



10-1982

Simopoulos v. Virginia

Lewis F. Powell Jr.

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CFR with view to affirm or reverse

Involves validity of Va's
requirement that second-trimester
abortion be performed in a
hospital - & other issues

We have denied ~~the~~ review of this
issue in a case from Indiana (1980)
- WQB, TM & HARB would grant.

But on its facts there is a
poor case to take, & I think
case is correctly decided by Va S/Ct

PRELIMINARY MEMORANDUM

October 9 Conference
List 1, Sheet 1

No. 81-185 ASY

Simopoulos (doctor/criminal defendant)

Appeal from Va S Ct
(Poff for the ct)

v.

Virginia

State/Criminal Timely (w/ext)

SUMMARY: Appt argues that (1) the Va abortion statutes
shift to the defendant the burden of establishing a medical
necessity for an abortion, (2) his conviction violated due
process because the prosecution presented no evidence that appt's
acts caused the destruction or expulsion of the fetus, (3) Va's
mandatory hospitalization requirement for second trimester
abortions is unconstitutional, and (4) on the facts of this case.

CFR although I think affirmance is appropriate. See issues
3+4 at pages 8-12

DL

NO
HUNTON
& W.
PROBLEM
OK

the mandatory hospitalization requirement is unconstitutional because the only available hospital required minors seeking second trimester abortions to have parental consent.

FACTS and DECISIONS BELOW: Appt is a licensed gynecologist. P.M., who was 17 and five and one-half months pregnant, came to appt and requested an abortion. In his clinic, appt injected saline solution into P.M.'s amniotic cavity. She went to a motel room and two days later expelled the fetus.

Appt was indicted under Va. Code §18.2-71 for performing a second trimester abortion outside a hospital. He was convicted and appealed to the Va S Ct. The Va S Ct rejected each of the contentions appt places before this Court.

Appt argued that the indictment was defective because the state did not assume the burden of proving lack of a medical necessity for the abortion. In appt's view, shifting the burden of proof to the defendant violated United States v. Vuitch, 402 U.S. 62 (1971). The Va S Ct pointed out that §18.2-71 makes no mention of medical necessity when defining an illegal abortion. Medical necessity is established as a defense in a later section, §18.2-74.1. Unlike this case, in Vuitch medical necessity was part of the enacting clause. Here, once the defendant invokes the medical necessity defense, the state has the burden of negating medical necessity beyond a reasonable doubt. Furthermore, in this case the evidence clearly showed an absence of medical necessity. Appt testified that his patient was depressed and that he was concerned about suicide. But the

patient testified she was merely scared, and appt's own handwritten notes described her conditions as "normal."

The Va S Ct also found that there was sufficient evidence that appt had destroyed the fetus. Appt acknowledged that he administered saline solution to terminate the pregnancy, and his patient testified that appt told her that the fetus was destroyed. A medical examiner reported that the fetus was born dead. The court concluded that, in the absence of evidence of any other causative factor, the evidence was sufficient to show that the saline solution injection destroyed the fetus.

Appt's challenge to the hospital requirement, §18.2-73, was also unpersuasive, according to the Va S Ct. In Roe v. Wade, 410 U.S. 113 (1973), the Court recognized that the state's interest in the mother's health becomes compelling at approximately the end of the first trimester. The Court specifically stated: "Examples of permissible state regulation in this area are requirements ... as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic" Id. at 163. In Doe v. Bolton, 410 U.S. 179 (1973), the Court struck down the Georgia hospitalization requirement because it included the first trimester and the evidence was insufficient to show that the requirement was reasonably related to maternal health.

Applying these principles, the Va S Ct found sufficient evidence to support the second trimester hospitalization requirement. Appt's expert witnesses testified that a second-trimester out-patient saline injection was a reasonably safe

medical procedure and explained that abortion patients could suffer from the disdain of hospital staff members. One expert cited a study that 65 percent of saline injection patients required no hospitalization after expelling the fetus, and another testified that complication rates are about the same whether the injection is given inside or outside a hospital.

At the same time, though, on cross-examination the experts conceded that complications could develop. One acknowledged that major problems could arise if the solution entered the bloodstream too fast and bleeding occurred. Another admitted that saline injections entail risks which may require observation of the patient, including headache, vomiting, and on rare occasions abrupt swelling of the uterus. The same expert agreed that saline injections can result in extensive hemorrhaging, although hemorrhaging occurs for the most part only during labor.

Thus, from the time the solution is injected until the fetus is expelled, the patient is exposed to certain risks, "some minor, others major, none precisely predictable." J.S. App 18a. The hospitalization requirement is reasonably related to the state's interest in protecting the mother's health.

✓ Nor is the hospitalization requirement unreasonable as applied to Virginia. This case is unlike Margaret S. v. Edwards, 488 F. Supp. 181 (ED La 1980), in which no Louisiana hospital performed second-trimester abortions, and Planned Parenthood Ass'n of Kansas City v. Ashcroft, 483 F. Supp. 679 (WD Mo 1980), in which only one Missouri hospital did so. Two northern

Virginia hospitals and 24 hospitals in the rest of Virginia provided abortion services in 1977.

Even if access to abortion services was inconvenient or conditioned on parental consent, those difficulties were not created by the state. Section 18.2-75 permits hospitals to place certain restrictions on abortion services or to refuse to perform abortions altogether, but it does not require them to do so. See Harris v. McRae, 100 S.Ct. 2671, 2688 (1980) (state need not remove obstacles to abortions which it did not create). Statutes are presumptively constitutional, and appt failed to carry his burden to overcome that presumption.

Appt's conviction was thus affirmed.

CONTENTIONS: Appt takes issue with the Va S Ct's rulings

(1) Burden of Proof for Medical Necessity. In Vuitch, 402 U.S. at 71, the Court stated that "the burden is on the prosecution to plead and prove that an abortion was not 'necessary for the preservation of the mother's life or health.'" The result in this case should not be different simply because of the location of the maternal health exception in the statutory scheme.

(2) Proof of Causation. The prosecution presented no proof of whether a saline injection caused the fetus' demise and failed to demonstrate that there were no intervening causes during the two days while the patient was in the motel. Medical experts testified that not all saline injections cause a fetus to be expelled. When the Va S Ct observed that there was no proof of another causative factor, it missed the point; the critical fact

is that there was no proof that the saline injection was the causative factor.

(3) Mandatory Hospitalization. Appt's experts testified that a second-trimester out-patient saline injection is an acceptable medical practice. The prosecution produced no evidence and no witnesses to counter this testimony. Some lower courts have declared a second trimester hospital requirement unconstitutional. See Margaret S. v. Edwards, supra; Wolfe v. Stumbo, No. C80-0285 L(A) (WD Ky Dec. 3, 1980) (not yet reported).

Gary-Northwest v. Bowen, 496 F. Supp. 894 (ND Ind 1980), aff'd mem., 451 U.S. ____ (1981), is not controlling. In that decision, the DC upheld a mandatory hospitalization requirement for second trimester abortions, and this Court affirmed. But Gary-Northwest was complicated by procedural issues; it was an attempt to reopen the denial of a preliminary injunction five years earlier. In addition, the statute in Gary-Northwest defined hospital to include ambulatory out-patient surgical centers, whereas the Virginia statute is more restrictive. Nor did Gary-Northwest present the argument that mandatory hospitalization is an unconstitutional delegation of power to hospitals, which can decide whether or not to perform abortions and on what conditions. Gary-Northwest was only a decision that the DC did not abuse its discretion in denying a preliminary injunction.

The Va S Ct erred when it relied upon a presumption of constitutionality. Strict scrutiny is applicable to abortion statutes.

) argument

(4) Mandatory Hospitalization in Virginia. Only twenty-six Virginia hospitals perform any abortions. Only two in northern Virginia permit any second trimester abortions. Both of those require minors to have parental consent. If the state conditioned abortions on parental consent, it would violate Planned Parenthood v. Danforth, 428 U.S. 52 (1976). Here, the state is responsible for the parental consent requirement because it authorized hospitals to impose the requirement under the conscience clause, §18.2-75. In effect, the state has permitted the denial of abortions to all minors who are afraid to obtain parental consent.

DISCUSSION: (1) Burden of Proof for Medical Necessity. This issue is ☒ not a substantial federal question. Vuitch is not directly controlling, because it dealt with the construction of the D.C. abortion statute. Moreover, the Va S Ct adequately distinguished Vuitch when it pointed out that lack of medical necessity is not part of the offense. Medical necessity is an exception to the abortion offense, set forth in a section subsequent to the definition of the crime. See Patterson v. New York, 432 U.S. 197 (1977).

Furthermore, the Va S Ct did not hold that the defendant bears the burden of proof. It only held that the defendant bears the burden of production; the Va S Ct stated that the prosecution has the burden of negating the maternal health necessity exception beyond a reasonable doubt once the defendant "invokes" the defense. J S App 10a.

In addition, in this case the prosecution proved lack of medical necessity beyond a reasonable doubt. The patient testified that she was only scared, and appt's own notes characterized her condition as normal.

(2) Proof of Causation. Nor is this issue a substantial federal question. The patient testified that she took no drugs during her stay in the motel other than an analgesic which appt had prescribed. It was undisputed that appt had injected saline solution into the amniotic cavity. This evidence was sufficient to establish a connection between the destruction of the fetus and the saline injection.

Appt notes that his experts testified that saline injections do not always cause a fetus to be expelled. But appt was not indicted for causing the fetus to be expelled. He was indicted for causing the fetus to be destroyed. See J S App 11a.

(3) Mandatory Hospitalization. At the outset, it should be underscored that neither appt nor the Va S Ct give appt's evidence its full due. In Simopoulos v. Virginia State Board of Medicine, 644 F.2d 321 (CA4 1981), the CA4 rejected on abstention grounds appt's attempt to prevent the Board from suspending his right to practice medicine. In the course of his opinion, 644 F.2d at 332 (Butzner, J., concurring and dissenting), Judge Butzner spelled out the evidence appt presented at trial:

[Appt] presented as witnesses the chairman of the department of obstetrics and gynecology at the Albert Einstein College of Medicine, an associate clinical professor in obstetrics and gynecology at George Washington University, and a Virginia physician who specializes in obstetrics and gynecology. These witnesses testified that the procedure followed by the doctor is acceptable medical practice in an outpatient

facility, and they stated that the doctor's clinic was well equipped for such practice. One of the witnesses added that even when treatments to induce a second trimester abortion are administered at a Virginia hospital, where he had served as chairman of the department of obstetrics and gynecology, the patients are frequently allowed to leave the hospital before they abort. The state presented no witness to contradict this testimony.

The lower courts have reached varying results on the constitutionality of second trimester hospitalization requirements. See Margaret S., 488 F. Supp. at 194-96 (hospitalization requirement unconstitutional because no Louisiana hospitals perform second trimester abortions and because D & E method is as safe as childbirth up to eighteenth week); Planned Parenthood Ass'n of Kansas City, 483 F. Supp. at 686-87 (D & E procedure safest second trimester abortion method and hospitalization requirement invalid because only one western Missouri hospital will perform it) ; Akron Center for Reproductive Health v. City of Akron, 479 F. Supp. 1172, 1215 (ND Ohio 1979) (refusing on the basis of plaintiff's evidence to abandon Roe v. Wade language that state may regulate after first trimester); Wynn v. Scott, 449 F. Supp. 1302, 1317-18 (ND Ill 1978) (citing Roe v. Wade and upholding hospitalization requirement).

In a recent decision, the CA8 vacated the DC holding in Planned Parenthood Ass'n of Kansas City. Planned Parenthood Ass'n of Kansas City v. Ashcroft, Nos. 80-1130 & 80-1530 (CA8 July 15, 1981) (slip op.). The CA8 accepted the DC's premise that a second trimester hospitalization requirement could be rendered

invalid by improved abortion procedures. But the CA8 remanded for further factual findings to determine whether the hospitalization requirement in fact discouraged D & E abortions and whether nonhospitalized D & E abortions are considerably more dangerous than hospital procedures. Slip op. at 8-14.

In Gary-Northwest, the DC rejected a challenge to a hospitalization requirement as applied to the D & E procedure, and this Court affirmed. 49 U.S.L.W. 3806. ✓ Justices Brennan, Marshall, and Blackmun would have noted probable jurisdiction. It is difficult to discern whether the Gary-Northwest affirmance governs this appeal. The DC rested its constitutional argument on the Roe v. Wade language that hospitalization during the second trimester is permissible. The DC upheld the hospitalization requirement by finding that it furthered maternal health. 496 F. Supp. at 901-02. But at the same time, the DC stated that even if the plaintiffs prevailed on their legal theory that a safer abortion procedure could require alteration of Roe v. Wade, they would still lose because they had presented insufficient proof of safety to justify a preliminary injunction. Id. at 902-03.

If the Gary-Northwest affirmance amounted to a holding that second trimester hospitalization requirements are per se constitutional, this issue is not now a substantial federal question. But if the affirmance rested on the quantum of the Gary-Northwest appt's proof, the Court should at least call for a response. The state in this case presented no evidence other than what it elicited on cross-examination, and appt's evidence

tended to show that saline injections could be performed safely outside hospitals.

It should be noted, however, that this case is not an ideal one to review the hospitalization requirement. As Gary-Northwest illustrates, most of the challenges to the hospitalization requirement have been based on the newly-developed D & E method. The saline injection method is not as safe as the D & E procedure, and the saline injection method existed when Roe v. Wade was decided. See Planned Parenthood Ass'n of Kansas City, 483 F. Supp. at 686 n. 13.

(4) Mandatory Hospitalization in Virginia. The only two northern Virginia hospitals that perform second trimester abortions require minors to have parental consent. According to appt, the hospitalization requirement combined with the practice of the only two available hospitals amounts to an invasion of a minor's privacy in violation of Danforth. One DC has accepted a virtually identical argument. Planned Parenthood Ass'n of Kansas City, 483 F. Supp. at 687 (second trimester hospitalization requirement falls because no hospital in Missouri will admit minor without parental consent). But the DC was subsequently reversed by the CA8. Planned Parenthood Ass'n of Kansas City, slip op. at 5-8 (constitutionality depends upon health-based rationale for state's requirement, not on the actions of private entities).

A variation on this argument was rejected by the DC in Gary-Northwest. See 496 F. Supp. at 896-7 (only one Indiana hospital performed nontherapeutic second trimester abortions). The DC,

like the Va. S. Ct., cited language in Harris v. McRae that the government need not remove obstacles that it did not create. Again, if this Court meant to endorse all the reasoning of Gary-Northwest when it affirmed, there is no need to give this aspect of this case close attention.

However, the Court may have rested the Gary-Northwest affirmance on the DC's decision not to grant a preliminary injunction because of the plaintiffs' proof. If so, then it cannot be said that this issue is insubstantial. The Harris v. McRae language may govern. On the other hand, the state may not have responsibility for a poor woman's indigency and at the same time have responsibility for parental consent requirements when it mandates hospitalization and then permits hospitals to require parental consent. Also, this aspect of the appeal is not hindered by the problems of proof surrounding the safety of the saline injection method, as is appt's general challenge to the hospitalization requirement.

Given the ambiguity of the Gary-Northwest affirmance, call for a response.

Of course, there is [✓]no response.

September 21, 1981

Holleman

Opn in petn

Court
Argued, 19...
Submitted, 19...

Voted on....., 19...
Assigned , 19...
Announced , 19...

81-185
No.

SIMOPOULOS

vs.

VIRGINIA

Relected
on WLB
Jan 1982
Conference
Jan 5th.

[illegible]

Court
Argued, 19...
Submitted, 19...

Voted on....., 19...
Assigned, 19...
Announced, 19...
No.

81-185

*Abortions
cases*

SIMOPOULOS

vs.

VIRGINIA

*4/29
Grant - Best case
Presents both
issues (parental consent
& hospitalization 2nd
trimester)*

FCR CONFERENCE FRIDAY, APRIL 16, 1982

STATEMENTS AS TO JURISDICTION

DISCUSS

81-185-ASY

SIMPOULLOS, CHRIS V. VIRGINIA
(Relist)

*Envolver Va -
Deny or Hold*

DISCUSS

81-746-CFX

AKRON, OHIO V. AKRON CENTER, ET AL.
(Relist)
(This is a petition for certiorari)

*City Ordinance
similar to MO
statute in Ashcroft
Grant*

DISCUSS

81-854-CFX

SEGUIN, FRANCOIS, ET AL. V. AKRON CENTER, ET AL.
(Relist)
(This is a petition for certiorari)

DISCUSS

81-1178-CFX

AKRON CENTER, ET AL. V. AKRON, OHIO, ET AL.
(Response requested and received)
(This is a petition for certiorari)

DISCUSS

81-1255-CFX

PLANNED PARENTHOOD OF KANSAS CITY V. ASHCROFT, A.G.
(Response requested and received)
(This is a petition for certiorari)

*no statute
like Akron
ordinance
Grant*

DISCUSS

81-1623-CFX

ASHCROFT, ATTY. GEN. OF MO V. PLANNED PARENTHOOD, ET AL.
(Waiver of right to file brief by respondents)
(This is a petition for certiorari)

O'Connor, J.....

turner

Reluct
for
Feb 18th
(W & B)

[illegible]

Court

Voted on....., 19...

Argued, 19...

Assigned, 19...

No. 81-185

Submitted, 19...

Announced, 19...

VS.

VIRGINIA

appeal

front of
several
abn time cover

[illegible]

Content Case (5/3/82)

Best
est. Case
me

81-185 Simopoulos v. Va - Grant
Both issues: parental consent
& second trimester hospitalization)

Both
may
be
most.
The pregnant
daughters
are
now
over 15

81-746 Akron v Akron Center - Deny
Parental mootness ~~issue~~
(Consent issue)

81-854, Sequin v. Akron Center - Deny
(Curved lined with 81-746)

81-1172, Akron Center v Akron - Grant?
also curve lined with 81-746
But is not most as it also
presents "hospitalization issue" ←

81-1255 Planned Parenthood & Deny
v. ~~Super~~ Ashcraft
(Consent issue poorly presented)

81-1623 Ashcraft v. Planned Parenthood Grant
Hospitalization
issue - but with some
variations.

Voted on....., 19...

Argued, 19...

Assigned, 19...

No. 81-185

Submitted, 19...

Announced, 19...

SIMOPOULOS

vs.

VIRGINIA

Noted

[illegible]

Lucas (Petr)

Only two hospitals in Va. permit 2nd Tri. abortions.

If Point I or II is decided in favor of Petr, we don't reach the hospitalization issue.

Va law as ~~const~~ construed would outlaw all 2nd T. abortions.

Burrows (Dep AG)

Relier on Roe

2nd Tri - only 3 conditions:

1. Informed consent
2. Physician
3. Hospital - including Outpatient Surgical Hospital. (Part II)

all hospitals must be licensed

Relier on Engle
v. Isaac
on the Q of
burden of
proof
on necessity

Va law requires no standards that would be incompatible with the standards of our College.

Petr's ev. supported her position that his facilities would have entitled her to a license.

Petr left decision entirely up to women.

App - 5
Remand - 2
Reverse - 1

Vote on
Hospitalization
issue

81-185 Simopoulou v Va Conference
12/16/82

C.J. Absent - ill.

Read
statement

W.J.B. Issue No 1 - Affirm

Va Court's construction of statute
should be accepted. Necessity is an
affirmative defense.

Issue No 2 - Affirm

Evidence was sufficient - causation, OK.

B.P.W. Agrees with WJB on both of these
issue - affirm

T.M. Agree? - affirm tentative
~~Remand~~

L.F.P. Agree with WJB - Affirm both issues

J.P.S. Agree - affirm on both

S.O.C. Agree - affirm on both

Issue No 3 - Hospitalization - Affirm

WJB - Va statute quite different from
that of Ark + Mo. Clinics are authorized

Do not impose sig. burden if
construed narrowly. But Va authorized
clinics are elaborate & may be
expensive. Clinic of Petr did not qualify.

(See next page
for continued discussion)

Issues
#1 & 2
were
discussed
together

Va Case - Hospitalization issue (continued)

~~so~~ under Va law. But this abortion was performed at 5 1/2 mo. - rather late. May not meet standards of Am. College O.G.

Va S/ct could be affirmed ^{on} ~~the~~ ground that Va may regulate 2nd semester abortion. But would affirm on narrower ground that Petr. didn't apply - & we don't need to decide whether this clinic would be OK.

BRW - Aff on any ground.

T.M. - ^{Rev. &} Remand - on E/P grounds

H.A.B. - ^{Rev. &} Remand - agree

Va Regs. seem reasonable - but not sure Va S/ct passed on validity of the Regs. in question. No other surgery results in a ~~fatal~~ fatality.

E/P argument is ^{persuasive} ~~not persuasive~~

L.F.R. - Aff - Va Statute & Regs OK

W.H.R. - Aff on any ground. Agree with ^{BRW}

J.P.S. - Reverse & Remand

Uncertain what Regs require. Regs must serve health purposes. Va. statute is not neutral. ~~no~~

S.O.C. - Aff on any grounds.

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE WM. J. BRENNAN, JR.

December 16, 1982

MEMORANDUM TO THE CONFERENCE

RE: ABORTION CASES

Attached is my record of today's conference
votes on the several issues in the three abortion cases.

Bill
W.J.B.Jr.

