vastly underreporting the number of second-trimester abortions he performed. *Compare id.* at 156 (“The most recent report filed by Gosnell’s clinic stated that it had performed 118 first-trimester and 2 second-trimester abortions in the fourth quarter of 2009.”), *with id.* at 171 (“The forms that Gosnell filed between 2000 and 2010—the ones DOH

patients died from abortion complications during that time period and several others sued Gosnell for malpractice.<sup>100</sup>

- When an ultrasound showed that a fetus was beyond twenty-four weeks gestation, Dr. Gosnell trained his staff to “fudge the measurement process” by “aim[ing] the ultrasound probe at an angle to make the fetus look smaller.”<sup>101</sup>
- When a fetus was beyond twenty-four weeks gestation, Gosnell would record in the file that the gestational age was 24.5 weeks, regardless of the actual gestational age.<sup>102</sup>
- Much of the time Gosnell performed illegal abortions in front of his staff.<sup>103</sup> But there were some, abortions of “the really big ones,” that even he was afraid to perform in front of others. These abortions were scheduled for Sundays, a day when the clinic was closed and none of the regular employees were present. Only one person was allowed to assist with these special cases—Gosnell’s wife.<sup>104</sup>
- According to clinic staff, Gosnell took patient files home and did not keep files for most of his late-term abortions at the clinic.<sup>105</sup> Only some of these files were recovered and one was found in his car, partially shredded.<sup>106</sup>

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then relied on to compile its reports to the Legislature—recorded only one second-trimester abortion and no complications.”).

100. See *infra* notes 131 and 140 and accompanying text for a discussion of the two women who died from complications after receiving abortions at Gosnell’s clinic.

101. GRAND JURY REPORT, *supra* note 67, at 75; see also *id.* at 79–81 (including testimony from former employees of Dr. Gosnell who were trained to manipulate ultrasound images so that fetuses appeared smaller).

102. See *id.* at 4 (explaining that for almost every second ultrasound performed, a gestational age of 24.5 weeks was recorded even though “most of these pregnancies were considerably more advanced”).

103. *Id.*

104. *Id.* at 5–6; see also *id.* at 81 (“Lewis and Massof both testified that they believed Gosnell dealt with some of the patients with the longest-term pregnancies on Sundays, when his staff was not at the clinic.”).

105. See *id.* at 83 (recounting testimony of two clinic employees who stated that Dr. Gosnell destroyed patient files or took them home if he did not believe the files should be in the clinic due to the advanced stage of the pregnancy).

106. See *id.* (noting that some patient files were found in a search of Dr. Gosnell’s home and car, and of these files, one was partially shredded). The grand jury believed that falsification, removal and destruction of files prevented

- Doctors in Pennsylvania are supposed to send tissue from late term abortions to a pathologist to examine for evidence that the fetus was viable or born alive.<sup>107</sup> Gosnell did not comply with this requirement.<sup>108</sup>

While the grand jury had voluminous evidence of the general course of practice at Gosnell's clinic, they found it difficult to pursue charges in many of the particular cases because it was difficult to secure evidence clear enough for criminal prosecution: "Gosnell, we are convinced, committed *hundreds* of acts of infanticide. He got away with them for decades because they all took place inside his clinic."<sup>109</sup>

#### *IV. Regulators in Some States Are Unwilling to Closely Supervise Abortion Providers*

The Gosnell case shows how one abortion provider, over the course of many years, avoided detection as he and his employees ended the lives of hundreds of viable fetuses and newly delivered infants. One possible solution to such problems would be close oversight by state officials responsible for regulating abortion clinics. The Gosnell case, however, highlights a third barrier to state protection of viable fetuses. As documented by the Gosnell grand jury, officials responsible for protecting public health in Pennsylvania proved unwilling to enforce applicable laws regulating abortion, in part for political or ideological reasons.<sup>110</sup>

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prosecution in a large number of cases where charges would have been appropriate. *See id.* at 115

We believe, given the manner in which Gosnell operated, that he killed the vast majority of babies that he aborted after 24 weeks . . . . Because files were falsified or removed from the facility and possibly destroyed, we cannot substantiate all of the individual cases in which charges might otherwise have resulted.

107. *See* 18 PA. CONS. STAT. ANN. § 3214(c) (West 2103) ("When there is an abortion performed after the first trimester of pregnancy where the physician has certified the unborn child is not viable, the dead unborn child and all tissue removed at the time of the abortion shall be submitted for tissue analysis to a . . . pathologist.").