CASE	ISSUE/REQUIREMENT	DECISION BELOW	VOTE
<u>Simopoulos v. Virginia</u> No. 81-185 S.Ct. Va.	Failure to allege or prove lack of maternal necessity	Defendant must raise necessity defensively; State must disprove it.	<i>Affirm 8-0</i>
	Failure to prove causation	State proved causation.	<i>Affirm 8-0</i>
	Hospitalization in 2d trimester	Requirement held valid	<i>Affirm 5 - WJB, BRW, LFP, WHR, SOC</i> <i>Reverend 2 - TM, HAB</i> <i>Rev-1 J</i>
<u>Planned Parenthood v. Ashcroft</u> No. 81-1255 CA8	Parental Consent (i) Should Court abstain? (ii) Merits	No. 8-0 Statute given construction consistent with <u>Bellotti II</u> .	<i>Aff-4 BRW, LFP, WHR, JPS</i> <i>Rev-4 WJB, TM, HAB, JPS</i>
<u>Ashcroft v. Planned Parenthood</u> No. 81-1623	Hospitalization in 2d trimester (i) Hospitals require parental consent to admit minors	Invalidated after remand Hospitalization requirement not invalidated on this basis.	<i>Aff-5 WJB, TM, HAB, LFP, JPS</i> <i>Rev-3 BRW, WHR, SOC</i> <i>no discussion</i>
	Pathologist must examine tissue samples	Invalid. "	<i>Rev-6 WJB, BRW, TM, LFP, WHR, SOC</i> <i>Aff-2 HAB, JPS</i>
	Second physician for fetus after viability	Invalid.	<i>Rev-5 BRW, LFP, WHR, JPS, SOC</i> <i>Aff-3 WJB, TM, HAB</i>
	Attorneys fees	Awarded in full to PP for work in 1255&1623.	<i>Noted for Hensley v. Eckerhart</i>
<u>Akron v. Akron Ctr for Reproductive Health</u> No. 81-746 CA6	Parental Consent (i) Jurisdiction (ii) Merits Parental Notification Informed Consent (i) Severability (ii) Provisions (iii) Attending doctor must counsel personally Waiting Period Disposal of Fetal Remains	Yes - 7 no-1 HAB Invalid. Valid under Matheson. <i>If before CT</i> Invalid Invalid. Invalid Invalid	<i>Aff-5 WJB, TM, HAB, LFP, JPS</i> <i>Rev-3 BRW, WHR, SOC</i> <i>Aff-4 BRW, WHR, JPS, SOC</i> <i>Rev-4 WJB, HAB, TM, LFP</i> <i>inconclusive discussion</i> <i>Aff-6 WJB, TM, HAB, LFP, JPS, SOC</i> <i>Rev-2 BRW, WHR</i> <i>Aff-5 WJB, TM, HAB, LFP, JPS</i> <i>Rev-3 BRW, WHR, SOC</i> <i>Aff-6 WJB, TM, HAB, LFP, JPS, SOC</i> <i>Rev-2 BRW, WHR</i>
<u>Akron Ctr for Reproductive Health v. Akron</u> No. 81-1172	Hospitalization in 2d trimester	Valid.	<i>Rev-5 WJB, TM, HAB, LFP, JPS</i> <i>Aff-3 BRW, WHR, SOC</i>

The issue of "Parental Notification" in the Akron case was considered on the merits with a vote of 4 - 4. Actually, the question is not before the Court. It was held valid below and nobody sought review of that holding here.

lfp/ss 12/17/82

81-185 Simopoulos v. Virginia - Conference 12/16/82

CJ absent due to illness.

This memorandum will summarize the votes on the three issues before us. My yellow notes give some - but by no means all - of the details.

Issue No. 1 - Burden of Proof on "Necessity"

Affirmed: 8-0.

Issue No. 2 - Sufficiency of Evidence and Causation

Affirmed: 8-0.

Issue No. 3 - Hospitalization

Affirmed: 5-3

Votes to affirm: WJB (tentative), BRW, LFP, WHR,
and SO'C.

Reverse and remand: TM, HAB and JPS

Virginia's provision for clinics distinguishes
this case from Akron and Ashcroft.

lfp/ss 04/05/83

SIM SALLY-POW

MEMORANDUM

81-185 Simopoulos

TO: Jim and Mark

DATE: April 5, 1983

FROM: Lewis F. Powell, Jr.

This memo is being dictated Monday evening at home as I reread our opinion. It is prompted by our discussion of revising our opinion with the view of forestalling a move by other Chambers to vacate and remand. The observations and comments below are made at random, with no attempt at cohesion.

1. At page 11 we say that the issue:

"Is whether Virginia's licensing requirements for outpatient surgical clinics performing second trimester abortions are reasonable means of furthering the state's compelling interest in the woman's health". (p. 11).

This framing of the issue is not likely to be accepted by Justices who wish to vacate and remand. I will not try to anticipate how they might define the issue. We might reframe our draft roughly as follows:

"The issue here is the validity of Virginia's requirement that second trimester abortions be performed in a licensed 'hospital' as the term hospital is defined by regulations to include 'outpatient surgical hospitals'."

2. We have talked about the possibility of describing the regulations in general terms without making judgments as to the validity of specific provisions. The holding would be that the Virginia requirements that second trimester abortions be performed in outpatient hospitals, and the regulations implementing these requirements, are facially valid.

3. I am inclined to think we could leave Part II, including subpart C, substantially as now written.

4. Part III would have to be revised substantially. The first two paragraphs that begin on page 14, except for the last sentence thereof (commencing at the top of p. 15), probably could be retained with some editing.

The entire remaining portion of Part III would be rewritten briefly and in general terms. I will not undertake this beyond suggesting some thoughts as to what we might say and not say.

First, we would not discuss specifically any of the "categories" of regulations identified briefly in Part II-C. Rather, the opinion could move summarily to a conclusion of facial validity on the record before us. We would repeat that appellant for its own reasons has chosen

to challenge Virginia's entire regulatory requirements of second trimester abortions. The Virginia statutes require "hospital" facilities that may include "clinics". They authorize the State Board to adopt regulations, and these permit such abortions only in outpatient surgical hospitals.

Appellant has not questioned the validity of any particular regulation applicable to second trimester abortions. We therefore have no occasion to consider the validity of each of them as applied in this case. Appellant's attack is focused on - and limited to - Virginia's hospitalization requirements in total. He contends specifically, with respect to this case, that his conviction was unlawful because Virginia may not require second trimester abortions - even after 20/22 week of pregnancy - to be performed in the facilities authorized by Virginia law. Appellant knew - at least by time of his trial (see, supra, at ____) - that the specific hospitalization requirement was a licensed outpatient facility. But he chose to question any "hospitalization" requirement for second trimester abortions and to attack the entire Virginia framework.

This requires that we consider only the facial validity of the Virginia requirements. We have compared these with the recommendations of ACOG and APHA, to be set forth either in the footnotes or in an appendix. Although there are differences in detail, the Virginia regulations are carefully drawn to conform generally with the standards recommended by ACOG and APHA. It clearly appears that the Virginia regulations are compatible with generally accepted medical standards applicable to the performance of second trimester abortions. We therefore conclude, on the basis of the record before us, that Virginia's regulations further the state's controlling interest in the health and safety of the pregnant woman.

We could put a footnote here somewhat along the lines of what we now have in the text on page 19. A state cannot be expected to adopt regulations that serve every case with the same degree of relevance, as "[a] state necessarily must have some latitude in adopting regulations of general application in this sensitive area" (perhaps including the balance of the paragraph beginning on page 19).

5. I hardly need say that the foregoing is the roughest sort of summary of how Part III might be

rewritten. I have made no attempt to frame precise language or to identify footnotes to be included and excluded. Perhaps we should consider seriously, as a means of reducing the footnotes and also preserving most of the relevant regulations of ACOG and APHA, including these in an appendix.

5. In addition to changes along the foregoing lines, it would be necessary to confront specifically the inclination - if not conviction - of those who would vacate and remand. I have not thought this through with any care. Nor do I have Cory's memo before me. Tentative views as to what might be included at an appropriate place are as follows:

For the first time in his reply brief filed with this Court, appellant focuses specifically on the hospitalization outpatient regulations. In addition to embracing them within his general challenge to Virginia's entire hospitalization requirements, appellant says that the state did not rely on the regulations at trial and therefore he had no opportunity to contest them.

As noted (n. 2), appellant was indicted for violating §§18.2-71 and 18.73 that make it a crime, so far as relevant - to perform an abortion within the second

trimester except in a "licensed hospital". As stated in the text (p. 4) the term "hospital" is defined in §32.1-123.1 to include "outpatient . . . hospitals", and the regulations duly adopted by the Department Health include carefully drawn regulations and prescribe minimum standards for these hospitals. The regulations also make clear that second trimester abortions are to be performed in them. No question is raised as to the adequacy of the indictment. Nor has appellant denied that he failed to comply with the state requirements. From the outset, he simply has challenged them all. The state met the challenge on the terms in which it was made:

The transcript of the trial records that on direct examination by his counsel, appellant acknowledged the existence of the outpatient regulations, stated that he was seeking a license, but denied that he knew of the regulations when the abortion was performed - even though they had been considered at public hearings and adopted some two and a half years earlier (see n. 7). Despite full knowledge of the regulations at the time of trial, appellant elected to defend only by a sweeping attack on all of Virginia's hospitalization requirements.

His belated claim of no opportunity to contest the regulations, made only in a few sentences in his reply brief here, comes too late. Whether a trial tactic or not, deferring until this Court to advance this claim in a procedural default.

* * *

Jim and Mark: The foregoing contains much of what we have in the opinion. Perhaps some or all of the new thoughts included above could be woven into the text of our present opinion. The alternative would be to make appropriate changes in the text and present footnotes and try to deal with all of this textually or in revised notes.

I see that I have not mentioned the Brennan/Blackmun point that it is not clear whether the Virginia court considered the regulations - even facially. It certainly had the statutes that authorized the regulations before it, and it decided the case on the basis of appellant's challenge. We are not obligated to remand in light of this.

L.F.P., Jr.

ss

lfp/ss 04/07/83

MEMORANDUM

TO: Jim DATE: April 7, 1983
FROM: Lewis F. Powell, Jr.

81-185 Simopoulos

Your suggested revisions of this date, marked on a copy of Chambers Draft No. II, are quite an improvement in organization.

I still would like to try out on you and Mark the following thoughts as to what might be added at appropriate places, in the text or notes.

1. Section 18.2-73 provided an "exception" - i.e. a defense - to the felony for which appellant was indicted. The abortion would have been lawful if "performed in a licensed hospital". As appellant had not applied for a license this defense was not available. He therefore broadly attacked Virginia's entire hospitalization requirements, equating them erroneously to the acute care hospitalization requirements before this Court in City of Akron and Askcroft.

2. I agree, Jim with your idea to put the details of appellant's reply brief arguments in a

footnote. In addition to the general "brush off" that we give them at present, I am inclined to think, subject to what you and Mark think, that something more should be said, for example:

We can be reasonably sure that the opinion we expect from Justice Blackmun will rely heavily on respondent's belated argument that the Virginia courts "had no opportunity to construe the 'licensing statutes and regulations'." I would answer by saying that appellant chose to attack the entire Virginia framework of regulation. As appellant neither the invalidity of the outpatient surgical clinic regulations adopted pursuant to the Virginia statutes, nor presented any evidence bearing on their validity, the Virginia court did not address the regulations apart from its specific approval of the entire Virginia regulatory provision. It is too late for appellant now to rely on grounds he had never advanced below, did not present as an issue in his jurisdictional statement, and did not mention here until his reply brief.

3. In holding as it did that "second trimester abortions must be performed in hospitals as required by Virginia law", the State Supreme Court necessarily

sustained the validity of the duly adopted regulations pursuant to the Virginia statutes.

4. On p. 15, you have added a sentence to the effect that possibly certain individual regulations are unreasonable. We need not go this far. It is important to make entirely clear that even appellant's reply brief finds no fault with any specific regulation. It would be appropriate, perhaps, simply to say in a footnote that as appellant has made only a facial challenge in the broadest language, we need not consider whether a particular requirement in the regulations may be invalid as applied. As Akron makes clear, in view of a state's compelling interest it may adopt regulations. Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on the entire Virginia scheme.

5. We have speculated as to what would happen if this Court vacated and remanded. In the absence of evidence with respect to the regulations, the Virginia Supreme Court could simply do as we would: find them facially valid. It is unlikely, however, that Justice

Blackmun would consider this satisfactory. My guess, therefore, is that he may well argue that the regulations never entered into this case at all; that the Commonwealth was as neglectful as Simopoulos, and that the conviction should be set aside and a new trial ordered. I suppose at such a trial, the defendant would then attack the regulations as applied.

I am not suggesting that we anticipate what Justice Blackmun may do in this respect. We simply should keep it in mind.

L.F.P., Jr.

SS

April 8, 1983

81-185 Simopoulos v. Virginia

Dear Chief:

Thank you for your recent note. I am making some clarifying changes in note 12, page 10 (note 10, page 7 of the 1st draft) that I think will meet your suggestions. I have the documentation that assures the accuracy of these notes.

Your letter gives me an opportunity to bring you down to date on the situation with respect to the three abortion cases as I understand it.

Simopoulos

First as to Simopoulos. You are the only member of the Court who has approved it even informally. Bill Brennan has suggested in a letter to me that we should vacate and remand the case for reconsideration by the Supreme Court of Virginia. Harry and John have the same view - at least tentatively.

They make the point that the Virginia court did not specifically address the validity of the regulations, and neither did the parties below. In my view, the reason that court wrote as if it were reviewing acute care, general hospitalization requirement without specifically addressing the regulations, is that Simopoulos elected to challenge Virginia's hospitalization requirements as if they were the same as those reviewed in City of Akron and Ashcroft. He did not distinguish between full service hospitals and the ambulatory surgical hospitals (clinics) that Virginia law contemplates.

We are entitled, I think, to decide the case on the record on which Simopoulos chose to rest his defense. I therefore have no disposition to remand rather than affirm the conviction.

I have spoken briefly to Sandra who is writing in all three of these cases. She indicated that though she did

not expect to join in my analysis, she would affirm the conviction. I believe Bill Rehnquist also is of this view, and Byron voted at Conference to affirm. If the case were vacated and remanded it would be back here in a year or two, and meanwhile we would have given no guidance as to the validity of performing abortions in outpatient clinics.

I am considering making some revisions in section III that now may address the Virginia regulations in too much detail.

* * *

Akron and Ashcroft

It is also important that you join as much of these two cases as you can. The "hospitalization" issue is the principal one. It also is the issue that has caused the greatest confusion - a confusion arising primarily as to how Roe would be construed. I have a bare Court for Akron, and presumably will have a Court on the hospitalization issue in Ashcroft that is identical to the hospitalization requirement in Akron.

When you reread Roe, I think you will agree that I have written the hospitalization issue as narrowly as possible consistently with that case.

* * *

You noted when you asked me to write these opinions that you and I were in accord on most of the numerous issues. I know that you have had strong feelings as to parental notice, and yet - also as we mentioned - the combination of what I wrote in Bellotti II (a plurality of four) and our combined opinions in Matheson have settled the rule with respect to parental notification. It is not the rule for which HAB contended in Bellotti II.

Forgive this "long winded" letter. These are important cases, and the Court needs the authority of the Chief Justice in deciding them.

Sincerely,

The Chief Justice

lfp/ss

April 12, 1983

81-185 Simopoulos v. Virginia

Dear Bill and Harry:

I enclose for your consideration a substantially revised draft of an opinion.

The basic change is the elimination of the discussion of particular regulations. This draft also makes clearer that we would be deciding the case only on the record before us - a record containing no evidence as to unreasonableness of individual regulations.

With full knowledge of the regulations, appellant elected to ignore them - apparently as a trial strategy - and to analogize Virginia's overall regulation of abortions to those before us in City of Akron and Ashcroft. This is even clearer to me now than at the time of my first circulation.

As your Chambers know, we have since obtained the entire available record including the history of the adoption of the regulations almost two and a half years before the abortion at issue was performed. Appellant had a full opportunity to attack the reasonableness of the regulations. My guess is that since he had made no effort to obtain a license, he chose the strategy of arguing that the entire Virginia scheme is invalid.

In these circumstances, I remain persuaded that it is appropriate and desirable to affirm. Appellant should not benefit from his own choice of defense strategy. The opinion as now drafted clearly holds only that on the basis of the record before us the regulations appear to be compatible with accepted medical standards.

I add that our clerks have been collaborating - constructively I think. Of course, I do not suggest "politicizing" of any kind: merely that they have been mutually helpful.

I add one caveat. The Chief Justice has indicated that he approved my prior drafts. As the enclosed is a major revision, I would have to submit this to him.

Sincerely,

Justice Brennan
Justice Blackmun

lfp/ss

April 28, 1983

81-185 Simopoulos v. Virginia

MEMORANDUM TO THE CONFERENCE:

Here is another draft of my opinion in this case. There are a number of changes throughout.

The principal change is the elimination of specific consideration of each of the regulations individually. The record contains no evidence as to the unreasonableness of individual regulations. Rather, with full knowledge of the regulations (see n. 19, p. 12), appellant elected - apparently as a trial strategy - to challenge Virginia's overall regulations of abortions, arguing that in effect they were comparable to those in City of Akron.

Since my earlier circulation, I have obtained the entire available record including the history of the adoption of the regulations almost 2-1/2 years before the abortion at issue was performed. (See n. 6, p. 6-8).

The opinion as now drafted would hold that, on the basis of the record before us, the regulations on their face appear to be compatible with accepted medical standards.

L.F.P., Jr.

lfp/ss 02/02/83

MEMORANDUM

TO: Jim

DATE: Feb. 2, 1983

FROM: Lewis F. Powell, Jr.

Simopoulos

This memo relates only to the description of the requirements of the Virginia regulations, and particularly to the category of descriptions beginning on p. 14.

I have dictated a separate rider covering the first category, my purpose being to de-emphasize the "corporate" requirements.

I suggest that you consider doing substantially the same thing with respect to the second category. The construction standards for the physical facilities will be used against us by dissenters. Although we can't ignore them, try your hand at a summary paragraph. If you can reduce it to a couple of sentences, it could be added to the same paragraph with the first grouping. For example, I see no reason to talk about parking and fire codes. It is well to emphasize to the extent it is true, that the requirements apply to all outpatient surgical clinics.

As noted in the margin on page 15, if the provision authorizing "deviations" applies to all of the regulations, this should be emphasized separately.

As indicated in the margin of page 15, I would omit notes 13-15, but save a couple of copies of your first draft as we may need them when dissents come in. Possibly

to avoid being criticized for overlooking these sections,
you could say - in a single note - that the regulations contain customary provisions with respect to meeting building codes, zoning ordinance and the like.

L.F.P., Jr.

ss

lfp/ss 02/02/83

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TO: Jim DATE: Feb. 2, 1983
FROM: Lewis F. Powell, Jr.

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L.F.P., Jr.

ss

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
THE CHIEF JUSTICE

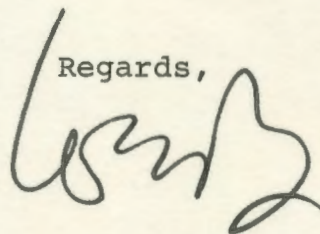
March 11, 1983

Re: No. 81-185, Simopoulos v. Virginia

Dear Lewis:

I am with you but will have a few small suggestions
that will give you no trouble.

Regards,



Justice Powell

Copies to the Conference



Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
THE CHIEF JUSTICE

PERSONAL

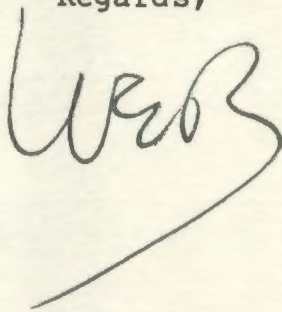
April 4, 1983

Re: No. 81-185, Simopoulos v. Virginia

Dear Lewis:

I am not at rest on the two "Akron" cases yet. I am generally on the above. However I am "uncomfortable" with the declaratory statements in note 10, page 7. They are, of course, attributable to the source cited at the end of the statements. But would it not help if a "said to be" were inserted early in Note 10, with a similar qualifier in the second paragraph of note 7? Quoted out of context it could appear the Court is making the statements, as to which we are not informed first hand.

Regards,



Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE WILLIAM H. REHNQUIST

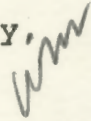
March 7, 1983

Re: No. 81-185 Simopoulos v. Virginia

Dear Lewis:

I will await Sandra's writing.

Sincerely,



Justice Powell

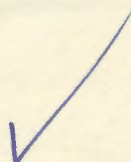
cc: The Conference



Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE SANDRA DAY O'CONNOR

March 7, 1983



No. 81-185 Simopoulos v. Virginia

Dear Lewis,

I will concur in the judgment in this case
and will circulate something in due course.

Sincerely,

Justice Powell

Copies to the Conference

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE JOHN PAUL STEVENS

March 7, 1983

Re: 81-185 - Simopoulos v. Virginia

Dear Lewis:

It seems doubtful to me that in 1979 either the Virginia Legislature or the medical profession understood that the statutory requirement that a second trimester abortion must be performed in a hospital could be satisfied by making use of an out-patient surgical clinic. I shall therefore wait for further writing in this case.

Respectfully,



Justice Powell

Copies to the Conference

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE HARRY A. BLACKMUN

March 8, 1983

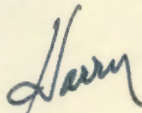
Re: No. 81-185 - Simopoulos v. Virginia

Dear Lewis:

After reading and reflecting upon your proposed opinion for this case, I have settled down at the alternative position I took at conference. I now have concluded to vote to vacate the judgment and remand the case for reconsideration in the light of Akron.