108. *See* GRAND JURY REPORT, *supra* note 67, at 75 (noting Gosnell's various violations of the Pennsylvania Abortion Control Act).

109. *Id.* at 247.

110. *See id.* at 137–215 (detailing lack of investigation of Gosnell's practices

As a consequence, abortion providers in Pennsylvania operated without significant oversight.<sup>111</sup>

The agency with the principal statutory authority to regulate abortion clinics in Pennsylvania is the state Department of Health.<sup>112</sup> The grand jury concluded that “[t]he Department of Health conducted sporadic, inadequate inspections [of Gosnell’s clinic] for 13 years, and then none at all between 1993 and 2010.”<sup>113</sup> The clinic was inspected when it opened in 1979, with later reviews in 1986 (for which no documentation was located), 1989, 1992, and 1993.<sup>114</sup> The 1989 inspection report noted a number of violations of applicable regulations, including “no board-certified doctor on staff or contracted as a consultant; no nurses overseeing the recovery of patients; no transfer agreement with a hospital for emergency care; and no lab work recorded in several files.”<sup>115</sup> When the clinic was next inspected in 1992, Gosnell still did not employ any nurses.<sup>116</sup> Nevertheless, the inspectors reported “no deficiencies,” leaving blank the portions of the form dealing with anesthesia and postoperative care—where the inadequate staffing should have been noted.<sup>117</sup> Gosnell still had not hired any nurses by the time of the 1993 inspection, and there were other deficiencies noted at that time, such as lab work missing from patient files.<sup>118</sup> A few months later, however, a

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by various state departments and officials).

111. *Id.*

112. *See id.* at 137 (noting that the state Department of Health holds the responsibility of “writing and enforcing regulations to protect health and safety in abortion clinics” and other health care facilities).

113. *Id.* at 138.

114. *Id.* at 138–43. Gosnell was initially a staff physician at the clinic, but by 1989, he was the only doctor practicing there. *Compare id.* at 139 (“The [1979] DOH ‘site review’ at the time identified a certified obstetrician/gynecologist, Joni Magee, as the medical director, with Gosnell listed as a staff physician.”), *with id.* at 140 (“By 1989, Gosnell, who is not board-certified as either an obstetrician or a gynecologist, was the only doctor at the facility.”).

115. *Id.* at 140.

116. *See id.* (noting that the 1992 DOH inspection found that there were still no nurses employed by the clinic for the purpose of monitoring patient recovery).

117. *See id.* at 140–41 (describing a meeting in 1999 at which high-level government officials rejected the recommendation to reinstitute regular inspections of abortion clinics).

118. *See id.* at 141–42 (describing the 1992 Department of Health inspection of Dr. Gosnell’s clinic).

Department of Health employee, without a follow up inspection, recorded that the deficiencies had been corrected.<sup>119</sup>

Even these half-hearted and ineffective inspections came to a halt after 1993, as reported by the grand jury:

[T]he Pennsylvania Department of Health abruptly decided, for political reasons, to stop inspecting abortion clinics at all. The politics in question were not anti-abortion, but pro. With the change of administration from Governor Casey to Governor Ridge, officials concluded that inspections would be “putting a barrier up to women” seeking abortions.<sup>120</sup>

There was a discussion of reinstating inspections in 1999, but the decision was made not to do so.<sup>121</sup> According to an attorney who participated in that meeting:

[T]here was a concern that if they did routine inspections, that they may find a lot of these facilities didn’t meet [the standards for getting patients out by stretcher or wheelchair in an emergency], and then there would be less abortion facilities, less access to women to have an abortion.<sup>122</sup>

After 1993, the Department of Health’s official policy was that abortion clinics would only be inspected in response to complaints.<sup>123</sup> Over the years, the Department received multiple complaints about Gosnell’s clinic:

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119. *See id.* at 142 (noting that it was reported that the deficiencies found in the 1993 inspection had been corrected without follow-up and Dr. Gosnell was sent another Certificate of Approval from the Department of Health).

120. *Id.* at 9. *But see id.* at 147 (noting that regular inspection of abortion clinics was reinstated in February of 2010, “finding authority in the same statute they used earlier to justify not inspecting”).

121. *See id.* (describing a meeting at which high-level government officials rejected the option of reinstating regular inspections of abortion clinics).

122. *Id.* at 147. Sadly, Gosnell’s failure to comply with the requirements concerning emergency evacuation of patients contributed to the death of patient Karnamaya Mongar. *See id.* at 77

Another violation of Pennsylvania law proved significant the night Karnamaya Mongar died: Clinics must have doors, elevators, and other passages adequate to allow stretcher-borne patients to be carried to a street-level exit. Gosnell’s clinic, with its narrow, twisted passageways, could not accommodate a stretcher at all. And his emergency street-level access was bolted with no accessible key. Any chance Mongar had of being revived was hampered by the time wasted looking for keys to the door.