I am inclined to this conclusion because your opinion deals at length with the Virginia regulations. Yet those regulations were not really considered by the Supreme Court of Virginia. They are hardly mentioned in their opinion, and the regulations, of course, were issued long after the statute was enacted. I would be far happier to have the Virginia Supreme Court consider those regulations, their meaning, and their reach and application in the first instance, and then let the case return here.

Sincerely,



Jutsice Powell

cc: The Conference

CHAMBERS OF
JUSTICE WM. J. BRENNAN, JR.

March 9, 1983

No. 81-185 Simopoulos v. Virginia

Dear Lewis:

As with your Akron opinion, I am impressed with the effort and thought you have so clearly devoted to this case. Your opinion makes a very strong case that Virginia's hospitalization requirement, as you interpret it, meets our constitutional standard, and it generally conforms to the view I expressed at conference. However, after giving the matter some thought, I am inclined to agree with Harry and John that we should not be the ones to interpret the Virginia statute in the first instance.

Sorry though I would be to see your careful work go for nought, I ask you to consider whether it wouldn't be a good idea to dispose of this case with a brief per curiam vacating and remanding for reconsideration in light of Akron. I make this suggestion for two reasons. First, although there is no absolute bar to interpreting the Virginia statute for the first time in this Court, and although I think your interpretation is correct, surely if all other things were equal we would prefer to let the Virginia Supreme Court say what "hospital" means before we addressed the constitutionality of the statute. Second, given the likely outcome in Akron, Simopoulos will be a very important case, for it will tell the states what they can do by way of regulating abortions. If we can avoid it, I think we should not let such a crucial opinion issue without a clear majority.

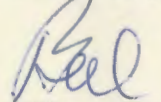
At the same time, I believe (and I'm sure you agree) that the states should have some guidance. A per curiam opinion in Simopoulos might well serve that function. In vacating and remanding, we could focus attention on the possibility that Virginia's hospitalization requirement, if in fact it is what you say, would pass muster under the Akron standard. A remand would also permit full airing of the issues involved in regulating outpatient second-trimester abortions. I am afraid that many pro-

fessional groups and other amici have overlooked the importance of Simopoulos in this year's trilogy.

Accordingly, I offer the following rough suggestion as something that might prove acceptable to a majority--indeed, perhaps to all of us:

The only substantial federal question presented by this appeal is similar to one addressed today in City of Akron v. Akron Center for Reproductive Health, ante, at 12-20: Is Virginia's statute requiring doctors to perform all second-trimester abortions in a hospital constitutional? We are informed, however, that the relevant statute, Va. Code §18.2-73, may incorporate by reference a definition of "hospital" in Va. Code §32.1-123.1 and regulations promulgated thereunder, which include as "hospitals" certain facilities providing surgical services primarily on an outpatient basis. If so, the Virginia hospitalization requirement differs materially from the corresponding provision in Akron. The Virginia statute so interpreted may burden women and their doctors far less than a statute requiring that all second-trimester abortions be performed in an acute-care hospital. In the opinion under review, however, the Virginia Supreme Court did not adopt or even address the interpretation of §18.2-73 pressed in this Court by Virginia's Attorney General. Rather, it relied on grounds much like those we reject today in Akron. See 221 Va. 1059, 277 S.E.2d 194 (1981). If we were to consider the Attorney General's argument, we would have to interpret the statutory law of Virginia in the first instance. Prudence suggests that the highest court of the Commonwealth should have the opportunity to address the crucial question of what the word "hospital" in §18.2-73 means before we do. Therefore, we vacate the judgment of the Virginia Supreme Court and remand for reconsideration in light of our opinion today in Akron.

Sincerely,


WJB, Jr.

Justice Powell

Not Sent

lfp/ss 03/14/83

SIM SALLY-POW

81-185 Simopoulos v. Virginia

MEMORANDUM TO THE CONFERENCE:

This refers to Harry's letter of March 8 stating that he will vote to vacate the judgment and remand [this] case for reconsideration in the light of Akron. He suggests that the Virginia regulations were not "really considered by the Supreme Court of Virginia", and that they were issued "long after the statute was enacted". Bill Brennan has told me that he rather shares Harry's view, and John's letter of March 7 expresses a somewhat similar view, though he is awaiting "further writing".

I recognized, of course, that vacating and remanding is an option available. I adhere to the view, however, that we should decide the case. In my view, the

issue on which we granted the case is here, and it was argued in briefs and at oral argument, and there I think we should decide it.

It is true that the primary focus in this case has been, as appellant describes it, on the "mandatory hospitalization requirement of Virginia law". Appellant had good reason to refrain from making the distinction under Virginia law between full service, acute care "hospitals" and "out-patient surgical hospitals" where second trimester abortions also may be performed. Appellant did not wish to call our attention to the latter and their implementing regulations as he had made no effort to comply with them. Moreover, appellant has never denied that he knew about the regulations. As I have now made clear in footnotes ____ and ____ in the second draft of

my opinion, the regulations were adopted two years and five months prior to the abortion at issue. They were adopted only after public hearings at which several abortions clinics and representatives of the medical profession appeared and testified.

It is entirely clear from the Virginia statutes that the term "hospitals" includes outpatient clinics though they are characterized as "outpatient . . . hospitals". It also is clear that Part II of the regulations was adopted expressly to accommodate second trimester abortions. See fn. ____ and _____. As the Attorney General of Virginia stated in his brief:

"Under Virginia law, a second trimester abortion may be performed in an outpatient surgical clinic provided that the clinic has been inspected and licensed as a hospital by the state". Br., 19.

The opinion of the Supreme Court of Virginia, as Harry notes, apart from a reference to the relevant Virginia statutes, did not address the outpatient hospitals separately from general, acute care hospitals. This is understandable as appellant's position has been a sweeping attack on all "mandatory hospitalization requirements". There certainly is no basis for reversing Simopoulos' conviction. As he elected, apparently as a tactic, not to challenge the outpatient regulations, it is too late for him now to advance this distinction.

If we were to remand this case for reconsideration in light of Akron, it would be an unmerited victory for appellant's tactics. Moreover, it is not clear what the Virginia Supreme Court can do that we also cannot do properly. There is no factual evidence

in this case with respect to the regulations as distinguished from appellant's general attack on the validity of all mandatory hospitalization requirements. The Virginia Supreme Court rejected this defense, and its opinion can be read - in light of Virginia law - as sustaining facially both of the state's hospitalization requirements, including those for second trimester abortions as well as for those performed in acute care hospitals. Akron and Ashcroft settled the issue with respect to the latter type of hospitals. This leaves, as the issue before us whether the mandatory outpatient type hospitals requirements are valid on their face. We would have a different case if appellant had elected to challenge - as unduly costly or otherwise - specific provisions of these requirements.

It is well to bear in mind that this case involves an abortion performed some 20 to 22 weeks after gestation, on the edge of the period of potential viability. Under any view of our prior decisions, including Akron, the interest of the state at this point is compelling. All that my opinion does is to hold that the Virginia regulations "on the record before us" (see pp. 12 and 17) are not invalid. We certainly do not decide whether each of the specific regulations would be valid if, for example, they were applied to a D&E abortion quite early in the second trimester.

At the prudential level, there also are rather compelling reasons to decide this case rather than remand it. The latter action would leave the law in Virginia - and probably in a number of other states - unsettled as to

the validity of requiring that second trimester abortions be performed in state licensed outpatient clinics that conform generally to accepted medical practice and requirements.

My recollection is that there were seven or eight cases pending here that involved the validity of state regulation of abortions. After consideration at two or more of our Conferences, we selected for plenary consideration the three cases now before us. In the decade since Doe states have been endeavoring to adjust their laws and regulations to the new constitutional requirements. Decisions by us in all three of these cases should go far to resolve the existing uncertainties.

L.F.P., Jr.

ss

~~Next~~

Next to final
draft.

lfp/ss 03/15/83

SIM SALLY-POW

81-185 Simopoulos v. Virginia

Dear Bill:

Thank you for your recent letter and kind remarks on my opinion in this case. I believe your concerns are similar to those expressed by Harry in his letter of March 8.

I recognized, of course, that vacating and remanding on Akron is an option available. As you note, however, the case is properly before us on appeal. The issue has been briefed and argued. I remain of the opinion that we should decide it.

It is true that the primary focus in this case has been, as appellant describes it, on the "mandatory hospitalization requirement of Virginia law". Appellant

had good reason to refrain from making the distinction under Virginia law between full service, acute care "hospitals" and "out-patient surgical hospitals" where second trimester abortions may be performed. Appellant had made no effort to comply with the implementing regulations. Moreover, appellant has not denied that he knew about the regulations.

As footnotes ____ and ____ in the second draft of my opinion show, the regulations became effective two years and five months prior to the abortion at issue. They had been fully considered at public hearings.

It is clear from the Virginia statutes that the term "hospitals" includes outpatient clinics though they are characterized as "outpatient surgical hospitals", and that Part II of the regulations apply to second trimester

abortions. See fn. ____ and _____. As the Attorney General of Virginia stated in his brief:

"Under Virginia law, a second trimester abortion may be performed in an outpatient surgical clinic provided that the clinic has been inspected and licensed as a hospital by the state". Br., 19.

The opinion of the Supreme Court of Virginia, as Harry notes, apart from a reference to the relevant Virginia statutes, did not address the outpatient hospitals separately from general, acute care hospitals. This is understandable in view of appellant's position that all "mandatory hospitalization requirements" for second trimester abortions are invalid. He elected, apparently as a tactic, not to challenge separately any of the applicable regulations.

If we were to remand this case for reconsideration in light of Akron, it is not clear what

the Virginia Supreme Court can do that we also cannot do properly. There is no factual evidence with respect to the regulations as distinguished from appellant's general challenge to all mandatory hospitalization requirements. No specific regulations were questioned. There certainly is no basis for a new trial.

There are also prudential reasons to decide the case: Any remand would leave the law unsettled to some degree as to the validity of requiring that second-trimester abortions be performed in state-licensed outpatient clinics that conform generally to accepted medical practice and requirements. A decision by us in all three of these cases should go far to resolve the existing uncertainties.

Sincerely,

Justice Brennan

lfp/ss

cc: Justice Blackmun

March 15, 1983

81-185 Simopoulos v. Virginia

Dear Bill:

Thank you for your recent letter and kind remarks on my opinion in this case.

I believe your concerns are similar to those expressed by Harry in his letter of March 8. I recognize, of course, that vacating and remanding in light of Akron is an available option. As you note, however, the case is properly before us on appeal. The issue has been briefed and argued. I remain of the opinion that we should decide it.

The primary focus in this case has been, as appellant describes it, on the "mandatory hospitalization requirement of Virginia law". Appellant had good reason to refrain from making the distinction under Virginia law between general, acute care "hospitals" and "outpatient surgical hospitals" where second-trimester abortions may be performed. Appellant had made no effort to comply with the implementing regulations. Moreover, appellant has not denied that he knew about the regulations.

As footnotes 6 and 7 in the second draft of my opinion show, the regulations became effective two years and five months before the abortion at issue. They had been fully considered at public hearings. Moreover, it is clear from the Virginia statutes that the term "hospitals" includes outpatient clinics though they are characterized as "outpatient surgical hospitals", and that Part II of the regulations applies to second-trimester abortions. See nn. 7 and 9. As the Attorney General of Virginia stated in his brief:

"[U]nder Virginia law, a second-trimester abortion may be performed in an outpatient surgical clinic provided that [the] clinic has been inspected and licensed as a hospital by the State". Brief of Appellee 19.

The opinion of the Supreme Court of Virginia, as Harry notes, apart from a reference to the relevant Virginia

statutes, did not address the outpatient hospitals separately from general, acute care hospitals. This is understandable in view of appellant's position that all "mandatory hospitalization requirements" for second-trimester abortions are invalid. He elected, apparently as a tactic, not to challenge separately any of the applicable regulations.

If we were to remand this case for reconsideration in light of Akron, it is not clear what the Virginia Supreme Court can do that we properly cannot do as well. There is no factual evidence with respect to the regulations as distinguished from appellant's general challenge to all mandatory hospitalization requirements, because no specific regulations were questioned. There certainly is no basis for a new trial.

There are also prudential reasons to decide the case: Any remand would leave the law unsettled as to the validity of requiring that second-trimester abortions be performed in state-licensed outpatient clinics that conform generally to accepted medical practice and requirements. A decision by us in all three of these cases should go far to resolve the existing uncertainties.

Sincerely,

Justice Brennan

lfp/ss

cc: Justice Blackmun

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Powell
Justice Rehnquist
Justice O'Connor

From: **Justice Stevens**

Circulated: JUN 1 '83

Recirculated: _____

1st DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[June —, 1983]

JUSTICE STEVENS, dissenting.

Prior to this Court's decision in *Roe v. Wade*, 410 U. S. 113 (1973), it was a felony to perform any abortion in Virginia except in a hospital accredited by the Joint Committee on Accreditation of Hospitals and licensed by the Department of Health, and with the approval of the hospital's Abortion Review Board (a committee of three physicians).^{*} In 1975, the Virginia Code was amended to authorize additional abortions, including any second trimester abortion performed by a physician "in a hospital licensed by the State Department of Health or under the control of the State Board of Mental Health and Mental Retardation." Va. Code § 18.2-73 (1982).

The amended statute might be interpreted in either of two ways. It might be read to prohibit all second trimester abortions except those performed in a full-service, acute-care hospital facility. Or it might be read to permit any abortion performed in a facility licensed as a "hospital" in accord with any regulations subsequently adopted by the Department of Health. The Court today chooses the latter interpretation. See *ante*, at 5-6.

^{*}An in-hospital abortion was also unlawful unless (a) it was necessary to protect the life or health of the mother, (b) the pregnancy was the product of rape or incest, or (c) there was a substantial medical likelihood that the child would be born with an irremediable and incapacitating mental or physical defect. 1970 Va. Acts, ch. 508.

Interesting to see
JRB

There is reason to think the Court may be wrong. At the time the statute was enacted, there were no regulations identifying abortion clinics as "hospitals." The structure of the 1975 amendment suggests that the Virginia General Assembly did not want to make any greater change in its law than it believed necessary to comply with *Roe v. Wade*, and it may well have thought a full-service acute-care hospitalization requirement constitutionally acceptable. Moreover, the opinion below does not suggest that the Supreme Court of Virginia believed the term "hospital" to incorporate licensed abortion clinics. It only discussed testimony pertaining to full-service, acute-care hospitals like Fairfax Hospital. See Juris. Statement 16a. And it stated that "two hospitals in Northern Virginia and 24 hospitals located elsewhere in the State were providing abortion services in 1977," Juris. Statement 19a, again referring to acute-care facilities. The opinion refers to "clinics" only once, as part of a general statement concerning the variety of medical care facilities the state licenses and regulates; even there, the term is included in the list as a category that is distinct from "hospitals." Juris. Statement 18a.

On the other hand, the Court may well be correct in its interpretation of the Virginia statute. The word "hospital" in § 18.2-73 could incorporate by reference any institution licensed in accord with Va. Code § 32.1-123.1 and its implementing regulations. See *ante*, at 5-6. It is not this Court's role, however, to interpret state law. We should not rest our decision on an interpretation of state law that was not endorsed by the court whose judgment we are reviewing. The Virginia Supreme Court's opinion was written on the assumption that the Commonwealth could constitutionally require all second trimester abortions to be performed in a full-service, acute-care hospital. Our decision today in *City of Akron v. Akron Center for Reproductive Health, Inc.*, *ante*, p. —, proves that assumption to have been incorrect. The proper disposition of this appeal is therefore to vacate the

judgment of the Supreme Court of Virginia and to remand the case to that court to reconsider its holding in the light of our opinion in *Akron*.

I respectfully dissent.

File

lfp/ss 06/03/83

MEMORANDUM

TO: Jim DATE: June 3, 1983
FROM: Lewis F. Powell, Jr.

Ashcroft

After a rereading of the opinions below on the "second physician" issue (that I had not reread since preargument), and again reading HAB's dissent, I do not believe proposed Rider A - as you and I have draft it - is quite fair. As a means of focusing my own thinking (and so you can check it), I dictate this memo.

The DC invalidated the second physician requirement as overbroad, devoting only a paragraph to it (A 26). Its findings included: "D&E may be the procedure of choice, even after viability, in cases in which there are positive contraindications to the use of saline or prostaglandins installation"; "no chance of fetus survival" when D&E is used; and, the concluding sentence: "the attendance of a second physician during an abortion procedure which holds no possibility of fetal survival does not further [the state's] interest."

The finding relied on by HAB is that D&E "may be the procedure of choice even after viability", but

apparently only in cases in which the woman's health requires this because it might be endangered by the "use of saline or prostaglandins installation". We would agree, if the woman's life is endangered by methods other than D&E. Thus, the question seems to be whether there is substantial evidence that during the third trimester D&E may be required in the interest of the mother's health?

A footnote cites, without quoting, the testimony of "Doctors Robert Crist for plaintiffs and Richard Schmidt for defendants". It seems to me that HAB's opinion correctly states the DC's holding (p. 6), concluding that "in some cases . . . maternal health considerations will preclude the use of procedures that might result in a live birth . . . [the second doctor in such circumstances] "is superfluous".

CA 8 quoted Dr. Crist as testifying that "D&E may be the best medical procedure at 28 weeks" because there were "contraindications" to the use of other methods. (A 80) CA8 does state that "Missouri points to testimony by other physicians that do not or would not use D&E at this stage, and therefore the evidence indicates that "the question is one in which medical opinions may differ".

If I am reading the foregoing correctly, it seems to me that our rider A needs substantial revision. Sadly, I don't think we can hang HAB directly with Dr. Crist's testimony, as he does not mention him at all. He simply latches on to the findings of the two courts below, and relies on the "two court" rule.

You are far more familiar with all of this, Jim, than I am. Unless I am mistaken or have overlooked something important, it seems to me we must refocus our response on this aspect of the two physician issue. CA8 concedes that medical opinions differ. At best, this is the ultimate finding of fact below. This entitles us to do two things: (i) show, as you have devastatingly (subject to a comment below) that on the plaintiff's side the only "differing view" is that of Dr. Crist, whereas the other view is that few if any physicians ever use a D&E during third trimester; and (ii) given this contradictory evidence, with the great weight of it contrary to Dr. Crist's views, the state's interest in protecting a viable fetus justifies the second physician requirement even though there may be the rare case where a doctor may think honestly that D&E is required for the mother's health.

My one qualification about Dr. Crist's testimony is the possible ambiguity in his long answer to the question in the middle of the page (A 130). I believe, however, that your reading of this testimony (at least that reprinted in the appendix) is correct. The final question and answer on p. 131 was as follows:

Q. And do you believe that as a general principle . . . where there is an abortion there should never be a live fetus?

A. That is correct."

We should discuss this.

L.F.P., Jr.

ss

For The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Powell
Justice Rehnquist
Justice Stevens

From: Justice O'Connor

Circulated: _____

Recirculated: JUN 13 1983

2-1 DRAFT
SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT v. VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[June 15, 1983]

JUSTICE O'CONNOR, with whom JUSTICE WHITE and JUSTICE REHNQUIST join, concurring in part and concurring in the judgment.

I agree with the Court's treatment of the appellant's arguments based on *United States v. Vuitch*, 402 U. S. 62 (1971) and *Patterson v. New York*, 432 U. S. 197 (1977). Accordingly, I join parts I and II of the Court's opinion.

I concur in the judgment of the Court insofar as it affirms the conviction. For reasons stated in my dissent in No. 81-746, *Akron v. Akron Center for Reproductive Health* and in No. 81-1172, *Akron Center for Reproductive Health v. Akron*, I do not agree that the constitutional validity of the Virginia mandatory hospitalization requirement is contingent in any way on the trimester in which it is imposed. Rather, I believe that the requirement in this case is not an undue burden on the decision to undergo an abortion.

This is an appeal from the Supreme Court of Virginia. The appellant is an obstetrician-gynecologist. At his unlicensed clinic, he performed an abortion - by injection of saline solution - on a 17-year-old woman who was approximately 22 weeks pregnant.

Appellant was convicted of violating the Virginia statute requiring that second-trimester abortions be performed in a licensed hospital. The Supreme Court of Virginia *is* affirmed the conviction.

Under Virginia law, the term "hospital" is defined to include outpatient hospitals. Regulations of the Virginia Department of Health provide that second-trimester abortions may be performed in outpatient surgical hospitals licensed by the state. Unlike the City of Akron ordinance and the State of Missouri statute, Virginia does not require that second-trimester abortions be performed in acute-care, full-service hospitals.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards ^{*governing*} governing outpatient second-trimester abortions.

*We have not
considered*

We have not considered whether the regulations are constitutional in every particular, for appellant declined to challenge them specifically.

We have no reason to doubt, however, that an adequately equipped clinic upon proper application could be licensed to perform second-trimester abortions.

We conclude, therefore, that ^{- at least, at least locally} Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the state's compelling interest in protecting the woman's health.

The judgment of the Supreme Court of Virginia is affirmed.

Justice O'Connor, joined by Justices White and Rehnquist, has filed an opinion concurring in part and concurring in the judgment in part. Justice Stevens has filed a dissenting opinion.

81-185# Simopoulos v. Virginia (Jim)

LFP for the Court

1st draft 3/3/83

2nd draft 3/16/83

3rd draft 4/28/83

4th draft 5/23/83

5th draft 6/9/83

Joined by CJ, WJB, TM, HAB

SOC concurring in part and in judgment

1st draft 5/5/83

2nd draft 6/13/83

Joined by BRW, WHR

JPS dissent

1st draft 6/1/83

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE HARRY A. BLACKMUN

May 4, 1983

Re: No. 81-185, Simopoulos v. Virginia

Dear Lewis:

As you know, my original and preferred vote in this case was to vacate and remand. In my letter of March 8, I noted my discomfort with the Court's reaching out to consider the constitutionality of the Virginia regulations when they had not been interpreted by the Supreme Court of Virginia. I do think, however, that it is important that we have an opinion for the Court in this case, or at least an opinion that commands a substantial plurality. Thus, although I would still prefer to vacate and remand, I could join a narrowly-written opinion affirming the judgment. Your third draft comes a long way toward assuaging my concerns -- a fact I deeply appreciate -- but I am still somewhat troubled by it.

1, My major concern is that you still come out to uphold the regulations, although now only on the basis of the record before us. I am reluctant to affirm on this ground. I do not mean to suggest that I think the regulations are unconstitutional, or that I would not vote to uphold them in an appropriate case, but I do not regard this case as an appropriate one. Because neither the parties nor the courts below have addressed the constitutionality of the particular regulations adopted by Virginia, we have no really firm basis on which to determine whether these regulations are justified by the State's interest in protecting maternal health. Ordinarily, we would not make such a decision without the benefit of a record, briefing, and argument. If the record is inadequate, we would remand for further proceedings. It is not our practice to decide constitutional questions on the basis of an insufficient record, while noting that a better record might lead to a different result.

They
did
as I
wrote
lt.

2 My second concern is with the way in which you uphold the regulations. You conclude that the regulations appear to be medically reasonable, and you then rely on the fact that appellant has failed to introduce evidence to the contrary. The problem I have with this approach is that I am not sure appellant has the burden of proof on this point. Ordinarily, the State must bear the burden of demonstrating that its regulations on the practice of abortion are sufficiently related to its interest in protecting maternal health. See City of Akron, at 12; Doe v. Bolton, 410 U.S. 179, 195 (1973). In this case,

Unless
challenged

because the constitutionality of the regulations was not litigated below, the State has introduced no evidence whatsoever to show that the regulations promote maternal health. As you pointed out in your letter of April 12, this is "a record containing no evidence as to the unreasonableness of individual regulations." I would only add that the record is equally devoid of any evidence as to the regulations' reasonableness. It is not enough for me just to place the regulations side-by-side with the ACOG standards; I think our adversary system demands that the parties be permitted to put in evidence and litigate the issue.

?
True -
but
Peter
chose
chose
this
strategy.
Peter would have two opportunities

I would prefer to take a slightly different approach. You say that appellant failed to introduce evidence regarding the constitutionality of the regulations, and that we therefore should uphold them. I would say, rather, that appellant failed to raise the issue, and that we therefore need not reach it. As you pointed out in your April 12 letter, appellant was aware of the regulations by the time of trial but chose not to challenge them. In fact, it appears to me that appellant has expressly declined to contest the constitutionality of a clinic-licensing scheme like Virginia's. He challenged Virginia's abortion statute on the sole ground that a restriction to full-service general hospitals was unconstitutional, and he repeatedly asserted that the proper course would be for Virginia to permit second-trimester abortions in appropriately licensed outpatient clinics. This, of course, is just what Virginia has done. It seems to me that we justifiably could hold appellant to this choice of litigation strategy, and conclude that the constitutionality of the regulations is not at issue. This would make it unnecessary for the regulations to be addressed at all, other than to note that they permit second-trimester abortions to be performed in outpatient clinics as well as in full-service general hospitals.

Did
he?

1 year

Your opinion appears to be inconsistent with this approach at only a few points. I do not know whether you feel inclined to make any further changes, but if what I have outlined above would be acceptable to you, and in an effort to be helpful, I offer on the following pages suggestions for your consideration.

This is a large and difficult task. I am grateful for your efforts.

Sincerely,

Justice Powell

P.S. I enclose a copy of your opinion with the suggested changes marked up. They are not so bad as the two pages of "suggestions" seem to indicate.

expressly,

"Given the plain language of the Virginia regulations and the history of their adoption, see notes supra, we have no reason to doubt that an adequately equipped clinic could obtain, upon proper application, an outpatient hospital license permitting the performance of second-trimester abortions. Appellant has thus challenged a statutory scheme that does not exist in Virginia: a requirement that second-trimester abortions be performed in full-service hospitals. Since appellant ~~has declined to challenge~~ the constitutionality of the Virginia regulations, we have no occasion to pass on them."

*elects
not*

conclude that on this record

(6) Page 13, footnote 20. I would prefer to eliminate the first two sentences (through "and thus also invalid") and the last three sentences (beginning "And certainly appellant cannot"). At the end of fourth from last sentence (beginning "Some of these arguments"), I would add "and none have been raised below."

(7) Pages 13-14. I would prefer the first (run-over) sentence of this paragraph to read as follows: "We conclude that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's compelling interest in 'protecting the woman's own health and safety.'"

(8) Page 14, footnote 21. I would prefer the last sentence to read: "The only issue before us, however, relates to second-trimester abortions."

(9) Page 14. I would rewrite the last sentence of Part IV to read: "Rather, the State's requirement that second-trimester abortions be performed in licensed clinics appears to comport with accepted medical practice, and leaves the method and timing of the abortion precisely where they belong -- with the physician and the patient."

(10) Finally, I would simply eliminate the first sentence of Part V.

Suggestions

(1) Page 5, footnote 3. The last sentence of this footnote states that "the validity of these requirements" is at issue. I would prefer the sentence to read: "Thus, it is irrelevant to the issue before us whether appellant's clinic and his procedures would have complied with the Virginia regulations."

(2) Pages 9-10, footnotes 9-17. These footnotes spell out the details of the Virginia regulations, in contrast to the textual description of the areas covered. If the validity of the regulations is reached, I would prefer to see these footnotes eliminated.

(3) Page 11. I would prefer to eliminate the first sentence of the second paragraph and the first sentence of the third (run-over) paragraph, as well as footnote 18.

(4) Pages 12-13. I would re-write the run-over paragraph to read as follows:

"We need not consider whether Virginia's regulations are constitutional in every particular. Despite personal knowledge of the regulations at least by the time of his trial, appellant has not attacked them as being insufficiently related to the State's interest in protecting maternal health.¹⁹ His challenge throughout this litigation has been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. Indeed, appellant has taken the position, both before the lower courts and before this Court, that a state licensing requirement for outpatient abortion facilities would be constitutional. See 9 Record 196a, 214a; Brief for Appellant in No. 801107 (Va.S.Ct.), p. 35; Juris. Statement 16; Brief for Appellant 32, 43, n. 75, 46. In essence, appellant has argued that Virginia's hospitalization requirements are no different in substance from those reviewed in the City of Akron and Ashcroft cases.²⁰ Not until his reply brief in this Court did appellant criticize the regulations apart from Virginia's statutory hospitalization requirement."

(5) Page 13. I would add the following paragraph prior to the one beginning "We therefore conclude."

This necessarily implies that Va's Regs are invalid.

This de-

pends

I suppose

on what

he means

by "out-

patient

facilities?"

Va had Regs

for both trimesters

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Powell
Justice Rehnquist
Justice Stevens

From: **Justice O'Connor**

Circulated: MAY 5 1983

Recirculated: _____

1st DRAFT

SUPREME COURT OF THE UNITED STATES

Nos. 81-1255 AND 81-1623

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
ET AL., PETITIONERS

81-1255

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL.

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL., PETITIONERS

81-1623

v.

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
ET AL., PETITIONERS

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE EIGHTH CIRCUIT

[May —, 1983]

JUSTICE O'CONNOR, concurring in part in the judgment
and dissenting in part.

For reasons stated in my dissent in No. 81-746, *Akron v. Akron Center for Reproductive Health* and in No. 81-1172, *Akron Center for Reproductive Health v. Akron*, I believe that the second-trimester hospitalization requirement imposed by § 188.025 does not impose an undue burden on the limited right to undergo an abortion. Assuming *arguendo* that the requirement was an undue burden, it would nevertheless "reasonably relate[]" to the preservation and protection of maternal health." *Roe v. Wade*, 410 U. S. 113, 163

*new
definition*

Expected - No changes necessary yet.
Job

(1973). I therefore dissent from the Court's judgment that the requirement is unconstitutional.

I agree that second-physician requirement contained in §188.030.2 is constitutional because the State possesses a compelling interest in protecting and preserving fetal life, but I believe that this state interest is extant throughout pregnancy. I therefore concur in the judgment of the Court.

I agree that pathology-report requirement imposed by §188.047 is constitutional because it imposes no undue burden on the limited right to undergo an abortion. Because I do not believe that the validity of this requirement is contingent in any way on the trimester of pregnancy in which it is imposed, I concur in the judgment of the Court.

Assuming *arguendo* that the State cannot impose a parental veto on the decision of a minor to undergo an abortion, I agree that the parental consent provision contained in §188.028.2 is constitutional. However, I believe that the provision is valid because it imposes no undue burden on any right that a minor may have to undergo an abortion. I concur in the judgment of the Court on this issue.

I also concur in the Court's decision to vacate and remand on the issue of attorney's fees in light of *Hensley v. Eckerhart*, — U. S. — (1983).

as to hospitalization

concur
in judg.

"

??

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Powell
Justice Rehnquist
Justice Stevens

From: **Justice O'Connor**

Circulated: MAY 5 1983

Recirculated: _____

1st DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[May —, 1983]

JUSTICE O'CONNOR, concurring in part and concurring in the judgment.

I agree with the Court's treatment of the appellant's arguments based on *United States v. Vuitch*, 402 U. S. 62 (1971) and *Patterson v. New York*, 432 U. S. 197 (1977). Accordingly, I join parts I and II of the Court's opinion.

I concur in the judgment of the Court insofar as it affirms the conviction. For reasons stated in my dissent in No. 81-746, *Akron v. Akron Center for Reproductive Health* and in No. 81-1172, *Akron Center for Reproductive Health v. Akron*, I do not agree that the constitutional validity of the Virginia mandatory hospitalization requirement is contingent in any way on the trimester in which it is imposed. Rather, I believe that the requirement in this case is not an undue burden on the decision to undergo an abortion.

I am pleased that we got a vote for part of this opn, but I do not see any way to meet these concerns as to the trimester question. There may be one change that we want to make — that Justice Blackmun has suggested — that she votes against us in Akron. See p. 12-16 of her Akron draft. JOB

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE WILLIAM H. REHNQUIST

May 5, 1983

Re: 81-185 Simopoulos v. Virginia

Dear Sandra:

Please join me.

Sincerely,



Justice O'Connor

cc: The Conference

Supreme Court of the United States
Washington, D. C. 20543

✓

CHAMBERS OF
JUSTICE BYRON R. WHITE

May 6, 1983

Re: 81-185 Simopoulos v. Virginia

Dear Sandra:

Please add my name to your opinion in this case.

Sincerely,

Byron

Justice O'Connor

cc: The Conference

THE DIOCESE OF FARGO

1310 BROADWAY

BOX 1750

FARGO, NORTH DAKOTA 58107

CHANCERY

May 11, 1983

Mr. Harry Blackmun
Associate Justice of the Supreme Court
c/o President Thomas Clifford
University of North Dakota
Grand Forks, ND 58202

Dear Mr. Blackmun,

This letter is written in response to the news item of Fargo Forum (5/8/83) that you will be the speaker at the graduation exercises of the Law School of the University of North Dakota, May 15, 1983.

Commencement exercises are happy occasions, and I join the people of this state in wishing the graduates good fortune, indeed, God's blessings in their years of study, interpretation, and practice of law.

I am certain your presence as an Associate Justice of the U.S. Supreme Court and the graduation-speaker will have meaning and significance not only to the graduates, but likewise to the entire University Family at Grand Forks. This is as it should be, I feel.

Yet, your presence at the University of North Dakota, and more especially your address to the graduates, both fill me with anguish and travail.

I realize as I reflect with deep sadness, Mr. Justice Blackmun, that a decade has passed since you master-minded the Roe vs Wade and Doe vs Bolton decision of the U.S. Supreme Court: the decision that denied and deprived legal protection to the Unborn Child. You are aware, I am confident what that decision has meant to this Nation in terms of human life, in terms of approximately 15 million young Americans who never will be given the opportunity to live, to study law, or to be numbered among school children of this great nation.

On various occasions, I have read news items in which you were quoted about the abortion decision, about the hidden rights you found lodged in the U.S. Constitution, to deny the Unborn Child the gift of life, the privilege to be born.

Somehow I have always sensed, in your statements, a great

uncertainty, a lack of conviction or inner peace with the abortion decision. It is wrong, and I am convinced you are fully aware of that fact. That is why I am writing this letter. As the U.S. Catholic Bishops recently stated in their Pastoral Letter on Peace, "No society can live in peace with itself, or with the world, without a full awareness of the worth and dignity of every human person, and the sacredness of human life" (Jas. 4: 1-2).

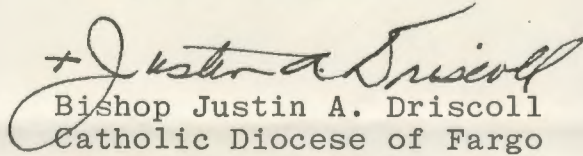
Your presence at the graduation of the Law School of the University of North Dakota on May 15th, then, gives me and, I am certain, numerous people of North Dakota the opportunity to reflect anew on the value of the sacredness of human life, and on the tragedy and devastation of the Abortion Decision of the U.S. Supreme Court, January 22, 1973.

I am asking the Catholic people of this Diocese, and people of all Religious Faiths to join me, especially on May 15th, in thanking God for His gift of human life and to beg His pardon and mercy for the wanton destruction of human life, caused by the Abortion Decision of the Supreme Court and by all forms of Violence, oppression, and exploitation in our day.

Sincerely, I regret your coming to the University of North Dakota as the graduation speaker on May 15th, and openly I express that deep lament.

With every best wish, I remain

Sincerely yours,


Bishop Justin A. Driscoll
Catholic Diocese of Fargo

cc: President Thomas Clifford

May 13, 1983

Abortion Cases

Dear Chief:

The purpose of this letter is to review the situation in these three "headache" cases that you asked me to write.

Akron

I have a bare Court (WJB, TM, HAB, JPS and LFP), and Sandra - for her all-out dissent - has three votes (BRW, WHR and SOC).

As I point out in n. 1, p. 2, of my Akron opinion, Sandra's position simply emasculates Roe and the several cases that have accepted its basic principles. You have not voted, though I consider your joining as essential.

Ashcroft

I have no votes for my opinion. John has indicated by letter that he expects to join all but Part V of my opinion. My understanding is that Harry is writing a long opinion (presumably for WJB and TM). He will join Part II of my opinion that invalidates Missouri's requirement of an acute-care general hospital. There are, as you know, several other issues in Ashcroft, and Harry is dissenting as to parental consent (5-4) (WJB, TM, HAB, JPS), the pathology report (8-1) (HAB) (WJB, TM were tentative), and the second-doctor requirement (6-3) (WJB, TM, HAB).

The O'Connor trio agrees with my result as to all issues except hospitalization.

Simopoulos

This case, in many ways the most important of the three, is at a critical stage and I need your help.

I had hoped that the Justices sharing Sandra's view would at least be with us in Simopoulos. They would

affirm the judgment, but on entirely different reasoning: namely, that a state may impose virtually any limitation it wishes.

The only hope of a Court affirming along the lines of your vote and mine lies essentially with what Harry and Bill Brennan (who are cooperating) are willing to join.

I have had a considerable private exchange with Harry and Bill. Until recently, they were adamant in their unwillingness to affirm. Their position has been that we should vacate and remand to allow the Virginia court to construe and pass upon the validity of the regulations. In view of the curious way - if not negligent way - in which Simopoulos was tried by both parties, the regulations never were expressly addressed by the Supreme Court of Virginia. I remain firm in my view, however, that this is the result of a strategy choice by Simopoulos. As he challenged the entire Virginia regulatory scheme, it is appropriate to reject his challenge and affirm.

Harry has now given me a list of specific changes in my third draft of the opinion that, if I accept, will enable him to join. I deliver to you herewith a proposed fourth draft (not yet circulated) in which I have gone much - but not all of the way - with Harry, but not as far as he would like.

If you can find the time (perhaps today or tomorrow) to take a look at the changes I have made, I will be grateful. If these meet with your approval, I will go back to Harry and see if he will accept them as a compromise between us. Although I have eliminated a good deal of language I would have preferred to keep in the opinion, I think the proposed fourth draft would fairly well settle the validity of regulations like those of Virginia. This is our basic objective.

I will be happy to discuss this with you at any time. We should try to get this off of "dead center" before next week's hectic schedule. Also, HAB is expecting some reply from me.

Sincerely,

The Chief Justice

lfp/ss

Supreme Court of the United States
Washington, D. C. 20543

✓

CHAMBERS OF
THE CHIEF JUSTICE

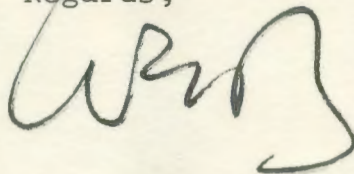
May 16, 1983

Re: 81-185 - Simopoulos v. Virginia

Dear Lewis:

I join.

Regards,



Justice Powell

Copies to the Conference

*I believe the C.J. is joining
my 4th draft but w/o focusing
on fact that I sent it privately
to him.*

① Pathologist - ~~future~~

Says I err in relating to accepted
medical practice - 2, 3 (HAB's quote ~~not~~ *permade*
\$40 cost - is "significant" - 5)

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Powell
Justice Rehnquist
Justice Stevens
Justice O'Connor

L.F.P.

② Second physician - 5

Unnecessary for D & E - 6

Answer by saying choice of
abortion method is the critical decision, - 7
As Somopolis illustrates, not all physicians
are like those at 1st DRAFT *Mays* - (answer their
argument)

From: Justice Blackmun

MAY 17 1983

Circulated: _____

Recirculated: _____

SUPREME COURT OF THE UNITED STATES

Rejects my view as to "emergency" - 8
Nos. 81-1255 AND 81-1623

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
ET AL., PETITIONERS

~~Unnecessary~~
③ Parental consent or court order - 10
81-1255

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL.

Says we can't accept *CA 8's* construction of
statute - 11

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL., PETITIONERS

81-1623

v.

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC., ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE EIGHTH CIRCUIT

[May —, 1983]

JUSTICE BLACKMUN, concurring in part and dissenting in
part.

The Court's decision today in *Akron v. Akron Center for
Reproductive Health, Inc.*, ante, invalidates the city of Ak-
ron's hospitalization requirement and a host of other provi-
sions that infringe on a woman's decision to terminate her
pregnancy through abortion. I agree with the Court that
Missouri's hospitalization requirement is invalid under the
Akron analysis, and I join Parts I and II of the Court's opin-
ion in the present cases. I do not agree, however, that the
remaining Missouri statutes challenged in these cases satisfy

the constitutional standards set forth in *Akron* and the Court's prior decisions.

I

Missouri law provides that whenever an abortion is performed, a tissue sample must be submitted to a "board eligible or certified pathologist" for a report. Mo. Rev. Stat. § 188.047 (1983). This requirement applies to first trimester abortions as well as to those performed later in pregnancy. Our past decisions establish that the performance of abortions during the first trimester must be left "free of interference by the State." *Akron, ante*, at 12, quoting *Roe v. Wade*, 410 U. S. 113, 163 (1973). As we have noted in *Akron*, this does not mean that every regulation touching upon first-trimester abortions is constitutionally impermissible. But to pass constitutional muster, regulations affecting first-trimester abortions must "have no significant impact on the woman's exercise of her right" and must be "justified by important state health objectives." *Akron, ante*, at 11; see *ante*, at 8.

Missouri's requirement of a pathologist's report is not justified by important health objectives. Although pathology examinations may be "useful and even necessary in some cases," *ante*, at 10, Missouri requires more than a pathology examination and a pathology report; it demands that the examination be performed and the report prepared by a "board eligible or certified pathologist" rather than by the attending physician. Contrary to the Court's assertion, *ante*, at 9, this requirement of a report by a pathologist is not in accord with "generally accepted medical standards." The routine and accepted medical practice is for the attending physician to perform a gross (visual) examination of any tissue removed during an abortion. Only if the physician detects abnormalities is there a need to send a tissue sample to a pathologist. The American College of Obstetricians and Gynecologists (ACOG) does not recommend an examination by a pathologist in every case:

Pathologist

Says I erred

"In the situation of elective termination of pregnancy, the attending physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy must be submitted to a pathologist for gross and microscopic examination.

"... Aspirated tissue should be examined to ensure the presence of villi or fetal parts prior to the patient's release from the facility. If villi or fetal parts are not identified with certainty, the tissue specimen must be sent for further pathologic examination. . . ." ACOG, Standards for Obstetric-Gynecologic Services 52, 54 (1982).¹

Nor does the National Abortion Federation believe that such an examination is necessary:

"All tissue must be examined grossly at the time of the abortion procedure by a physician or trained assistant and the results recorded in the chart. In the absence of visible fetal parts or placenta upon gross examination, obtained tissue may be examined under a low power microscope for the detection of villi. If this examination is inconclusive, the tissue should be sent to the nearest suitable pathology laboratory for microscopic examination." National Abortion Federation Standards 6 (1981) (emphasis deleted).