123. *See id.* at 143 (noting that after 1993 the Department of Health’s policy was to inspect abortion clinics only if a complaint were filed, yet the department

- In 1996, an attorney informed the Department of Health that his client had suffered a perforated uterus, requiring a hysterectomy, as a result of Gosnell's negligence.<sup>124</sup>
- In 1996 or 1997, a pediatrician hand-delivered a complaint to the Department of Health after multiple teenage patients referred to Gosnell for abortions were "infected with trichomoniasis, a sexually transmitted parasite."<sup>125</sup> The doctor sent a social worker to visit Gosnell's clinic and then stopped referring patients there. The Department of Health did not keep a record of the complaint.<sup>126</sup>
- In January 2002, an attorney contacted the Department of Health on behalf of the family of a twenty-two-year-old woman who died following an abortion by Gosnell. The department informed the attorney that no site inspections had been performed at Gosnell's clinic because no complaints had been received (information that was inaccurate).<sup>127</sup>
- In February 2002, a paralegal for another attorney representing an abortion patient contacted the Department of Health asking for information about the clinic.<sup>128</sup>
- In 2007, an investigator for the medical examiner of Delaware County spoke with several employees of the Department of Health after an autopsy of a stillborn

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failed to respond to numerous complaints).

124. *See id.* at 143–44 (noting that one Department of Health employee reported that no complaints had been filed from 1993–2002, yet that employee had access to a 1996 complaint regarding a patient who suffered a perforated uterus).

125. *See id.* at 144 (detailing a complaint originally filed by a pediatrician who began noticing that patients returning from Gosnell's clinic were infected with a sexually transmitted parasite that they did not have before their abortions).

126. *See id.* (noting that the pediatrician never heard back from the Department of Health regarding his complaint, nor was it included in response to the Grand Jury's subpoena requesting all such complaints relating to Gosnell's clinic).

127. *See id.* (explaining that, though the department told the attorney that there were no inspections of the clinic because there had been no complaints, complaints against the clinic had been filed between 1993 and 2002).

128. *See id.* at 145 (mentioning two other complaints received by the department).



infant showed that Gosnell had induced delivery in preparation for aborting a thirty-week-old fetus, in violation of the twenty-four-week limit under Pennsylvania law.<sup>129</sup> Department of Health officials recommended that the investigator report the matter to a district attorney.<sup>130</sup>

- In November 2009, Gosnell notified the Department of Health that another patient, Karnamaya Mongar, had died following an abortion at his clinic.<sup>131</sup>

None of these inquiries, reports, and complaints prompted the Department of Health to visit Gosnell's clinic.<sup>132</sup> The clinic was not inspected for compliance with Pennsylvania laws and regulations for a period of over sixteen years, from 1993 to 2010.<sup>133</sup> Following the 1993 change in policy, the Department of Health did not visit Gosnell's clinic again until they were asked to join law enforcement personnel investigating allegations that Gosnell wrote illegal prescriptions for controlled substances.<sup>134</sup> The grand jury concluded that the Department of Health's failure to enforce Pennsylvania's abortion laws and regulations went beyond bad management and appeared to amount to "purposeful neglect."<sup>135</sup>

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129. *See id.* at 146 (noting the Department of Health's failure to investigate or file a complaint when a medical examiner reported a thirty week abortion performed by Gosnell).

130. *See id.* (explaining that the department referred the medical examiner to the District Attorney's office because neither the Department of Health nor the state medical board had authority over the issue); *id.* at 84–86 (noting that a medical examiner reported Gosnell's abortion of a thirty week fetus to the Department of Health, but the department "took no action").

131. *See id.* at 149 (noting that on November 24, 2009, Gosnell faxed the Department of Health a letter notifying it that Mongar died following an abortion, though he incorrectly stated the date of her procedure).

132. *See id.* at 143 ("The state Department of Health failed to investigate Gosnell's clinic even in response to complaints.").

133. *See id.* at 142–43 (noting that after the 1993 inspection, sixteen years passed without further on-site inspection).

134. *See id.* at 152 ("It was not until February 18, 2010, when DOH representatives were escorted in by law enforcement agents, that they finally inspected the clinic that they had not bothered to visit in 13 years.").

135. *See id.* at 170 (noting that the Department of Health's policy of inspecting abortion clinics only in response to complaints and its failure to respond to complaints "reflect[s] purposeful neglect" and raises the question

The Pennsylvania Department of State, which oversees medical licensing through its Board of Medicine, was another agency that could have exercised regulatory authority with respect to Gosnell's practice.<sup>136</sup> Like the Department of Health, the Board of Medicine received a number of complaints about Gosnell over the years:

- In December 2001, a former employee of Gosnell's, Marcella Stanley Choung, filed a complaint about the clinic.<sup>137</sup> According to the grand jury, she reported that Gosnell was using unlicensed workers (including herself) to give IV anesthesia to patients when he was not at the clinic; that his facility was filthy; that two sick, flea-infested cats roamed freely in the procedure rooms, vomiting throughout; that Gosnell ate in the procedure rooms; that the autoclave used to sterilize instruments was broken; that he reused single-use curettes; that there were no licensed nurses at the facility when IV anesthesia was administered; that Gosnell allowed one patient to use her cousin's insurance card to pay for an abortion; that Gosnell performed abortions on 'underage children' against their will if their mothers asked him to; and that he performed other abortions without consent forms.<sup>138</sup>

A cursory investigation was done of some of Choung's claims, though simple steps were not taken, such as visiting the clinic or interviewing other unlicensed employees, which could have verified her allegations.<sup>139</sup>

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whether it actually intended to protect the health and safety of women seeking abortions).

136. *See id.* at 173 (explaining that the Department of State's Bureau of Professional and Occupational Affairs oversees twenty-nine boards, including the Board of Medicine, which was aware of Gosnell's illegal practices).

137. *See id.* at 176–80 (detailing Choung's complaint and noting the Department of States's failure to adequately investigate).

138. *Id.* at 177.

139. *Id.* at 177–79.

- In 2002, an insurance company reported that it had paid \$400,000 to settle a claim by the family of Semika Shaw, a twenty-two-year-old who died following an abortion by Gosnell.<sup>140</sup>
- In 2005, an attorney sent the Board of Medicine a malpractice complaint alleging that Gosnell had administered an anesthetic that should not be given to a methadone patient like the plaintiff, resulting in a seizure.<sup>141</sup> The Board of Medicine took no action, even though the attorney pointed out that Gosnell was uninsured at the time of the incident.<sup>142</sup>
- A different official at the Board of Medicine was handling a report that Gosnell did not have insurance as required by law, a violation that could have been verified through investigation.<sup>143</sup> Gosnell in fact performed abortions in Pennsylvania for ten months without insurance, telling his insurer that he was only practicing in Delaware at the time.<sup>144</sup>
- In 2008, the Board of Medicine received a copy of a malpractice complaint against Gosnell for tearing a patient's cervix, uterus, and bowel during an incomplete abortion that left fetal parts in the patient's body.<sup>145</sup> Gosnell allegedly delayed sending the patient to the hospital, where she required extensive surgery.<sup>146</sup> A

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140. *See id.* at 174 (noting that the Department of State took no action though it received notification of a \$400,000 settlement to the family of Semika Shaw).

141. *See id.* at 181–82 (detailing the complaint).

142. *See id.* at 182–83 (noting that the Department of State closed the case even though Gosnell failed to satisfy insurance coverage requirements).

143. *See id.* at 183 (noting that an attorney for the Bureau of Professional and Occupational Affairs continuously checked with compliance officers to ascertain whether or not Gosnell was insured, but ultimately closed the file in 2008 without further investigation); *id.* at 183–84 (explaining that by conducting a real investigation or subpoenaing documents, attorneys could have discovered Gosnell's lack of insurance).

144. *See id.* at 183–84 (noting that Gosnell did not have insurance between July 15, 2004, and April 18, 2005, and that during this time he told his insurance agent that he was only practicing in Delaware).

145. *See id.* at 184–85 (reciting facts of the complaint).

146. *See id.* at 184 (noting that Gosnell refused to call an ambulance, forcing the patient to wait for several hours before she was finally taken to a hospital,

simple search of a database maintained by the U.S. Department of Health and Human Services could have disclosed that at least five other women had previously successfully sued Gosnell for perforating their uteruses, but the Board's investigator allegedly did not have access to the database.<sup>147</sup>

The grand jury was particularly surprised that Department of State officials closed the files on both the allegations by former employee Marcella Choung and the reported death of patient Semika Shaw on the same day without further action.<sup>148</sup>

A third agency that failed to take action despite reports of major problems at Gosnell's clinic was the Philadelphia Department of Public Health.<sup>149</sup> A city employee visited Gosnell's clinic in July 2008 in connection with a vaccine program.<sup>150</sup> She found the clinic being run by "clueless" employees<sup>151</sup> and noted pervasive unsanitary conditions: "[T]he office was not clean at all, and many areas of the clinic smell like urine."<sup>152</sup> Expired vaccines were kept in a refrigerator with incomplete temperature logs.<sup>153</sup> Chicken pox vaccines were stored in a freezer along with the

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where she required surgery).