The Court fails to distinguish between the medical practice

I fail to distinguish

¹See also ACOG, Standards for Obstetric-Gynecologic Services 66 (1982):

"Tissue removed should be submitted to a pathologist for examination. . . . An exception to the practice may be in elective terminations of pregnancy in which definitive embryonic or fetal parts can be identified. In such instances, the physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy must be submitted to a pathologist for gross and microscopic examination."

of performing a "tissue examination," *ante*, at 11, and Missouri's requirement that this examination be performed by a pathologist. As the Court of Appeals pointed out, there was expert testimony at trial that a nonpathologist physician is as capable of performing an adequate gross examination as is a pathologist, and that the "abnormalities which are of concern" are readily detectable by a physician. 655 F. 2d 848, 871, n. 37 (CA8 1981); see App. 135.² While a pathologist may be better able to perform a microscopic examination, Missouri law does not require a microscopic examination unless "fetal parts or placenta are not identified." 13 Mo. Admin. Code § 50-151.030(1) (1981). Thus, the effect of the Missouri statute is to require a pathologist to perform the initial gross examination, which is normally the responsibility of the attending physician and which will often make the pathologist's services unnecessary.

On the record before us, I must conclude that the State has not "met its burden of demonstrating that [the pathologist requirement] further[s] important health-related State concerns." *Akron*, *ante*, at 12. There has been no showing that tissue examinations by a pathologist do more to protect health than examinations by a nonpathologist physician. Moreover, I cannot agree with the Court that Missouri's pathologist requirement has "no significant impact" *ante*, at 8, on a woman's exercise of her right to an abortion. It is undisputed that this requirement may increase the cost of a first-trimester abortion by as much as \$40. See *ante*, at 10, n. 12; 483 F. Supp., at 700, n. 48. Although this increase may seem insignificant from the Court's comfortable perspective, I cannot say that it is equally insignificant to every woman seeking an abortion. For the woman on welfare or the unemployed teenager, this additional cost may well put

² The District Court made no findings on this point, noting only that some witnesses for the State had testified that "pathology should be done" for every abortion. 483 F. Supp. 679, 700, n. 49 (WD Mo. 1980).

CA 8's new

may increase
cost by \$40

the price of an abortion beyond reach.³ Cf. *Harper v. Virginia Board of Elections*, 383 U. S. 663, 668 (1966) (\$1.50 poll tax “excludes those unable to pay”); *Burns v. Ohio*, 360 U. S. 252, 255, 257 (1959) (\$20 docket fee “foreclose[s] access” to appellate review for indigents).

In *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S. 52, 81 (1976), the Court warned that the minor record-keeping requirements upheld in that case “perhaps approach[ed] impermissible limits.” Today in *Akron*, we have struck down restrictions on first-trimester abortions that “may in some cases add to the cost of providing abortions.” *Ante*, at 30; see *ante*, at 31–32. Missouri’s requirement of a pathologist’s report unquestionably adds significantly to the cost of providing abortions, and Missouri has not shown that it serves any substantial health-related purpose. Under these circumstances, I would hold that constitutional limits have been exceeded.

*Does not
add
significantly*

II

In Missouri, an abortion may be performed after viability only if necessary to preserve the life or health of the woman. Mo. Rev. Stat. § 188.030.1 (1983). When a post-viability abortion is performed, Missouri law provides that “there [must be] in attendance a [second] physician . . . who shall take control of and provide immediate medical care for a child born as a result of the abortion.” Mo. Rev. Stat. § 188.030.3 (1983). The Court recognized in *Roe v. Wade*, 410 U. S., at

³ A \$40 pathologist’s fee may increase the price of a first-trimester abortion by 20% or more. See 655 F. 2d, at 869, n. 35 (cost of first-trimester abortion at Reproductive Health Services is \$170); F. Jaffe, B. Lindheim, and P. Lee, *Abortion Politics: Private Morality and Public Policy* 36 (1981) (cost of first-trimester clinic abortion ranges from approximately \$185 to \$235); Henshaw, *Freestanding Abortion Clinics: Services, Structure, Fees*, 14 *Family Planning Perspectives* 248, 255 (1982) (average cost of first-trimester clinic abortion is \$190); NAF Membership Directory 18–19 (1982/1983) (NAF clinics in Missouri charge \$180 to \$225 for first-trimester abortion).

164-165, that a State's interests in preserving maternal health and protecting the potentiality of human life may justify regulation and even prohibition of post-viability abortions, except those necessary to preserve the life and health of the mother. But regulations governing post-viability abortions, like those at any other stage of pregnancy, must be "tailored to the recognized state interests." *Id.*, at 165; see *H.L. v. Matheson*, 450 U. S. 398, 413 (1981) ("statute plainly serves important state interests, [and] is narrowly drawn to protect only those interests"); *Roe*, 410 U. S., at 155 ("legislative enactments must be narrowly drawn to express only the legitimate state interests at stake").

A

The Court upholds the second physician requirement on the basis that it "furthers the State's compelling interest in protecting the lives of viable fetuses." *Ante*, at 8. While I agree that a second physician indeed may aid in preserving the life of a fetus born alive, this type of aid is possible only when the abortion method used is one that may result in a live birth. Although Missouri ordinarily requires a physician performing a post-viability abortion to use the abortion method most likely to preserve fetal life, this restriction does not apply when this method "would present a greater risk to the life and health of the woman." Mo. Rev. Stat. § 188.030.2 (1983).

The District Court found that the dilatation and evacuation (D&E) method of abortion entails no chance of fetal survival, and that it will nevertheless be the method of choice for some women who need post-viability abortions. In some cases, in other words, maternal health considerations will preclude the use of procedures that might result in a live birth. 483 F. Supp., at 694.⁴ When a D&E abortion is performed, the

True

⁴The Court of Appeals upheld this factual finding. 665 F. 2d, at 865. As a general rule, we do not review a District Court's factual findings in

second physician can do nothing to further the State's compelling interest in protecting potential life. His presence is superfluous. The second-physician requirement thus is overbroad and "imposes a burden on women in cases where the burden is not justified by any possibility of survival of the fetus." 655 F. 2d, at 865-866.

The Court reasons that the State's interest in preserving potential life "justifies the State in requiring a second physician at *every* third-trimester abortion" because "[w]e . . . cannot assume that *all* third-trimester abortions will be D&E abortions, or that there will be no live births." *Ante*, at 7, n. 7 (emphasis added). But the fact that other methods of post-viability abortions may result in live births cannot justify requiring a second physician to attend an abortion at which the chance of a live birth is nonexistent. The choice of method presumably will be made in advance,⁵ and any need for a second physician disappears when the woman's health requires that the choice be D&E. Because the statute is not tailored to protect the State's legitimate interests, I would hold it invalid.⁶

*But who
determines
choice of
method?*

which the Court of Appeals has concurred. *Branti v. Finkel*, 445 U. S. 507, 512, n. 6 (1980).

⁵ In addition to requiring the physician to select the method most likely to preserve fetal life, so long as it presents no greater risk to the pregnant woman, Missouri requires that the physician "certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed." Mo. Rev. Stat. § 188.030.2 (1983). This ensures that the choice of method will be a reasoned one.

⁶ The State argues that its second-physician requirement is justified even when D&E is used, because "[i]f the statute specifically excepted D&E procedures, abortionists would be encouraged to use it more frequently to avoid the expense of a second physician, to ensure a dead fetus, to prevent the presence of a second professional to observe malpractice or the choice of a questionable procedure from a safety viewpoint, a fetus-destroying procedure, or to avoid their own awakening to concern for the newborn." Brief for Cross-Petitioners in No. 81-1623, p. 44. The Court rejected this purported justification for a second physician in *Doe v. Bol-*

B

In addition, I would hold that the statute's failure to provide a clear exception for emergency situations renders it unconstitutional. As the Court recognizes, *ante*, at 7, n. 8, an emergency may arise in which delay could be dangerous to the life or health of the woman. A second physician may not always be available in such a situation; yet the statute appears to require one. It states, in unqualified terms, that a post-viability abortion "*shall* be performed . . . *only* when there is in attendance" a second physician who "*shall* take control of" any child born as a result of the abortion, and it imposes certain duties on "the physician *required* by this section to be in attendance." Mo. Rev. Stat. §188.030.3 (emphasis added). By requiring the attendance of a second physician even when the resulting delay may be harmful to the health of the pregnant woman, the statute impermissibly fails to make clear "that the woman's life and health must always prevail over the fetus' life and health when they conflict." *Colautti v. Franklin*, 439 U. S. 379, 400 (1979).

The Court attempts to cure this defect by asserting that the final clause of the statute, requiring the two physicians to "take all reasonable steps . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman," could be construed to permit emergency post-viability abortions without a second physician. *Ante*, at 7, n. 8. This construction is contrary to the plain language of the statute; the clause upon which the Court relies refers to the duties of both physicians during the performance of the abortion, but it in no way suggests that the second physician may be dispensed with.

Rejects my view as to emergency

ton, 410 U. S. 179, 199 (1973): "If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

Moreover, since the Court's proposed construction is not binding on the courts of Missouri,⁷ a physician performing an emergency post-viability abortion cannot rely on it with any degree of confidence. The statute thus remains impermissibly vague; it fails to inform the physician whether he may proceed with a post-viability abortion in an emergency, or whether he must wait for a second physician even if the woman's life or health will be further imperiled by the delay. This vagueness may well have a severe chilling effect on the physician who perceives the patient's need for a post-viability abortion. In *Colautti v. Franklin*, we considered a statute that failed to specify whether it "require[d] the physician to make a 'trade-off' between the woman's health and additional percentage points of fetal survival." 439 U. S., at 400. The Court held there that "where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions." *Id.*, at 400-401.⁸ I would apply that reasoning here, and hold Missouri's second-physician requirement invalid on this ground as well.⁹

⁷ "Only the [Missouri] courts can supply the requisite construction, since of course 'we lack jurisdiction authoritatively to construe state legislation.'" *Gooding v. Wilson*, 405 U. S. 518, 520 (1972), quoting *United States v. Thirty-seven Photographs*, 402 U. S. 363, 369 (1971).

⁸ A physician who fails to comply with Missouri's second-physician requirement faces criminal penalties and the loss of his license. Mo. Rev. Stat. §§ 188.065, 188.075 (1983).

⁹ Because I would hold the statute unconstitutional on these grounds, I do not reach the question whether Missouri's second-physician requirement impermissibly interferes with the doctor-patient relationship. I note, however, that Missouri does not require attendance of a second physician at any other medical procedure, including a premature birth. There was testimony at trial that a newborn infant, whether the product of a normal birth or an abortion, ordinarily remains the responsibility of the woman's physician until he turns its care over to another. App. 133; see ACOG, Standards for Obstetric-Gynecologic Services 31 (1982) ("The individual who delivers the baby is responsible for the immediate post-delivery care of the newborn until another person assumes this duty").

This allocation of responsibility makes sense. Consultation and team-

III

Missouri law prohibits the performance of an abortion on an unemancipated minor absent parental consent or a court order. Mo. Rev. Stat. § 188.028 (1983). A minor who has not obtained parental consent may petition the juvenile court for court consent or the right to self-consent. The statute then provides that

“the court shall for good cause:

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

“(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion . . . ; or

“(c) Deny the petition, setting forth the grounds on which the petition is denied. . . .” § 188.028.2(4).

The Court recognizes that this statute “[o]n its face . . . authorizes juvenile courts to choose among any of the alternatives outlined in the section.” *Ante*, at 13 (footnote omitted). The District Court took a similar view, noting that “each of the three [alternatives] is clearly independent of the others, connected in the statute with the disjunctive ‘or.’” The District Court also concluded that “[a]lternative (c) permits the court to ‘deny the petition,’ guided only by the general standard that such action be ‘for good cause.’” 483 F. Supp., at 689. The District Court thus found it “clear . . . that alternative (c) authorizes the juvenile court to deny the minor’s petition for good cause, but does not require a prior finding that the minor is not sufficiently mature and not competent to make a decision regarding abortion independently.” *Ibid*.

If the statute is construed in accordance with its plain lan-

work are fundamental in medical practice, but in an operating room a patient’s life or health may depend on split-second decisions by the physician. If responsibility and control must be shared between two physicians with the lines of authority unclear, precious moments may be lost to the detriment of both woman and child.

guage, it would be unconstitutional under the standards set forth by the plurality in *Bellotti v. Baird*, 443 U. S. 622, 643-644, 647-648 (1979) (*Bellotti II*), and applied by the Court today. To avoid the necessity of invalidating the statute, the Court applies the maxim that, "[w]here fairly possible, courts should construe a statute to avoid a danger of unconstitutionality." *Ante*, at 14. The Court thus approves the construction adopted by the Court of Appeals, concluding that a Missouri juvenile court may not "deny a [minor's] petition 'for good cause' unless it first [finds] . . . that the minor was not mature enough to make her own decision." *Ante*, at 14.

The Court's maxim of statutory construction may be a wise one for federal courts to follow in discerning the meaning of federal statutes, but it is not one we can impose on state courts interpreting their own law. The interpretation of Missouri law is a matter for the courts of Missouri, and "[t]he majority's construction of state law is, of course, not binding on the Missouri courts." *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S., at 101, n. 4 (opinion of WHITE, J.). A Missouri juvenile court considering a petition brought by a mature minor may therefore conclude, despite this Court's optimistic assertion to the contrary, that Missouri's judicial consent statute means exactly what it says: the court may "for good cause . . . [d]eny the petition."¹⁰

¹⁰ This statute was enacted in 1979, after the Court's decision in *Bellotti v. Baird*, 428 U. S. 132 (1976) (*Bellotti I*), but very shortly before its 1979 decision in *Bellotti II*. The Massachusetts statute held invalid in *Bellotti II*, like the Missouri statute before us today, permitted a court to grant or deny a minor's petition "for good cause shown." See *Bellotti II*, 443 U. S., at 625. The Massachusetts Supreme Judicial Court interpreted this language to authorize the withholding of consent "in circumstances where [the court] determines that the best interests of the minor will not be served by an abortion," even if the minor "is capable of making, and has made, an informed and reasonable decision to have an abortion." *Id.*, at 630, quoting *Baird v. Attorney General*, 371 Mass. 741, 748, 360 N. E. 2d

I adopted
CAB's
construction
(Was this
challenged
by Petr?
What does
Mo. AG say
in his
Brief?

If so
we have
a dif. case

It is certainly possible that the courts of Missouri will agree with this Court and construe Missouri law as the Court does today. But this is a task that must be left to the state courts. We cannot perform it for them. In *Bellotti v. Baird*, 428 U. S. 132 (1976) (*Bellotti I*), the Court held that the District Court should have abstained where “an unconstrued state statute is susceptible of a construction by the state judiciary ‘which might avoid in whole or in part the necessity for federal constitutional adjudication, or at least materially change the nature of the problem.’” *Id.*, at 147, quoting *Harrison v. NAACP*, 360 U. S. 167, 177 (1959); see *Railroad Comm’n v. Pullman Co.*, 312 U. S. 496 (1941). I feel that the District Court should have abstained here as well.¹¹ Although Missouri does not have a certification procedure comparable to the one employed in *Bellotti I*, its rules of procedure provide for expedited review of questions of “general interest or importance.” Mo. S. Ct. Rules 83.02, 83.06 (1983). In *Bellotti I*, moreover, we did not “mean to intimate that abstention would be improper . . . were certification not possible.” 428 U. S., at 151.¹² In cases where

288, 293 (1977). The Court does not explain why it expects the Missouri courts to reach a different result.

¹¹ The Court’s interpretation of Missouri law is directly contrary to the interpretation given by the United States District Judge, who has been on the Missouri bench, state or federal, for over 30 years. The District Judge declined to abstain on the basis that “[i]t is clear to this Court that section 188.028 is *not* susceptible to a reasonable construction which would avoid the federal constitutional question controlling in *Bellotti II*.” 483 F. Supp., at 690 (emphasis added). This District Judge’s interpretation of the statute should indicate that it is at least sufficiently ambiguous to necessitate abstention. Cf. *Bishop v. Wood*, 426 U. S. 341, 345–347 (1976).

¹² While “speed in resolution” of this constitutional challenge remains important, *Bellotti I*, 428 U. S., at 151, it is worthy of note that enforcement of these statutes has been stayed pending the outcome of this litigation. The District Court would have been free to keep its stay in effect, in exercising its power to retain jurisdiction over the constitutional issue. See *England v. Medical Examiners*, 375 U. S. 411 (1964).

constitutional rights of this magnitude are at stake, we should refrain from speculating on the meaning of Missouri law when an authoritative interpretation may be obtained by other means.¹³

¹³ Because I believe abstention is appropriate, I do not reach the question whether Missouri's parental-judicial consent statute as construed by the Court is constitutional.

May 17, 1983

81-185 Simopoulos v. Virginia

Dear Harry:

Here are two copies of a proposed fourth draft of an opinion in this case. The margins are marked to indicate changes.

All of these changes are made to accommodate the suggestions in your letter and accompanying memorandum of May 4. Jim Browning, my clerk, has indicated in the margins of your memorandum the extent to which I have adopted your suggestions.

In summary, I have retained the footnotes on pp. 9 and 10 that describe the Virginia regulations. On page 11, I retained the first sentence in the third (run-over) paragraph. And I made modest revisions in your suggested language for pages 12 and 13.

In all other respects (unless inadvertently I have overlooked something), I have accepted your suggestions.

As the Chief joined an earlier draft, I felt I owed him the duty to show him these changes. You have seen his join note of yesterday. Apparently, he thought I had circulated this fourth draft to the Conference. I had discussed the general nature of the changes with him previously. In any event, although he said to me that he would prefer my first circulation, he recognizes the importance of putting together a solid Court.

I would very much prefer to retain the first sentence in the third paragraph on page 11. It is not a holding sentence. It merely states that on their face the Virginia regulations appear generally to be "compatible with accepted medical standards". In view of the qualifying language, I do not think there can be any doubt as to the accuracy of the sentence.

I am happy to discuss any of this with you. Our exchange of views has been constructive. On the basis of talks with him, I believe we can persuade the Chief also to join Akron. With six of us agreeing on Akron and Simopoulos (by far the two most important issues), each of which reaffirms Roe, I think we will have gone a long way to lay to rest the controversy of the last decade as to the faithfulness of this Court to your historic decision. Guidance also will be given legislatures and courts.

Sincerely,

Justice Blackmun

lfp/ss

- 20.2.14 Special Hospital - Institutions, as defined by Section 32-298(2), Code of Virginia (1950), as amended, which provide care for a specialized group of patients and/or limits in-patient admission to provide diagnosis and treatment for patients who have specified conditions (e.g., tuberculosis, orthopedic, pediatric).

Section 30.0 Procedures for Licensure or License Renewal

30.1 General

No person shall establish, conduct, maintain, or operate in this State any outpatient hospital as defined in and included within provisions of these regulations without having obtained a license. Any person establishing, conducting, maintaining, or operating an outpatient hospital without a license shall be guilty of a misdemeanor and upon conviction shall be punished by a fine of not less than twenty-five dollars nor more than five hundred dollars, or by confinement in jail for not more than twelve months, or both, and each day of such violation before any conviction shall constitute a separate first offense.

30.2 Classification

Hospitals to be licensed shall be classified and designated pursuant to Sections 20.2.8, 20.2.11, and 20.2.14 of these regulations.

30.3 Separate License

Separate license shall be required by outpatient hospitals maintained on separate premises even though they are operated under the same management. Separate license shall be required for separate buildings on the same grounds.

30.4 Special Facilities

Hospitals which have separate organized sections, units, or buildings to provide services of a classification covered by provisions of other state statutes or regulations may be required to have an additional applicable license for that type of service (e.g., maternity, psychiatric, nursing home).

30.5 Request for Issuance

Hospital licenses are issued by the Commissioner, but all requests for licensing shall be submitted initially to the Bureau of Medical and Nursing Facilities Services. The procedure for obtaining the license shall include the following steps:

- 30.5.1 Request for application forms shall be made in writing to the Bureau.
- 30.5.2 Application for license or license renewal to establish or maintain a hospital shall be made and submitted to the Bureau.

30.5.3 Application for original license, change in license, or license renewal shall be accompanied by a check or money order for the service charge, payable to the licensing agency, when requested.

30.5.4 Application for original license of a facility or for additions or major alterations to existing licensed facilities must be accompanied by a letter of approval indicating that the building meets the requirements of the Virginia Fire Safety Laws.

30.6 Service Charge

The service charge shall be \$10.00.

30.7 License Expiration

A license shall expire as specified or at midnight December 31 following date of issue, whichever is first, and shall be renewable annually, upon filing of application and payment of the service charge, unless cause appears to the contrary.

30.8 Name

Every outpatient hospital shall be designated by a permanent and appropriate name which shall appear on the application for license. The name shall not be changed without first notifying the licensing agency.

30.9 Posting of License

The outpatient hospital license issued by the Commissioner shall be framed and posted conspicuously on the premises, either in the main entrance or in a place clearly visible from the main entrance.

30.10 Return of License

The licensing agency shall be notified in writing within thirty (30) working days concerning any proposed change in location, ownership, or name of the facility. A license shall not be transferred from one owner to another or from one location to another.

The license issued by the Commissioner shall be returned to the Bureau when any of the following changes occur during the licensing year or if the facility is closed:

30.10.1 Revocation.

30.10.2 Change of location.

30.10.3 Change of ownership.

30.10.4 Change of name.

30.10.5 Voluntary closure of hospital.

30.11 Revocation or Suspension of License

A license to operate an outpatient hospital shall be revoked or suspended by the licensing agency upon the findings of one or more of the following:

- 30.11.1 Continuing violation of the provisions of the licensing act or the rules and regulations of the Board adopted thereunder.
- 30.11.2 Permitting, aiding, or abetting the commission of any illegal act in the facility.
- 30.11.3 Conduct or practice detrimental to the welfare or safety of any patient in the facility.