147. *See id.* at 185–86 (explaining that the National Practitioner Data Bank (NPDB) allows state boards of medicine to identify and discipline medical practitioners engaging in unprofessional behavior and that the NPDB or Department of State records should have easily revealed Gosnell's history of perforating uteruses). *See id.* at 11 for information on a successful civil suit filed against Gosnell after a twenty-two-year-old woman died from sepsis when Gosnell perforated her uterus during an abortion.

148. *See id.* at 181 (finding it "incomprehensible" that a single Board of Medicine prosecutor and his supervisor could dispose of the Choung and Shaw allegations at the same time).

149. *See id.* at 199–212 (detailing the Philadelphia Department of Public Health's failure to respond to various complaints).

150. *See id.* at 200–01 (detailing the July 2008 vaccine inspection of Gosnell's clinic).

151. *See id.* at 200 (noting that a Department of Public Health employee had trouble scheduling an appointment at Gosnell's clinic and that two women whom she described as "clueless" were present the day of the appointment rather than Gosnell or the office manager).

152. *Id.* at 201. The employee noted layers of dust on the baseboards and murky water in the fish tanks. *Id.*

153. *See id.* (noting that expired vaccines were found in the refrigerator with March 2006 and 2005 expiration dates and the temperature log had not been completed for nearly one and a half months).

bloody remains of aborted fetuses.<sup>154</sup> The employee returned in October 2009 and again wrote a report detailing problems at the clinic, raising the question of why she saw patients in the procedure area at a time when Gosnell was absent and the only “doctor” at the clinic did not have a Pennsylvania medical license.<sup>155</sup> Based on the employee’s reports, Gosnell’s clinic was suspended from the vaccine program, but no further action was taken.<sup>156</sup> City health officials never followed through on plans to report Gosnell to state licensing authorities.<sup>157</sup> The grand jury also found that at least five of Gosnell’s patients received emergency room care at nearby hospitals following abortions, but apparently in only one instance did the hospital satisfy its state law duty to report complications from abortions.<sup>158</sup>

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154. *Id.* at 201. Gosnell had previously been reported to the city health department for problems related to the storage and disposal of fetal remains. *See id.* at 204–07 (detailing the city health department’s inspections of Gosnell’s infectious waste disposal procedures and its failure to enforce the applicable regulations).

155. *See id.* at 202 (reporting that a doctor working at Gosnell’s clinic was not actually licensed in the state of Pennsylvania and falsely claimed to have a Delaware license); *id.* at 203 (“Matijkiw concluded her report to her boss: ‘If Dr. Gosnell was out of the office and [the unlicensed physician] had to call the other physician’s assistant on his cell phone and leave a message for his MA#, why were patients in the procedure area?’”).

156. *Id.* at 201.

157. *See id.* at 200–03 (noting that after the 2007 and 2009 visits, immediate action should have been taken by the city health department or the information should have been passed to other state departments, “yet the city health department did nothing”).

158. *See id.* at 213–14 (noting that of the five women who received emergency medical services at two nearby emergency rooms, the only report involved a woman who died at the Hospital of the University of Pennsylvania). Until recently, Maryland was another state that did not inspect abortion clinics. The state is in the process of implementing inspection procedures. *Cf.* Erik Eckholm, *Maryland’s Path to an Accord in Abortion Fight*, N.Y. TIMES (July 10, 2013), [http://www.nytimes.com/2013/07/11/us/marylands-path-to-an-accord-in-abortion-fight.html?\\_r=0](http://www.nytimes.com/2013/07/11/us/marylands-path-to-an-accord-in-abortion-fight.html?_r=0) (last visited Jan. 11, 2014) (noting that only recently did Maryland begin the process of implementing inspection procedures) (on file with the Washington and Lee Law Review); Andrea K. Walker, *Maryland Suspends Licenses of 3 Abortion Clinics*, BALTIMORE SUN (Mar. 12, 2013), [http://articles.baltimoresun.com/2013-03-12/health/bs-hs-abortion-clinic-suspension-20130308\\_1-abortion-clinics-clinics-face-surgical-abortion-procedures](http://articles.baltimoresun.com/2013-03-12/health/bs-hs-abortion-clinic-suspension-20130308_1-abortion-clinics-clinics-face-surgical-abortion-procedures) (last visited Jan. 11, 2014) (reporting the suspension of three Maryland abortion clinics nearly eight months after the state began regulating abortion facilities) (on file with the Washington and Lee Law Review). Other states have inspected abortion providers since well before the Gosnell case came to light. *See, e.g.,*

*V. Measures That Could Help States Protect Viable Fetuses*

We have to this point examined three different barriers that, individually and together, make it difficult for states to protect the lives of viable fetuses that could survive outside the womb. First, the Supreme Court's case law seems to call for some level of deference to a determination of nonviability by a doctor who wants to perform an abortion,<sup>159</sup> even though that determination may be erroneous and inconsistent with the conclusions that would be reached by other physicians.<sup>160</sup> Second, abortions near the viability threshold or beyond typically take place in private facilities operated by abortion providers, making it difficult to monitor compliance with a legal prohibition on postviability abortions.<sup>161</sup> Third, in some jurisdictions, public officials may be unwilling to provide close oversight of abortion clinics.<sup>162</sup> Now we will consider measures that, if permitted by the courts, might assist a state in vindicating its compelling interest in protecting the lives of viable fetuses.

The first difficulty arises from using a relatively uncertain medical determination, like the fact of fetal viability, as a regulatory line to be enforced by public authorities.<sup>163</sup> Bright lines make law enforcement easier.<sup>164</sup> Conversely, law enforcement

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Amended Order, Virginia Board of Medicine (May 23, 2006), <http://www.dhp.virginia.gov/Notices/Medicine/0101043653/0101043653Order11062006.pdf> (reporting the results of an unannounced inspection due to in-office use of anesthesia).

159. See *supra* note 46 and accompanying text (explaining relevant case law regarding the Court's deference to the physician's determination of viability).

160. See *Colautti v. Franklin*, 439 U.S. 379, 396 (1979) (noting that physicians may disagree about whether second trimester fetuses are viable).

161. See *supra* Part III (providing details on Gosnell's clinic, a private abortion facility that performed late term abortions and avoided regulation for several years).

162. See *supra* Part IV (discussing lack of investigation by state and local authorities in the Gosnell case).

163. See *Colautti*, 439 U.S. at 395–96 (describing factors which contribute to the uncertainty of determining fetal viability).

164. See, e.g., *Bridgeport Music, Inc. v. Dimension Films*, 383 F.3d 390, 397 (6th Cir. 2004) (“The music industry, as well as the courts, are best served if something approximating a bright-line test can be established.”); *New York v. Belton*, 453 U.S. 454, 459–60 (1981) (“When a person cannot know how a court will apply a settled principle to a recurring factual situation, that person cannot know the scope of his constitutional protection, nor can a policeman know the

efforts are hindered to the extent that the line between legal and illegal conduct is difficult to discern. A rule that doctors may perform an abortion on any nonviable fetus, combined with a requirement of deference to the doctor's conclusion, will make it hard to pursue cases near the margin of viability. The problem may be exacerbated by the due process requirement that guilt in criminal cases be proved beyond a reasonable doubt.<sup>165</sup> The Supreme Court's case law virtually guarantees that doctors will be able to perform abortions on some viable fetuses, even knowingly, and still avoid successful law enforcement efforts.

Various jurisdictions in recent years have enacted laws forbidding abortion after twenty weeks.<sup>166</sup> Such laws often measure the twenty week period from fertilization; as a consequence, they really apply twenty-two weeks after a woman's last menstrual period (LMP), a standard way of measuring gestation.<sup>167</sup> Many doctors believe that viability occurs in typical pregnancies around twenty-four weeks LMP.<sup>168</sup> As a consequence, such laws seek to restrict elective abortions a couple of weeks before viability might occur in a typical pregnancy.<sup>169</sup>

The twenty week abortion laws have often been defended based on contested evidence that the fetus might be capable of

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scope of his authority.”).

165. See *In re Winship*, 397 U.S. 358, 362 (1970) (stating that guilt in a criminal case must be proven beyond a reasonable doubt (citing *Brinegar v. United States*, 338 U.S. 160, 174 (1949))).