Before a revocation of a license is effective, the provisions of the Administrative Process Act shall be observed.

RULES AND REGULATIONS
FOR THE LICENSURE OF
OUTPATIENT SURGICAL HOSPITALS

PART II

ORGANIZATION, OPERATION AND CONSTRUCTION STANDARDS FOR
EXISTING AND NEW OUTPATIENT SURGICAL HOSPITALS

PART II: OUTPATIENT SURGICAL HOSPITALS

ORGANIZATION AND OPERATION OF EXISTING AND NEW HOSPITALS

Section 40.0 Organization and Management

40.1 Governing Authority

Each outpatient surgical hospital shall have a governing body or other legal authority responsible for the management and control of the operation of the facilities.

40.2 There shall be disclosure of hospital ownership. Ownership interest shall be made known to the licensing agency and in the case of corporations, all individuals or entities holding 10% or more of total ownership shall be identified by name and address. The licensing agency shall be notified of any changes in ownership.

40.3 The governing body shall provide facilities, personnel and other resources necessary to meet patient and program needs.

40.4 The governing body shall have a formal organizational plan with written by-laws, rules and regulations or their equivalent. These shall clearly set forth organization, duties, responsibilities, accountability, and relationships of professional staff and other personnel. The person or organizational body responsible for formulating policies shall be identified.

40.5 The by-laws, rules and regulations, or their equivalent, shall include at least the following:

40.5.1 A statement of purpose;

40.5.2 Description of the functions and duties of the governing body, or other legal authority;

40.5.3 A statement of authority and responsibility delegated to the chief administrative officer and to the medical staff;

40.5.4 Provision for selection and appointment of medical staff and granting of clinical privileges;

40.5.5 Provision of guidelines for relationship among the governing body, the chief administrative officer, and the medical staff.

40.6 Administrative Officer

40.6.1 The responsibility for administration and management of the outpatient surgical hospital shall be vested in an individual whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.

Section 41.0 Policies and Procedures

41.1 General Statement

Policies and procedures may vary depending on scope and type of service, personnel, equipment and location of the facility. It is recognized that no two facilities will be identical because of variations in the scope and objective of the outpatient service. Even though each facility may be different, certain standards and procedures shall be applicable to all in assuring the delivery of a high quality of care.

41.2 Policy and Procedures Manual

Each outpatient surgical hospital shall develop written policies and procedures which shall include provisions covering the following items:

* | 41.2.1 The types of emergency and elective procedures which may be performed in the facility;

41.2.2 Types of anesthesia which may be used;

41.2.3 Admissions and discharges, including criteria for evaluating the patient before admission and before discharge;

* | 41.2.4 Written informed consent of patient prior to the initiation of any procedure;

41.2.5 Procedures for housekeeping and infection control.

41.3 A copy of approved policies and procedures and revisions thereto, shall be made available to the Bureau upon request.

Section 42.0 Staffing

42.1 Medical Staff

The size and organizational structure of the medical staff will vary depending on the scope of service.

* [42.1.1 Professional and clinical services shall be supervised by a physician licensed to practice medicine or surgery in Virginia.

✓ 42.1.2 Surgical procedures shall be performed by a physician licensed to perform such procedures in Virginia.

42.1.3 Clinical privileges of physician and non-physician practitioners shall be clearly defined.

- 42.1.4 Credentials including education and experience shall be reviewed and privileges identified, established, and approved for each person allowed to diagnose, treat patients, or perform surgical procedures in accordance with guidelines, policies or by-laws adopted by the governing body and approved by the medical staff.

42.2 Nursing Staff

The total number of nursing personnel will vary depending upon the number and types of patients to be admitted and the types of operative procedures to be performed or the services programmed.

- 42.2.1 A registered nurse qualified on the basis of education, experience, and clinical ability shall be responsible for the direction of nursing care provided the patients.
- 42.2.2 The number and type of nursing personnel, including registered nurses, licensed practical nurses, and supplementary staff, shall be based upon the needs of the patients and the types of services performed.
- ✓ * [42.2.3 At least one registered nurse shall be on duty at all times while the facility is in use.
- 42.2.4 Job descriptions shall be developed for each level of nursing personnel and include functions, responsibilities, and qualifications.
- 42.2.5 Evidence of current Virginia registration required by state statute shall be on file in the facility.

*Reg. Nurse
at all times*

Section 43.0 Patient Care Services

43.1 Anesthesia Service

- 43.1.1 The anesthesia service shall be directed by and under the supervision of a physician licensed to practice medicine or surgery in Virginia.
- 43.1.2 The physician responsible for the anesthesia service shall be present for the administration of anesthetics and recovery of patients when any general or major regional anesthetic is used.
- 43.1.3 There shall be written procedures to assure safety in storage and use of inhalation anesthetics and medical gases.

- 43.1.4 Unless the hospital program and official written action by the governing body prohibit use of flammable anesthetics the requirements of "Rules and Regulations for the Licensure of General and Special Hospitals," Department of Health shall be met.

43.2 Sterile Supply Services

- 43.2.1 Adequate provisions shall be maintained for the processing, sterilizing, storing, and dispensing of clean and sterile supplies and equipment.
- 43.2.2 Written procedures shall be established for the appropriate disposal of pathological and other potentially infectious waste and contaminated supplies.

43.3 Dietary Service

- 43.3.1 If the program calls for the serving of snacks or other foods, adequate space, equipment, and supplies shall be provided. Applicable state and local codes pertaining to receiving, storage, refrigeration, preparation, and serving of food shall be followed.

43.4 Evacuation Plan

- 43.4.1 Each outpatient surgical hospital shall develop a written evacuation plan to assure reasonable precautions are taken to protect patients, employees, and visitors from hazards of fire and other disaster.
- 43.4.2 A program to acquaint all personnel with evacuation procedures shall be maintained.
- 43.4.3 A copy of the plan and procedures shall be made available to the Bureau upon request.

43.5 Emergency Services

- 43.5.1 Each outpatient surgical hospital shall maintain on the premises adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications.
- 43.5.2 A written agreement which ensures emergency transportation to a licensed general hospital shall be executed with an ambulance service.
- 43.5.3 A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times.

43.6 Laboratory and Pathology Services

- 43.6.1 Each patient admitted to the outpatient surgical hospital shall receive appropriate routine laboratory testing.
- 43.6.2 Outpatient surgical hospitals which provide abortion services shall provide laboratory services which meet the minimum requirements of Sections 64.1.3 and 64.1.4 of Part III of these regulations.
- 43.6.3 All tissue removed shall be submitted for histological examination by a pathologist and a written report of his examination provided to the attending physician. The report of findings shall be filed in the patient's clinical record. Pathology services for abortion patients shall meet the minimum requirements of Section 64.2.4 of Part III of these regulations.

43.7 Medical Records

- 43.7.1 An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the medical or surgical service. It shall include, when applicable, but not be limited to the following:
 - (a) Patient identification;
 - (b) Admitting information, including patient history and physical examination;
 - (c) Signed consent;
 - (d) Confirmation of pregnancy, if applicable;
 - (e) Physician orders;
 - (f) Laboratory tests, pathologist's report of tissue, and radiologist's report of X-rays;
 - (g) Anesthesia record;
 - (h) Operative record;
 - (i) Surgical medication and medical treatments;
 - (j) Recovery room notes;
 - (k) Physician and nurses' progress notes;
 - (l) Condition at time of discharge;
 - (m) Patient instructions, preoperative and postoperative;
 - (n) Names of referral physicians and/or agencies.
- 43.7.2 Provisions shall be made for the safe storage of medical records or accurate and legible reproductions thereof.
- 43.7.3 All medical records, either original or accurate reproductions, shall be preserved for a minimum of five (5) years following discharge of the patient.
 - (a) Records of minors shall be kept for at least five (5) years after such minor has reached the age of 18 years.

- (b) Birth and death information shall be retained for ten (10) years in accordance with Section 32-353.29, Code of Virginia (1950), as amended.
- (c) Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished the Bureau of Vital Records, Virginia Department of Health, within ten (10) days after the abortion.

43.8 Pre-Operative Admission

- 43.8.1 Prior to the initiation of any procedure, a medical history and physical examination shall be completed for each patient.
- 43.8.2 Where medical evaluation, examination, and referrals are made from a private physician's office, another hospital, clinic, or medical service, pertinent available records thereof shall be made and included as a part of the patient's medical record at the time the patient is admitted to the outpatient surgical hospital.
- 43.8.3 Sufficient time shall be allowed between initial examination and initiation of any procedure to permit the reporting and review of laboratory tests by the responsible physician.
- 43.8.4 In outpatient surgical hospitals which provide abortion services, the diagnosis of pregnancy shall be the responsibility of the physician performing the abortion procedure.
- 43.8.5 Outpatient surgical hospitals which provide abortion services shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods.

43.9 Post-Operative Recovery

- 43.9.1 Each patient shall be observed for post-operative complications under the direct supervision of a licensed nurse. Nurses who supervise the recovery area shall have specialized training in resuscitation techniques and other emergency procedures.
- ✓ * [43.9.2 The recovery period will vary according to the procedure performed but patients shall be observed for post-operative complications for a minimum of sixty (60) minutes.
- 43.9.3 A physician licensed in Virginia shall be present on the premises at all times during the operative and post-operative period until discharge of the patient.
- 43.9.4 Patients shall be discharged from the recovery only on written order of the attending physician.

- 43.9.5 Rh₀ (D) anti-immune globulin (human) shall be administered to Rh-negative patients who receive abortion services in accordance with requirements of Section 64.3.5 of Part III of these regulations.

43.10 Environment and Maintenance

- 43.10.1 All parts of the outpatient surgical hospital and its premises shall be kept clean, neat, and free of litter and rubbish.
- 43.10.2 Hazardous cleaning solutions, compounds, and substances shall be labeled, stored in a safe place, and kept in an enclosed section separate from other materials.

43.11 Laundry Service

- 43.11.1 Each outpatient surgical hospital shall make provisions for the cleaning of all linens.
- 43.11.2 There shall be distinct areas for the separate storage and handling of clean and soiled linens.
- 43.11.3 All soiled linen shall be placed in closed containers prior to transportation.

43.12 Physical Plant

43.12.1 Fire and Safety.

Each outpatient hospital shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations.

43.12.2 Lighting and Electrical.

- (a) Policies and procedures shall be established to minimize the hazards in the use and operation of all electrical equipment.
- (b) All electrical appliances used by the outpatient surgical hospital shall have the Underwriter Laboratories label or be approved by the local electrical inspection authority.

43.12.3 Plumbing.

- (a) All plumbing material and plumbing systems or parts thereof shall meet the minimum requirements of the State Uniform Building Code.
- (b) All plumbing shall be installed in such a manner as to prevent back siphonage or cross connections between potable and non-potable water supplies.

43.12.4 Sewage Disposal Systems.

Existing and new facilities shall be connected to an approved sewage system.

43.12.5 Waste Disposal.

Pathological and bacteriological wastes, dressings, and other contaminated wastes shall be incinerated in an approved incinerator or by other methods of disposal as approved by the licensing agency.

43.12.6 Water Supply.

- (a) Water shall be obtained from an approved water supply system.
- (b) The water shall be distributed to conveniently located taps and fixtures throughout the facility and shall be adequate in volume and pressure for all hospital purposes, including fire fighting.

CONSTRUCTION STANDARDS FOR NEW HOSPITALS AND ADDITIONS AND ALTERATIONS
TO EXISTING HOSPITALS

Section 50.0 General Considerations

50.1 Narrative Program

- 50.1.1 The owner or his representative shall provide a brief narrative which describes the functional space requirements, staffing patterns, departmental relationship, and other basic information relating to the fulfillment of the institution's objective.

50.2 Services

- 50.2.1 The narrative shall indicate the manner in which the services are to be made available to the outpatients. When services are to be shared or purchased, appropriate modifications or deletions in space and equipment requirements shall be considered to avoid duplication. In many instances, minimum requirements will need to be exceeded for the institution to function as programmed. These minimum requirements are not intended in any way to restrict innovations and improvements in design or construction techniques. Plans and specifications which contain deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled. Request to waive any specific requirement shall be submitted as early as possible in the planning process.

50.3 Size

- 50.3.1 The extent (number and type) of the diagnostic, clinical, and administrative facilities to be provided shall be determined by the services contemplated and the estimated patient load as described in the narrative program.

50.4 Applicable Requirements

- 50.4.1 If the outpatient surgical hospital is a physical part of an inpatient hospital and is intended to serve inpatients as well as outpatients, the applicable requirements of the "Rules and Regulations for the Licensure of General and Special Hospitals," Department of Health, shall apply.

50.5 Parking

- 50.5.1 In the absence of a formal parking study, vehicle parking for outpatient surgical hospitals shall be provided at the ratio of two parking spaces for each treatment room and each examining room plus sufficient parking spaces to accommodate the maximum number of staff on duty at one time. Exceptions may be made with approval of the Bureau for outpatient surgical hospitals located in areas with high population density if adequate public parking is available or if the hospital is accessible to a public transportation system.

50.6 Codes, Fire Safety, Zoning

- 50.6.1 All construction of new buildings and additions, alterations or repairs to existing buildings for occupancy as a "free-standing" outpatient hospital shall conform to state and local codes, zoning and building ordinances, and the State Uniform Building Code requirements applicable to type of occupancy. In case of a conflict, codes with the most strict standards shall apply. All codes applicable to the outpatient surgical hospital shall be noted on the preliminary and working drawings.

50.7 Conversions

- 50.7.1 Conversions of existing buildings to outpatient surgical hospital occupancy will be considered only in those buildings which meet or can be remodeled to meet the requirements of the State Uniform Building Code. When the licensing agency finds the enforcement of one or more of the requirements in the following sections would clearly be impractical, the Commissioner shall have the authority to waive, either temporarily or permanently, the enforcement of one or more of these requirements, provided patient care and safety to life from fire are not adversely affected. Life safety during construction of alterations, conversions, or additions shall be maintained. Additions shall conform to new construction requirements.

50.8 Site Requirements and Location

- 50.8.1 The site shall meet local zoning regulations.

- 50.8.2 Facilities not located on the ground floor of a building shall be served by an elevator(s) capable of accommodating a standard stretcher.
- 50.8.3 Facilities shall be located in buildings providing emergency electrical service. The emergency electrical service may be provided by an auxiliary generator, or, if available from the power company, two separate lines, each supplied from a separate generating source. The emergency electrical service shall have the capability to cover at least the operating, procedure, and recovery room(s) lighting and electrical equipment.
- 50.8.4 The sanitation, water supply, sewage, and disposal facilities shall comply with the applicable state and local codes and ordinances.
- 50.8.5 Adequate fire protection facilities or fire department services shall be available.

Section 51.0 Architectural Plan Review

51.1 General

- 51.1.1 During the early phase of architectural planning, prime consideration shall be given to patient traffic from the patient parking area to admissions and through the service areas to discharge offices and to areas for patient pick up. Also, personnel traffic patterns from other areas to the service area, as well as those related to internal operations, shall be considered. Traffic patterns for supply distribution are sometimes difficult to coordinate with personnel and patient traffic but are just as essential to the operations of the facility and therefore, shall be included in the planning.

51.2 Drawings and Specifications

- 51.2.1 When construction is contemplated for new buildings, additions, or substantial alterations, preliminary drawings and outline specifications shall be submitted to the Bureau, with a program narrative description, for review and approval prior to starting final working drawings and specifications.
- 51.2.2 The final working drawings and specifications shall be submitted to the Bureau for review and approval prior to release of contract documents for bidding. Change orders which affect scope and/or function shall be submitted for approval prior to execution.
- 51.2.3 The Bureau shall be notified of the award of contracts, of the date when construction has been completed, and of the estimated date of occupancy.

- 51.2.4 Minor alterations and remodeling - Minor alterations or remodeling changes which do not affect the structural integrity of the building, or change functional operation, or which do not affect safety, need not be submitted for approval.
- 51.2.5 The preparation and submission of drawings and specifications shall be executed by or under the immediate supervision of an architect registered in the State of Virginia.

Section 52.0 Construction Requirements

52.1 Administration and Public Areas

- 52.1.1 Entrance to the building shall be located at grade level, sheltered from the weather and able to accommodate wheel-chairs, if applicable.
- 52.1.2 While the same room may serve more than one function, the planning process shall assure that adequate space is available for all administrative services.
- 52.1.3 Reception area - Reception may be considered a part of administrative services. However, adequate space near the entrance shall be provided for receiving and registering patients. Work space shall provide privacy for obtaining confidential information and discussing financial arrangements.
- 52.1.4 Lobby and waiting area - Adequate waiting space designed for comfort shall be provided for at least one family member/friend per patient. Facilities shall include public toilets, public telephone(s), drinking fountains(s), and wheelchair storage.
- 52.1.5 Preoperative preparation and holding - Adequate space to assure privacy for both males and females shall be provided in dressing rooms and patient lockers, toilet and bathing facilities, pre-operative preparation, medication administration, and patient holding areas.
- 52.1.6 Counseling services - If the program calls for services requiring special patient counseling, private space shall be provided for this service.
- 52.1.7 Nourishment rooms - Facilities and space may be provided for preparation of light nourishment, and refrigeration of juices. An ice machine is desirable. Handwashing facilities shall be provided in the room.
- 52.1.8 Space for general storage for office supplies, sterile supplies, pharmacy and housekeeping supplies shall be provided.

- 52.1.9 Adequate janitor's closet(s) with floor receptor or service sink shall be provided.

52.2 Clinical Areas

- 52.2.1 Size and design - The size and design of units shall be in accordance with individual programs, but the following basic elements shall be incorporated in all facilities, where applicable.
- 52.2.2 Surgical suite - The plumbing, heating, and electrical systems for this service shall meet all codes applicable to the general hospital operating room as specified in the "Rules and Regulations for the Licensure of General and Special Hospitals," Department of Health.
- 52.2.3 Operating rooms.
- (a) Number - The architectural design of the facilities shall provide a sufficient number of rooms for the projected case load and types of procedures to be performed.
- (b) Size of rooms - Operating rooms shall have minimum dimensions of 16' X 18'. One smaller room may be reserved for very minor local excisions but that room shall be no less than 160 square feet.
- 52.2.4 Scrub-up facilities - Regular scrub sinks shall be provided. Scrub facilities shall be arranged to minimize any incidental splatter on nearby personnel or supply carts.
- 52.2.5 Personnel dressing - The personnel locker and dressing areas shall be so located that personnel enter from uncontrolled areas and exit directly into the surgical suite. Locker space shall be provided for each employee, and a toilet, shower, and dressing area shall be provided in each personnel dressing room.
- 52.2.6 Recovery room.
- (a) This room shall have handwashing facilities, medication storage space, clerical work space, storage for clerical supplies, linens, and patient care supplies and equipment; and an adjoining toilet which shall have a water closet and handwashing facilities.
- 52.2.7 General purpose examination rooms - The preoperative preparation area may be designed and equipped for examination. Each room shall have handwashing facilities and be equipped for patient examination.

- 52.2.8 Work and storage space - Separate rooms shall be provided for clean and sterile holding and for instrument or equipment clean-up functions.
 - 52.2.9 Anesthesia storage - Unless the narrative program and governing body action prohibits in writing the use of flammable anesthetics, a separate room shall be provided for storage of flammable gases.
 - 52.2.10 Anesthesia workroom - Anesthesia workroom and equipment storage facilities with adequate ventilation, work counter and sink shall be provided.
 - 52.2.11 Nurses, clerical or control station - Sufficient clerical control station(s) shall be appropriately designed and located. Suitable space shall be provided for the following activities: traffic control of the area; clerical functions related to room or case scheduling and record maintenance; personnel functions; and nursing activities related to medication administration and treatments.
 - 52.2.12 Doctors' dictation - Space shall be private and adequate in size for the total number of doctors who may be dictating at the same time. It may be located adjacent to but not inside the nurses' station, lounge, or doctors' dressing area.
 - 52.2.13 Housekeeping - A janitor's closet shall be conveniently located and designated to serve only the surgical suite. It shall have suitable storage facilities and receptacles for special equipment and supplies used in cleaning the operating rooms.
- 52.3 Laboratory and Radiology Services
- 52.3.1 Space and equipment requirements shall be determined by the workload described in the narrative program. These services may be provided within the outpatient surgical hospital or through an effective contractual arrangement with nearby facilities. If laboratory and/or radiology services are not provided by contractual agreement all applicable requirements of the "Rules and Regulations for the Licensure of General and Special Hospitals," Department of Health, shall apply.
- 52.4 General Requirements
- 52.4.1 Minimum public corridor width shall be 5'0".
 - 52.4.2 Each building shall have at least two exits remote from each other. Other details as to exits and fire safety shall be in accordance with the Virginia Fire Safety Code.