166. See Erik Eckholm, *Theory on Pain Is Driving Rules for Abortion*, N.Y. TIMES (Aug. 1, 2013), [http://www.nytimes.com/2013/08/02/us/theory-on-pain-is-driving-rules-for-abortions.html?pagewanted=all&\\_r=0](http://www.nytimes.com/2013/08/02/us/theory-on-pain-is-driving-rules-for-abortions.html?pagewanted=all&_r=0) (last visited Jan. 11, 2014) [hereinafter Eckholm, *Theory on Pain Is Driving Rules for Abortion*] (reporting various proposed bans on abortions at twenty weeks on the theory that fetuses can feel pain at that gestational age) (on file with the Washington and Lee Law Review).

167. See Julie Rovner, *State Laws Limiting Abortion May Face Challenges on 20-Week Limit*, NPR (July 22, 2013), <http://www.npr.org/blogs/health/2013/07/19/203729609/state-laws-limiting-abortion-may-face-challenges-on-20-week-limit> (last visited Jan. 11, 2014) (explaining that fertilization usually occurs about two weeks after the woman's last menstrual period) (on file with the Washington and Lee Law Review).

168. See *id.* (noting that there is a “consensus that viability doesn't happen before 24 weeks”).

169. See generally *id.* (explaining that “when we're talking about banning abortion at 20 or 22 weeks even, that's clearly at least two weeks before the earliest point in pregnancy where viability would be a concern”).

feeling pain at that stage of pregnancy.<sup>170</sup> However, an alternative ground for sustaining such laws would be the compelling state interest in protecting viable fetuses. The twenty-week line (or twenty-two weeks LMP) would be easier to ascertain and subject to fewer disagreements among medical professionals than a regulatory line based on fetal viability.<sup>171</sup> As a consequence, it would be an easier line for the state to enforce. Such a twenty-week limit on elective abortions would give the state a modest margin of error and help guard against the risk that viable fetuses will be aborted based on erroneous (or fraudulent) determinations that they are not viable.

States are also hindered in protecting viable fetuses because abortions are typically performed in private abortion facilities, making it possible for doctors who perform postviability abortions to conceal their conduct.<sup>172</sup> Though the problem might be addressed through close oversight of abortion clinics, public officials in some states have proved unwilling to monitor clinics to ensure compliance with the law.<sup>173</sup> These problems could be partially addressed through adoption of hospitalization requirements.

While the Supreme Court has declined to permit a hospitalization requirement for all second-trimester abortions,<sup>174</sup> there is strong evidence that risks from second-trimester abortions increase significantly with each additional week of

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170. See Eckholm, *Theory on Pain Is Driving Rules for Abortion*, *supra* note 166 (reporting proposed bans on abortions at twenty weeks, many of which are based on the theory that a fetus can feel pain at that stage in development).

171. The *Colautti* Court noted that gestational age is one of several uncertain factors that play into medical decisions about fetal viability. *Colautti v. Franklin*, 439 U.S. 379, 395–96 (1979). It is virtually axiomatic that there will be more grounds for disagreement over application of a multi-factor analysis than there will be over one of the factors considered in isolation.

172. See, e.g., GRAND JURY REPORT, *supra* note 67, at 247 (noting a lack of sufficient evidence because many of Gosnell's illicit activities were performed inside his private clinic).

173. See, e.g., *id.* at 137–215 (describing the lack of state and local supervision of Gosnell's private abortion clinic in Pennsylvania).

174. See, e.g., *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 452 (1983) (invalidating city ordinance requiring physicians to perform all second trimester abortions at accredited hospitals); *Planned Parenthood Ass'n of Kan. City v. Ashcroft*, 462 U.S. 476, 481–82 (1983) (striking a requirement that second semester abortions be performed in hospitals).



pregnancy.<sup>175</sup> Even Planned Parenthood is willing to acknowledge that “[a]fter 20 weeks, the risk of death from childbirth and abortion are about the same,”<sup>176</sup> but there is good reason to believe that carrying a pregnancy to term is in fact safer than abortion at advanced stages of pregnancy. The Guttmacher Institute acknowledges that abortion risks increase the later in pregnancy the abortion is performed.<sup>177</sup> The study cited by the Guttmacher Institute found that risks from abortion increase exponentially as pregnancy progresses:

Compared with women whose abortions were performed at or before 8 weeks of gestation, women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes. The relative risk (unadjusted) of abortion-related mortality was 14.7 at 13–15

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175. See ABORTION AFTER THE FIRST TRIMESTER, *supra* note 66, at 3 (noting that the rate of complication increases for each week of gestation after eight weeks).