- 52.4.3 Items such as drinking fountains, telephone booths, vending machines and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width below the required width.
- 52.4.4 Toilet rooms which may be used by patients shall be equipped with doors and hardware which will permit access from the outside in any emergency.
- 52.4.5 The minimum width of doors for patient access to examination and treatment rooms shall be 3'0".
- 52.4.6 No door shall swing into a corridor in a manner that might obstruct traffic flow or reduce the required corridor width, except doors to space such as small closets which are not subject to occupancy.
- 52.4.7 Rooms containing ceiling mounted equipment and those have ceiling mounted surgical light fixtures shall have height required to accommodate the equipment or fixture. All other rooms shall have not less than 8'0" ceilings except that corridors, storage rooms, toilet rooms and other minor rooms shall not be less than 7'8".
- 52.4.8 Cubicle curtains and draperies shall be non-combustible or rendered flame retardent.
- 52.4.9 Floor materials shall be easily cleanable and have wear resistance appropriate for the location involved.
- 52.4.10 Wall finishes shall be washable and, in the immediate area of plumbing fixtures, shall be smooth and moisture resistant.

RULES AND REGULATIONS
FOR THE LICENSURE OF
OUTPATIENT HOSPITALS
PERFORMING ABORTIONS ONLY

PART III

ORGANIZATION, OPERATION AND PHYSICAL FACILITY STANDARDS
FOR EXISTING AND NEW OUTPATIENT ABORTION HOSPITALS

- 30 -

PART III. OUTPATIENT HOSPITALS PERFORMING ABORTIONS ONLY

Section 60.0 Organization and Management

60.1 Governing Authority

Each outpatient abortion hospital shall have a governing body or other legal authority responsible for the management and control of the operation of the facilities.

60.2 There shall be disclosure of ownership. Ownership interest shall be made known to the licensing agency and in the case of corporations, all individuals or entities holding 10% or more of total ownership shall be identified by name and address. The licensing agency shall be notified of any changes in ownership.

60.3 The governing body shall provide facilities, personnel and other resources necessary to meet patient and program needs.

60.4 The governing body shall have an organizational plan. The organizational plan shall clearly set forth duties, responsibilities, accountability, and relationships of professional staff and other personnel. The person or organizational body responsible for formulating policies shall be identified.

60.5 The organizational plan shall include at least the following:

60.5.1 A statement of purpose;

60.5.2 A statement of authority and responsibility delegated to the chief administrative officer and to the medical staff;

60.5.3 Provision for selection and appointment of medical staff and granting of clinical privileges.

60.6 Administrative Officer

60.6.1 The responsibility for administration and management of the outpatient abortion hospital shall be vested in an individual whose qualifications, authority and duties shall be defined in a written statement adopted by the governing body.

Section 61.0 Policies and Procedures

61.1 General Statement

Policies and procedures may vary depending on types of termination of pregnancy technique, personnel and equipment required, and location of the facility. It is recognized that no two facilities will be identical. Even though each facility may be different, certain standards and requirements shall be applicable to all in assuring the delivery of quality care.

61.2 Policy and Procedures Manual

Each outpatient abortion hospital shall develop written policies and procedures which shall include provisions covering the following items:

61.2.1 Patient Eligibility

61.2.2 Personnel

61.2.3 Clinical Services

61.2.4 Medical Records

61.2.5 Physical Facilities

61.3 A copy of approved policies and procedures and revisions thereto, shall be made available to the Bureau upon request.

Section 62.0 Patient Eligibility

62.1 The outpatient abortion hospital is maintained and operated for the primary purpose of terminating a confirmed pregnancy of a patient who is medically eligible for an abortion performed on an outpatient basis.

62.1.1 Medical eligibility shall be determined by the attending physician based on the medical history and the findings of the physical examination.

62.1.2 Any procedure performed to terminate a pregnancy shall be performed prior to the end of the first trimester (12th week amenorrhea).

12th wk

62.1.3 Concomitant female sterilization or any other procedure requiring entry into the pelvic or abdominal cavity shall be prohibited.

Section 63.0 Personnel

63.1 Medical Staff

The size and organizational structure of the medical staff will vary depending on the scope of service.

63.1.1 Each outpatient abortion hospital shall have a Medical Director.

(a) The Medical Director shall be a physician licensed to practice medicine or surgery in Virginia; and

(b) Shall be certified by the American Board of Obstetrics and Gynecology and have training and experience in performing pregnancy termination procedures; and

Med.
Director

- (c) Shall supervise all medical aspects of the professional and clinical services in the facility; and
- (d) Shall review credentials of all professional staff including education, experience and hospital privileges and identify, establish, and approve privileges for each person allowed to diagnose, treat patients, or perform pregnancy termination procedures in accordance with guidelines or policies approved by the governing body.

63.1.2 All pregnancy termination procedures shall be performed by a physician licensed to practice medicine or surgery in Virginia.

63.2 Nursing Staff

The total number of nursing personnel will vary depending upon the number of patients to be admitted and the services performed.

63.2.1 A registered nurse qualified on the basis of education, experience, and clinical ability shall be responsible for the direction of nursing care provided the patients.

63.2.2 The number and type of nursing personnel, including registered nurses, licensed practical nurses, and supplementary staff, shall be based upon the needs of the patients and the types of services performed.

✓ [63.2.3 At least one registered nurse shall be on duty at all times while the facility is in use for termination of pregnancy procedures.

63.2.4 Job descriptions shall be developed for each level of nursing personnel and shall include functions, responsibilities, and qualifications.

63.2.5 Evidence of current Virginia registration required by state statute shall be on file in the facility.

63.3 Counseling Staff

63.3.1 Each outpatient abortion hospital shall offer each patient appropriate counseling and instruction in the pregnancy termination procedure and in birth control methods.

63.3.2 An individual qualified on the basis of education, training and experience shall be responsible for the supervision of the interviewing and counseling services provided the patients.

63.3.3 The counseling supervisor shall be available for consultation at all times the facility is open and receiving patients.

63.3.4 Individual interview and counseling shall be given prior to the termination of pregnancy procedure.

63.3.5 Information obtained at admission counseling shall be recorded in the medical record and brought to the attention of the physician prior to the termination of pregnancy procedure.

63.4 Laboratory Staff

63.4.1 Each outpatient abortion hospital shall have the capability to perform routine pre-operative laboratory examination on the premises.

63.4.2 An individual qualified on the basis of education, training and experience shall be responsible for the supervision of laboratory services provided the patients.

63.4.3 The laboratory supervisor should be a graduate of an accredited school of medical technology or a laboratory technician certified by the American Society of Clinical Pathologists.

Section 64.0 Clinical Services

64.1 Pre-Operative Admission

64.1.1 Prior to the initiation of any pregnancy termination procedure, a medical history and physical examination, including complete vaginal and bi-manual pelvic examination shall be completed for each patient.

64.1.2 Where medical evaluation, examination, and referrals are made from a private physician's office, another hospital, clinic, or medical service, pertinent available records thereof shall be included as a part of the patient's medical record at the time the patient is admitted to the outpatient abortion hospital.

64.1.3 The following laboratory procedures shall be conducted on each patient and results of (a), (b), (c), and (e) shall be available prior to the performance of the pregnancy termination procedure:

(a) Pregnancy test;

(b) Hemoglobin or hematocrit determinations;

(c) Blood and Rh typing;

(d) In the case of Rh-negative patients, a Coomb's test;

(e) Urinalysis for sugar and albumin; and

(f) Culture for gonorrheal infection.

64.1.4 When medically indicated, serologic test for syphilis and Papanicolaou smear shall be conducted.

64.1.5 Appropriate written informed consent of the patient shall be obtained prior to the initiation of any procedure.

64.2 Surgical Procedures

64.2.1 The anesthesia service shall be directed by and under the supervision of a physician licensed to practice medicine or surgery in Virginia.

64.2.2 There shall be written procedures to assure safety in storage and use of inhalation anesthetics and medical gases.

64.2.3 Only non-combustible agents shall be used for anesthesia or for pre-operative preparation.

64.2.4 Tissue removed shall be submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts. The attending physician shall document in the patient's medical record the presence or absence of fetal parts.

64.2.5 Each outpatient abortion hospital shall maintain on the premises suction apparatus, oxygen, and related items necessary for resuscitation or control of hemorrhage and other complications.

Such items shall include but not be limited to the following:

- (a) Blood pressure cuff;
- (b) Oxygen;
- (c) Suction machine;
- (d) Oral airway;
- (e) Resuscitation bag;
- (f) Endotracheal tube;
- (g) Laryngoscope;
- (h) Tracheotomy set;
- (i) Cut-down set;
- (j) Plasma expanders;
- (k) I-V sets;
- (l) Tilting stretcher;

- (m) Appropriate drugs for the treatment of anaphylactic reaction.

64.3 Post-Operative Recovery

- 64.3.1 Each patient shall be observed for post-operative complications under the direct supervision of a Registered Nurse. Nurses who supervise the recovery area shall have specialized training in resuscitation techniques and other emergency procedures.
- 64.3.2 The recovery period will vary but patients shall be observed for post-operative complications for a minimum of forty-five (45) minutes.
- 64.3.3 A physician licensed in Virginia shall be present on the premises at all times during the operative and post-operative period.
- 64.3.4 Patients shall be discharged from the recovery area only on written order of the attending physician.
- 64.3.5 Rh₀ (d) anti-immune globulin (human) shall be administered to all Rh-negative patients who receive abortion services, where medically indicated, unless refused. The patient's decision to reject or accept must be in writing and made a permanent part of the medical record.
- 64.3.6 Prior to discharge, each patient shall receive written instructions and counseling regarding post-abortion complications and self-care.
- 64.3.7 Prior to discharge, arrangements shall be made for post-operative examination, either in the same facility or elsewhere, within two (2) to four (4) weeks after discharge. Instructions for emergency care in the interim shall be given.
- 64.3.8 Each outpatient abortion hospital shall provide treatment on the premises or by referral of any abnormal condition(s) detected, such as venereal disease or cervical carcinoma.

64.4 Emergency Care

- 64.4.1 Each outpatient abortion hospital shall have a written plan for identifying medical emergencies and procedures.
- 64.4.2 Supplies and equipment reserved for emergency use shall be checked at least weekly to assure adequate supply and proper working order.

64.4.3 An agreement which ensures transportation of medical emergency cases to a licensed general hospital shall be executed with an ambulance service.

64.4.4 To ensure that patients of the outpatient abortion hospital shall receive needed emergency treatment there shall be:

- (1) A written agreement with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times; or
- (2) Evidence that two or more staff physicians have unsupervised obstetrical, gynecological, or general surgical privileges in an accessible licensed general hospital which meets the requirement of (1) above; or
- (3) A written agreement with two or more physicians who have unsupervised obstetrical, gynecological, or general surgical privileges in an accessible licensed general hospital which meets the requirements of (1) above.

64.5 Medical Records

64.5.1 An accurate and complete clinical record or chart shall be maintained on each patient. The record or chart shall contain sufficient information to satisfy the diagnosis or need for the service. It shall include where applicable, but not be limited to the following:

- (a) Patient identification;
- (b) Admitting information, including patient history and physical examination;
- (c) Pre-operative counseling notes;
- (d) Signed consent;
- (e) Confirmation of pregnancy;
- (f) Physician orders;
- (g) Laboratory tests, pathologist's report of tissue, and radiologist's report of X-rays;
- (h) Anesthesia record;

- (i) Operative record, including results of gross examination to determine presence or absence of fetal parts;
 - (j) Surgical medication and medical treatments;
 - (k) Recovery room notes;
 - (l) Physician and nurses' progress notes;
 - (m) Condition at time of discharge;
 - (n) Patient instructions;
 - (o) Post-operative counseling notes;
 - (p) Names of referral physicians and/or agencies.
- 64.5.2 Provisions shall be made for the safe storage of medical records or accurate and legible reproductions thereof.
- 64.5.3 All medical records, either original or accurate reproductions, shall be preserved for a minimum of five (5) years following discharge of the patient.
- (a) Records of minors shall be kept for at least five (5) years after such minor has reached the age of 18 years.
 - (b) Record of abortions and proper information for the issuance of a fetal death certificate shall be furnished the Bureau of Vital Records, Virginia Department of Health, within ten (10) days after the abortion.

Section 65.0 Physical Facilities

65.1 Codes and Zoning

- 65.1.1 All construction of new buildings and additions, alterations or repairs to existing buildings shall conform to all applicable state and local codes, zoning and building ordinances.

65.2 Fire and Safety

- 65.2.1 Each outpatient abortion hospital shall establish a monitoring program for the internal enforcement of all applicable fire and safety laws and regulations.
- 65.2.2 Each outpatient abortion hospital shall develop a written evacuation plan to assure reasonable precautions are taken to protect patients, employees, and visitors from hazards of fire and other disaster.

(a) A program to acquaint all personnel with evacuation procedures shall be maintained.

(b) A copy of the plan and procedures shall be made available to the Bureau upon request.

65.3 Site Requirements and Location

65.3.1 The site shall meet local zoning requirements.

65.3.2 Adequate fire protection facilities or fire department services shall be available.

65.3.3 Facilities not located on the ground floor of a building shall be served by an elevator capable of accommodating a standard stretcher.

65.3.4 Facilities should be located in buildings providing emergency electrical service.

65.4 Conversion of Existing Buildings

65.4.1 Conversions of existing buildings to outpatient abortion hospital occupancy will be considered only in those buildings which meet or can be remodeled to meet the requirements of the State Uniform Building Code. When the licensing agency finds the enforcement of one or more of the requirements in the regulations would clearly be impractical, the Commissioner shall have the authority to waive, either temporarily or permanently, the enforcement of one or more of these requirements, provided patient care and safety to life from fire are not adversely affected. Life safety during construction of alterations, conversions, or additions shall be maintained.

65.5 Building and Service Requirements

65.5.1 Administration and Public Areas

(a) While the same room may serve more than one function, the planning process shall assure that adequate space is available for all administrative services.

(b) Reception area - Reception may be considered a part of administrative services. However, adequate space near the entrance shall be provided for receiving and registering patients. Work space shall provide privacy for obtaining confidential information, discussing financial arrangements and counseling.

- (c) Lobby and waiting area - Adequate waiting space designed for comfort shall be provided for at least one family member/friend per patient. Facilities shall include public toilets, public telephone(s), drinking fountain(s).
- (d) Pre-operative preparation and holding - Adequate space to assure privacy shall be provided in dressing rooms and patient lockers, toilet, preoperative preparation, medication administration and patient holding areas.
- (e) If the program calls for the serving of snacks or other foods, adequate space, equipment, and supplies shall be provided. Applicable state and local codes pertaining to receiving, storage, refrigeration, preparation, and serving of food shall be followed.
- (f) Space for general storage for office supplies, pharmacy and housekeeping supplies shall be provided. Hazardous cleaning solutions, compounds, and substances shall be labeled, stored and kept in an enclosed section separate from other supplies.

65.5.2 Clinical Areas

- (a) Size and design - The size and design of units shall be in accordance with individual programs, but the following basic elements shall be incorporated in all facilities:
- (b) Procedures and Examining Rooms - The design of facilities shall provide a sufficient number of rooms for the projected case load and the types of procedures to be performed.
 - (1) Size of rooms - Rooms in which pregnancy termination procedures are performed shall have a minimum clear floor area of 100 square feet and have adequate lighting for surgical procedures.
 - (2) Conventional gynecological examination or operating tables with accessories, drapes, and/or linen shall be used in all procedures.
- (c) Scrub-up facilities - Regular scrub sinks shall be provided.
- (d) Personnel dressing - The personnel locker and dressing areas shall be so located that personnel enter from uncontrolled areas and exit directly into the surgical procedure area.

- (e) Recovery room - A separate recovery room shall be provided and shall have handwashing facilities, medication storage space, clerical work space, storage for clerical supplies, linens, and patient care supplies and equipment; and an adjoining toilet with handwashing facilities.
- (f) Sterile Supply Services - Adequate provisions shall be maintained for the processing, sterilizing, storing, and dispensing of clean and sterile supplies and equipment. Written procedures shall be established for the appropriate disposal of pathological and other potentially infectious waste and contaminated supplies
- (g) Anesthesia workroom - Anesthesia work areas and storage facilities with adequate ventilation shall be provided.
- (h) Emergency equipment storage - Space out of the direct line of traffic shall be provided for a "crash cart," stretcher and similar emergency equipment.
- (i) Laboratory facilities - Space and equipment shall be provided within the outpatient abortion hospital for conducting pregnancy tests, hematocrit or hemoglobin determination, urinalysis, blood grouping and Rh typing. The space shall be adequate to provide at least the following:
 - (1) Laboratory work counter;
 - (2) Lavatory or counter sink equipped for handwashing;
 - (3) Storage cabinet or closet.
- (j) Laundry and linen facilities - Provisions shall be made for cleaning, storage, and handling of all linen. There shall be distinct areas for the separate storage and handling of clean and soiled linen. All soiled linen shall be placed in closed containers prior to transportation.

65.5.3 General Requirements

- (a) Environment and Maintenance - All parts of the outpatient abortion hospital and its premises shall be kept clean, neat, and free of litter and rubbish.
 - (1) Floors shall be easily cleanable and shall have wear resistance appropriate to the area involved.
 - (2) Wall finishes shall be washable and in the immediate area of plumbing fixtures, shall be smooth, moisture resistant and easily cleanable.

- (b) Doors - Doors shall be not less than 3'0" in width in areas subject to patient occupancy. All doors to toilets which may be used by patients shall be equipped with hardware which will permit access in any emergency. No door shall swing into a corridor in a manner that might obstruct traffic flow or reduce the required corridor width, except doors to space such as small closets which are not subject to occupancy.
- (c) Corridors - Corridor width in areas of public use shall be 5'0".
- (d) Lighting and Electrical - Policies and procedures shall be established to minimize the hazards in the use and operation of all electrical equipment. All electrical appliances shall have the Underwriter Laboratories label or be approved by the local electrical inspection authority.
- (e) Plumbing - All plumbing material and plumbing systems or parts thereof shall meet the minimum requirements of applicable state and local codes. All plumbing shall be installed in such a manner as to prevent back siphonage or cross connections between potable and non-potable water supplies.
- (f) Sewage Disposal Systems - Existing and new facilities shall be connected to an approved sewage system.
- (g) Waste Disposal - Pathological and bacteriological wastes, dressings, and other contaminated wastes shall be incinerated in an approved incinerator or by other methods of disposal as approved by the licensing agency.
- (h) Water Supply - Water shall be obtained from an approved water supply system. The water shall be distributed to conveniently located taps and fixtures throughout the facility and shall be adequate in volume and pressure for all outpatient abortion hospital purposes, including fire fighting.

Section 66.0 Architectural Plan Review

66.1 General

- 66.1.1 During the early phase of architectural planning, prime consideration shall be given to patient traffic from the patient parking area to admissions and through the service areas to discharge offices and to areas for patient pick up.

Also, personnel traffic patterns from other areas to the service area, as well as those related to internal operations, shall be considered. Traffic patterns for supply distribution are sometimes difficult to coordinate with personnel and patient traffic but are just as essential to the operations of the facility and therefore, shall be included in the planning.

66.2 Drawings and Specifications

- 66.2.1 When construction is contemplated for new buildings, additions, or substantial alterations, preliminary drawings and outline specifications shall be submitted to the Bureau with a program narrative description for review and approval prior to starting final working drawings and specifications. All codes applicable to the building shall be noted on the preliminary and working drawings.
- 66.2.2 The final working drawings and specifications shall be submitted to the Bureau for review and approval prior to release of contract documents for bidding. Change orders which affect scope and/or function shall be submitted for approval prior to execution.
- 66.2.3 The Bureau shall be notified in writing of the award of contracts, of the date when construction has been completed, and of the estimated date of occupancy.
- 66.2.4 Minor alterations and remodeling - Minor alterations or remodeling changes which do not affect the structural integrity of the building, or change functional operation, or which do not affect safety, need not be submitted for approval.
- 66.2.5 The preparation and submission of drawings and specifications shall be executed by or under the immediate supervision of an architect registered in the Commonwealth of Virginia.

1 Organization

Quality obstetric-gynecologic care requires efficient organization of the medical staff and other personnel, whether the care is provided within an ambulatory or a hospital setting.

AMBULATORY CARE

✓ Ambulatory obstetric-gynecologic care is outpatient care that is provided in a physician's office, outpatient clinic, or free-standing or hospital-based surgical facility. The organization of the ambulatory care facility will vary depending on the kind of facility or type of practice and on the patient volume. However, certain standards are applicable to all types of settings, whether it be a solo physician's office, group practice, or outpatient clinic.

Personnel directly involved in the welfare of the obstetric and gynecologic patient should be organized into a health care team under the direction of an obstetrician-gynecologist. Staff should be sufficient in number and training to prevent undue delays and provide optimal care. Job descriptions and written policies should be prepared and reviewed periodically where appropriate. These policies should indicate specific responsibilities, as well as a plan for continuing education of personnel. While it may not be feasible to provide in-service education in all offices, it is desirable that personnel have access to such programs.

A free-standing ambulatory surgical facility should have a governing body, similar to a hospital board of trustees, that has final authority and responsibility for patient care, facilities, services, appointment of the medical staff, and establishment of clinical privileges. A mechanism similar to that used in the hospital for granting privileges should be established in an ambulatory surgical facility. Privileges granted to a physician should not exceed those held (by that physician) in at least one accredited hospital within the geographical area. A hospital-based facility usually functions under the hospital's governing body, and staff privileges will be established by hospital regulations.

Details on how either a free-standing or hospital-based ambulatory facility should be organized, and the relation of the hospital staff to the facility are available from the Joint Commission on Accreditation of Hospitals and the Accreditation for Ambulatory Health Care, Inc.

HOSPITAL CARE

Increasing medical knowledge and improved equipment and facilities have greatly increased the range and quality of care that can be offered in the hospital. However, information, equipment, facilities, and even skilled personnel cannot be used efficiently without effective organization of each department in the hospital.