176. See *In-Clinic Abortion Procedures*, PLANNED PARENTHOOD, <http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.asp> (last visited Aug. 10, 2013) (comparing the risk of abortion and childbirth) (on file with the Washington and Lee Law Review). A consent form used at one clinic performing late term abortions informs patients that “[t]he risk of terminating a pregnancy gradually increases throughout the course of pregnancy. These comparative risks become approximately equal at 16–18 weeks of pregnancy and increase so that pregnancy termination at 18 weeks and above involves a greater risk than carrying the pregnancy to term.” *Informed Consent for Pregnancy Termination Treatment, Anesthetic, and Other Medical Services, Southwestern Women’s Options*, PROTECT ABQ WOMEN & CHILDREN, <http://www.protectabqwomenandchildren.com/southwestern-womens-options-consent-form.html> (last visited November 23, 2013) (on file with the Washington and Lee Law Review); Betsy Woodruff, *Albuquerque Votes on Late-Term Abortion Ban*, NAT’L REV. ONLINE (Nov. 18, 2013), <http://www.nationalreview.com/article/364170/albuquerque-votes-late-term-abortion-ban-betsy-woodruff> (last visited Jan. 11, 2014) (“[T]he form clearly states that having an abortion after 18 weeks is more dangerous than carrying the pregnancy to term.”) (on file with the Washington and Lee Law Review).

177. See *Facts on Induced Abortion in the United States*, GUTTMACHER INST. (Feb. 2014), [http://www.guttmacher.org/pubs/fb\\_induced\\_abortion.html](http://www.guttmacher.org/pubs/fb_induced_abortion.html) (last visited Jan. 13, 2014) (“The risk of death associated with abortion increases with the length of pregnancy, from one death for every one million abortions at or before eight weeks to one per 29,000 at 16–20 weeks—and one per 11,000 at 21 weeks or later.” (citation omitted)) (on file with the Washington and Lee Law Review).

weeks of gestation, 29.5 at 16–20 weeks, and 76.6 at or after 21 weeks.<sup>178</sup>

The researchers found a mortality rate of 8.9 deaths per 100,000 abortions at 21 weeks and above.<sup>179</sup> By way of comparison, the Centers for Disease Control and Prevention reports that, as of 1997, overall maternal mortality from carrying a pregnancy to term was 7.7 deaths per 100,000 live births.<sup>180</sup> The researchers cited by the Guttmacher Institute developed a model from their data showing “a 38% increase in risk of death for each additional week of gestation.”<sup>181</sup>

In addition to the safety advantages of a hospitalization requirement partway through the second trimester, performance of late-term abortions in a hospital would make it more difficult to violate a law restricting elective, postviability abortions. With such a hospitalization requirement in place, abortions near the viability threshold would be performed in a mainstream medical facility, rather than a facility dedicated to performance of abortions. This would help promote the accuracy and availability of medical records relevant to issues of compliance with state law.<sup>182</sup> It would also ensure the presence of medical personnel with fewer incentives to violate the law or cover up violations by others.

## VI. Conclusion

When it comes to abortion, there are many points on which Americans disagree. One point of widespread agreement, however, is that states should be able to restrict access to abortion of viable fetuses capable of living independent of the

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178. Bartlett et al., *supra* note 67, at 729. The author has omitted certain 95% confidence interval data from this source to enhance readability.

179. *Id.* at 733.

180. *Achievements in Public Health, 1900–1999: Healthier Mothers and Babies*, CTRS. FOR DISEASE CONTROL & PREVENTION (Oct. 1, 1999), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm4838a2.htm> (last visited Jan. 11, 2014) (on file with the Washington and Lee Law Review).

181. Bartlett et al., *supra* note 67, at 731.

182. See GRAND JURY REPORT, *supra* note 68, at 247 (believing that Gosnell avoided many criminal charges because the illicit activities were isolated within his clinic and therefore it became difficult to secure ample evidence).

mother.<sup>183</sup> An examination of Supreme Court case law<sup>184</sup> and review of the Gosnell case show that even this relatively modest goal can be quite difficult for a state to attain.<sup>185</sup> It would be appropriate for the Supreme Court to help states vindicate their compelling interest in protecting viable fetuses by permitting a reasonable margin for enforcement prior to the uncertain viability threshold and by allowing a requirement of hospitalization as that threshold approaches.

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183. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992) (reaffirming *Roe's* holding that states may regulate abortions of viable fetuses); *Roe v. Wade*, 410 U.S. 113, 163–64 (1973) (concluding that the state's interest in protecting potential life becomes compelling at viability).

184. See *supra* Part II for more discussion of relevant case law.

185. See *supra* Part III for more on the Gosnell case.