Responsibility and Authority

Ultimate responsibility for patient care, staff, and facilities and services resides in the governing body, usually a board of trustees. The board customarily delegates administrative responsibility to an administrator and medical responsibility to the medical staff. Although it may be impossible to draw sharp lines of distinction between medical and administrative functions, the hospital should establish guidelines ensuring cooperation between these areas.

The responsibility of departments or sections of the medical staff should be established by the staff and approved by the hospital's governing body. As a major and well-defined specialty of medicine, obstetrics and gynecology should be organized as an independent department. The lines of authority within the department should be clearly delineated and understood and must apply to all individuals to whom privileges are granted.

Organization of Department

The organization of a department of obstetrics and gynecology is determined by the size and type of hospital in accordance with the bylaws of the medical staff. A hospital with full time attending staff members who also teach and do research will have different organizational needs than a hospital devoted exclusively to patient care. There are, however, principles and objectives common to all hospital departments. The following general guidelines should be adapted to local need and custom.

OFFICERS

Department Head. The staff of the department of obstetrics and gynecology should be headed by a director or chairman, who may be either elected or appointed. The choice of director or chairman should be based on professional

of family, drug, and environmental factors. Inquiries should be made about the outcome of previous pregnancies, mental retardation, or other known or suspected inherited or metabolic disease. Whenever possible, disorders should be diagnosed prior to pregnancy. When a genetic disorder is suspected, the gynecologist may, within limits of training or experience, counsel the patient on how the genetic disorder might affect her health and reproductive capabilities or the development of her offspring. When counseling a couple with a suspected genetic abnormality, the gynecologist should provide information necessary for the patient to decide whether to proceed with further investigation based on the potential social, emotional, and economic consequences. When this decision is made, many gynecologists will refer patients with potential genetic disorders to qualified genetic counseling and evaluation centers. It is the obligation of the gynecologist to be familiar with the availability of these services.

Health Education

Patients are now better informed about their bodies and health issues, and physicians and members of the health care team should accept the responsibility to integrate education into every aspect of their care. The physician should collaborate with other members of the health care team and use whatever resources are available.

Patient education should begin with the professional's first contact with the patient and continue for the length of their association. Content may include anatomy and physiology of the reproductive organs, procedures and plans of treatment, as well as means of promoting and maintaining health. Those providing the education should be aware of the patient's level of understanding, physical and emotional status, and readiness for learning.

SURGICAL SERVICES

Certain surgical procedures may be performed on an ambulatory outpatient basis to conserve time and expense for the patient and assist in efficient use of hospital facilities. A physician's office, an outpatient clinic, or a free-standing or hospital-based ambulatory surgical facility may be used. Procedures should be limited to those that can be performed safely with available medications and equipment and for which the participating personnel are trained. Only patients without major complicating medical disease should be selected. If a major medical disorder is present, appropriate consultation should be obtained before proceeding with a surgical procedure in an ambulatory facility.

Informed consent should be obtained before any surgical procedure is performed. On discharge, the patient should be given adequate postoperative instructions, preferably written, and arrangements should be made for routine

and emergency follow-up care. The importance of a follow-up evaluation should be stressed during both the preoperative and postoperative interviews.

Tissue removed should be submitted to a pathologist for examination. The patient should be informed of the operative findings, including tissue diagnosis. In the situation of elective termination of pregnancy, the attending physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy must be submitted to a pathologist for gross and microscopic examination.

Physician's Office and Outpatient Clinic

Procedures commonly performed in a physician's office or in an outpatient clinic include, but are not limited to:

- Abortion, uncomplicated, up to 14 weeks from last menstrual period
- Aspiration of a breast cyst
- Biopsy, aspiration, or washing of the endometrium
- Biopsy of the vulva, the vagina, or cervix
- Cervical polypectomy
- Colposcopy
- Cryosurgery or fulguration of the cervix or vulva
- Culdocentesis
- Cystoscopy
- Dilatation and curettage
- Hysterosalpingography
- Incision and drainage of vulvar or perineal abscesses
- Incomplete abortions, spontaneous and uncomplicated
- Insertion of intrauterine contraceptive device
- Proctosigmoidoscopy
- Removal of skin lesions
- Tubal insufflation
- Urethroscopy
- Uterine sounding

Free-Standing and Hospital-Based Facilities

Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation. Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals. Surgical procedures may be performed in these facilities under general or regional block anesthesia when it is expected that the postoperative recovery will permit discharge on the same day. There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication.

Prior to any surgical procedure, informed consent should be obtained in writing, signed by the patient, and included in the patient's chart.

When indicated, for patient safety or because of special circumstances, any procedure that can be performed in the physician's office or the outpatient clinic may be performed in a free-standing or hospital-based ambulatory surgical facility. Additional procedures commonly performed in a free-standing or hospital-based ambulatory surgical facility include but are not limited to:

- Colpotomy with or without tubal sterilization
- Examination under anesthesia
- Extensive biopsies or extensive fulgurations of vulvar lesions
- Hysteroscopy
- Laparoscopy, including diagnostic, tubal sterilization, or other surgical procedures if laparotomy is not anticipated
- Marsupialization of a Bartholin duct abscess or cyst
- Minilaparotomy for sterilization
- Simple perineoplasty

Anesthesia

Only surgical procedures that can be performed without anesthesia or with local anesthesia may be performed in the physician's office or in an outpatient clinic. When local anesthesia is used in these settings, equipment and trained personnel should be available for emergency resuscitation.

Any ambulatory surgical unit that utilizes general, epidural, or spinal anesthesia should do so under the direction of an anesthesiologist. These anesthetics should be administered by a qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation must be available.

Only a patient at low anesthetic risk should be considered for ambulatory surgery. The patient should be provided with preoperative instructions, especially regarding the restriction of food and fluids, and advised that noncompliance can result in cancellation of the procedure.

A recovery area is necessary. During the recovery period, the patient should be under continuous observation by a qualified member of the health care team. This person should maintain a complete record of the patient's general condition including vital signs, blood loss, and occurrence of complications. The patient should remain in the area until recovery is sufficient to permit safe discharge in the company of a responsible adult.

The supervising anesthesiologist, or another physician qualified in cardiopulmonary resuscitation, should be present in the ambulatory surgical facility until all surgical patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the back-up hospital.

Abortion

Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting. Physicians performing abortions in their offices should provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication. Clinics and free-standing ambulatory care facilities should have written agreements with nearby hospitals for the transfer of patients requiring treatment for emergency complications of abortion procedures.

Generally, abortions in the physician's office or outpatient clinic should be limited to 14 weeks from the first day of the last menstrual period. In a hospital-based or in a free-standing ambulatory surgical facility, or in an outpatient clinic meeting the criteria required for a free-standing surgical facility, abortions should be limited generally to 18 weeks from the last menstrual period. Prior to abortion, the woman should have access to special counseling that explores options for the management of an unwanted pregnancy, examines the risks, and allows sufficient time for reflection prior to making an informed decision. If counseling has been provided elsewhere, the physician performing the abortion should verify that the counseling has taken place.

In addition to the usual and customary history, physical examination, and indicated laboratory procedures, an Rh factor determination should be made. Aspirated tissue should be examined to ensure the presence of villi or fetal parts prior to the patient's release from the facility. If villi or fetal parts are not identified with certainty, the tissue specimen must be sent for further pathologic examination, and the patient must be alerted to the possibility of an ectopic pregnancy.

Rh immune globulin must be administered to every unsensitized Rh(D) negative woman who has an abortion except when it is definitely known that the father is Rh negative.

ADMINISTRATION OF PHYSICIAN'S OFFICE AND OUTPATIENT CLINIC

Medical Records

Physician's offices and outpatient clinics should maintain accurate medical records for each patient. The record should be legible, concise, cogent, and complete. Further, the record should allow easy assessment of the care provided to determine if the patient's health needs have been diagnosed and effectively managed. Because modern medical practice frequently involves several physicians and professionals, the record must serve as a vehicle for communication among all members of the health care team.

All pertinent medical information should be secure, confidential and readily accessible. All records should be retained by the physician's offices and outpatient facilities for the period of time prescribed by law or by good medical practice or state statute of limitations for personal injury.

At the initial visit a comprehensive data base should be established to include the following:

- Reason for visit
- Menstrual history
- Obstetric history
- Gynecologic history
- Contraceptive method
- Sexual history
- Past medical and surgical history
- Current medications
- Allergies
- Social history
- Family history
- Review of systems

If this information is supplied by the patient on a printed form prior to the initial consultation, it should be reviewed by the physician before examining the patient.

An appropriate physical examination should be recorded on the initial visit. The extent of the examination will vary with the patient's health needs. A minimum record should include height, weight, nutritional state, blood pressure, head and neck, heart, lungs, breasts, abdominal, pelvic, and rectal examinations. Other data should be recorded as obtained. All correspondence, operative notes, and laboratory data should be reviewed and filed chronologically in the patient's medical record.

When the patient returns for continuation of her health care, it will be necessary to update the original data base, as well as maintain concise progress notes. Any pertinent data regarding changes in health status or inpatient care should be recorded and may take the form of a diagnostic summary.

When a patient is seen in consultation, sufficient historical and physical data should be obtained and recorded to support the diagnosis. The consultant's findings should be reported promptly and a written report included in both the consultant's and referring physician's files.

Quality Assurance

Each physician's office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished.

In the outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnoses, appropriateness of use

of laboratory and other services, and outcome of care. It should include the identification of potential problems in the care of patients, the objective assessment of their cause, and designation of mechanisms to eliminate them. Efficient use of medical resources can be documented by evaluating use of personnel, finances, equipment, and facilities.

Patient care evaluation is difficult in the physician's office because few models of evaluation can be applied in this context. However, gynecologists should periodically review and compare their own experiences with standards of patient care and office practices suggested by the scientific literature and continuing medical education programs.

Personnel

Administrative and professional personnel requirements will vary considerably in each physician's office and outpatient clinic depending on the patient load, pattern of practice, and type of facility. Whether the health care team has one member or many individuals, the members of the team should participate in the specific areas of care according to their training and within written definitions of their responsibilities. Policies and responsibilities should be reviewed and revised periodically. Regular meetings of personnel should be encouraged, and there should be an ongoing program for in-service training.

Facilities and Equipment

The physical facilities and equipment described in the following sections should be reasonably available for the care of patients either within the office or clinic setting. Additional facilities and equipment beyond those recommended below will vary depending on the type of practice and patient volume.

PATIENT RECEPTION AREA

The reception area should provide comfortable seating, patient educational materials, and conveniently located restroom facilities. Provision should be made for privacy in discussing financial arrangements and other confidential information with the patient. Sufficient space should be provided to permit medical and financial records to be handled and stored with security and confidentiality.

CONSULTATION ROOM

A comfortable and private area should be provided for interviews and for counseling with the patient or her family. The physician's office could serve as a consultation room. Separate rooms, other than the physician's office, should be available for use by nurses, social workers, health educators, and other

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members of the health care team, if such are being employed. Minimal equipment for each room should include a desk or table with two chairs.

EXAMINING ROOM AREA

The following equipment should be accessible to, although not necessarily in, each room:

- Biopsy instruments
- Instruments for vaginal and rectal examinations
- Microscope
- Sphygmomanometer
- Stethoscope
- Reflex hammer
- Ophthalmoscope
- Scale
- Supplies for obtaining:
 - Specimens and cultures
 - Wet slide preparation and bacterial smears
 - Stool examinations
 - Cytologic studies
- Equipment necessary for diagnostic studies and operative procedures performed in the facility.

When local anesthesia is used, the following equipment should be available for possible emergency resuscitation:

- Positive pressure oxygen
- Intravenous equipment and fluids
- Suction
- Cardiac monitor
- Laryngoscope with assorted airways.

EXAMINING ROOMS

The exact number of examining rooms required will depend on the patient load and type of practice; however, at least two examination rooms are preferable even for a solo physician's office.

Equipment available for each examining room should include:

- Screening to permit patient privacy
- Handwashing facilities and paper towels
- Examination table with suitable disposable cover and a stool
- Examination light
- Gynecologic examination equipment and supplies
- Work counter or table

- Small desk, table, or shelf for writing
- Storage cabinet

UTILITY ROOM AND STORAGE

The utility room area should contain:

- Work counter
- Handwashing facilities and paper towels
- Deep sink
- Closed cabinets for storage
- Locked medicine cabinets
- Refrigerator for biologicals and specimens
- Facilities for sterilization unless central sterilization is available
- Waste receptacle

CONFERENCE ROOM

For larger practices or clinics, a conference and patient education room may contain:

- Comfortable chairs
- Conference table
- Educational materials and pamphlets
- Chalkboard
- Bulletin board
- Models and demonstrating equipment
- Screen
- Slide projector
- Movie projector
- Videotape equipment

SAFETY STANDARDS

Specific plans and procedures for the health and safety of patients and personnel should meet all applicable local and state safety, building, and fire codes and should include:

- Methods for controlling electrical hazards and preventing explosion and fire
- Procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies
- Methods for storing, preparing, and administering drugs, when applicable
- Plans for handling reasonably foreseeable emergencies, including methods for transferring a patient to a nearby hospital

- Plans for emergency patient evacuation and the proper use of safety, emergency, and fire extinguishing equipment
- Plans for training of personnel in cardiopulmonary resuscitation
- Plans for adequately maintaining and cleaning facilities.

ADMINISTRATION OF FREE-STANDING AND HOSPITAL-BASED AMBULATORY SURGICAL FACILITIES

Medical Records

All ambulatory facilities should maintain accurate medical records for each patient. An efficient record system should be established that conforms to a standard record used in that community or back-up hospital. All pertinent medical information should be secure, confidential, and readily accessible. The record should be legible, concise, cogent, and complete. Further, the record should allow easy assessment of the care provided to determine if the patient's health needs have been identified, diagnosed, and effectively managed. The patient's record should include the pertinent details of any anesthetic used, the procedure performed, any difficulties encountered, and the patient's subsequent condition. Because modern medical practice frequently involves several physicians and professionals, the record must serve as a vehicle for communication among all members of the health care team.

This record should contain sufficient information to justify the preoperative diagnosis and the operative procedure and to document the postoperative course. All diagnoses and operative procedures should be listed to facilitate data retrieval.

The record should contain:

- Patient identification data
- History and physical examination
- Provisional diagnosis
- Diagnostic and therapeutic orders
- Surgeon's and nurses' notes
- Laboratory data
- Operative consent
- Operative report
- Anesthesia report
- Tissue report
- Medications record
- Discharge summary and instructions

The appropriate records should be completed and laboratory data recorded prior to surgery. The laboratory data should include hemoglobin or hematocrit, urinalysis, and, in certain selected patients, other studies such as a chest x-ray, electrocardiogram, and electrolytes.

A preoperative history and physical examination should be completed and recorded no more than two weeks prior to the surgical procedure. The physician should strive to identify pre-existing or concurrent illness, medications, and adverse drug reactions that may have a bearing on the operative procedure or anesthesia. All records should be reviewed before any surgery is performed.

On the day of surgery a preanesthetic evaluation, including an interval history, medical record review, and heart and lung examination should be performed by a physician and the findings should be noted in the record.

The record should be completed promptly and signed by the attending physician. A discharge summary should be written or dictated; every effort must be made to forward information necessary for continuity of treatment to physicians who will subsequently care for the patient.

The ambulatory care facility should keep registries of admissions and discharges, operations, and controlled substances. Records should be kept confidential and should be protected against fire, theft, and other damage for the duration of time prescribed by law, or by good medical practice or state statute of limitations for personal injury.

Quality Assurance

The effectiveness of patient care and the appropriate use of the ambulatory surgical facility should be continually evaluated. Evaluation of patient care should be performed by a team of professionals qualified to assess all aspects of patient care, including the completeness of medical records, the accuracy of diagnoses, and outcome of care. The evaluation should include the identification of potential problems in the care of patients, the objective assessment of their cause, and designation of mechanisms to eliminate them. Particular care should be taken to identify ambulatory treatments that might have been undertaken more appropriately on an inpatient basis.

Personnel

The efficient operation of an ambulatory surgical facility requires adequate staffing with administrative and professional personnel. The assignment of personnel should be based on the number of patients, patient profiles, type of procedures, and facility design.

Written policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically. There should be an ongoing program for in-service training of personnel.

A governing body of the ambulatory surgical facility has the final authority and responsibility for the appointment of the medical staff. Privileges should be granted only to those who are properly trained, licensed, and who have demonstrated competence. These privileges should not exceed those granted to the same individual in at least one accredited hospital within a geographic area.

Facilities and Equipment

GENERAL DESIGN AND EQUIPMENT

The general physical design for a free-standing or hospital-based ambulatory surgical facility will depend on the number and types of surgical procedures to be performed. The facility should provide a comfortable, safe environment with minimal architectural barriers. Standards for both the construction and operation of ambulatory surgical facilities should be equivalent to those applied to an accredited hospital handling similar surgical procedures.

Attention should be given to a convenient and efficient traffic flow. In a multilevel facility, elevators that can accommodate stretchers should be available for immediate use.

The facility should include adequate space for:

- Reception and waiting
- Administrative activities, such as patient admission, record storage, and business affairs.
- Patient dressing and lockers
- Preoperative evaluation including physical examination, laboratory testing, and preparation for anesthesia
- Performance of surgical procedures
- Preparation and sterilization of instruments
- Storage of equipment
- Storage of drugs and fluids
- Postanesthetic recovery
- Staff activities
- Janitorial and utility support

Instruments, equipment, and supplies used in the ambulatory surgical facility should be equivalent to those used for similar procedures in an accredited hospital and should provide for:

- Control of sources and transmission of infection
- Infection surveillance
- Functional oxygen and suction
- Resuscitation and defibrillation
- Emergency lighting
- Sterilization
- Emergency intercommunication

SAFETY STANDARDS

Specific plans and procedures should be established for the health and safety of patients and personnel. Such plans and procedures should meet all state and local building, safety, and fire codes and should include:

- Methods of control against the hazards of electrical or mechanical failure, explosion, and fire
- Comprehensive emergency plans, including but not limited to patient evacuation and the proper use of safety, emergency and fire extinguishing equipment
- Equipment and personnel for handling reasonably foreseeable medical emergencies arising from services rendered
- Provision for transferring unanticipated emergency cases to a nearby back-up hospital
- Training of personnel in cardiopulmonary resuscitation
- Control and disposition of needles, syringes, glass, knife blades, and contaminated waste supplies
- Proper storage, preparation, and administration of drugs
- Facilities that are accessible, barrier free, and safe for all, including the handicapped
- Adequately maintained and clean facilities

Danforth

Abortion Cases
memo
file

HAB's ⁶⁰Opinion (Excerpts)

OCTOBER TERM, 1975

Opinion of the Court

428 U. S.

and retention of records. He also agreed with the majority that § 6 (1) was unconstitutionally overbroad. He dissented from the majority opinion upholding the constitutionality of §§ 3 (3), 3 (4), 7, and 9, relating, respectively, to spousal consent, parental consent, the termination of parental rights, and the proscription of saline amniocentesis.

In No. 74-1151, the plaintiffs appeal from that part of the District Court's judgment upholding sections of the Act as constitutional and denying injunctive relief against their application and enforcement. In No. 74-1419, the defendant Attorney General cross-appeals from that part of the judgment holding § 6 (1) unconstitutional and enjoining enforcement thereof. We granted the plaintiffs' application for stay of enforcement of the Act pending appeal. 420 U. S. 918 (1975). Probable jurisdiction of both appeals thereafter was noted. 423 U. S. 819 (1975).

For convenience, we shall usually refer to the plaintiffs as "appellants" and to both named defendants as "appellees."

III

In *Roe v. Wade* the Court concluded that the "right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." 410 U. S., at 153. It emphatically rejected, however, the proffered argument "that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses." *Ibid.* Instead,

this right "must be considered against important state interests in regulation." *Id.*, at 154.

The Court went on to say that the "pregnant woman cannot be isolated in her privacy," for she "carries an embryo and, later, a fetus." *Id.*, at 159. It was therefore "reasonable and appropriate for a State to decide that at some point in time another interest, that of health of the mother or that of potential human life, becomes significantly involved. The woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly." *Ibid.* The Court stressed the measure of the State's interest in "the light of present medical knowledge." *Id.*, at 163. It concluded that the permissibility of state regulation was to be viewed in three stages: "For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician," without interference from the State. *Id.*, at 164. The participation by the attending physician in the abortion decision, and his responsibility in that decision, thus, were emphasized. After the first stage, as so described, the State may, if it chooses, reasonably regulate the abortion procedure to preserve and protect maternal health. *Ibid.* Finally, for the stage subsequent to viability, a point purposefully left flexible for professional determination, and dependent upon developing medical skill and technical ability,¹ the State may regulate an abortion to protect the life of the fetus and even may proscribe abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother. *Id.*, at 163-165.

¹ "Viability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." *Roe v. Wade*, 410 U. S., at 160.

IV

With the exception specified in n. 2, *infra*, we agree with the District Court that the physician-appellants clearly have standing. This was established in *Doe v. Bolton*, 410 U. S., at 188. Like the Georgia statutes challenged in that case, "[t]he physician is the one against whom [the Missouri Act] directly operate[s] in the event he procures an abortion that does not meet the statutory exceptions and conditions. The physician-appellants, therefore, assert a sufficiently direct threat of personal detriment. They should not be required to await and undergo a criminal prosecution as the sole means of seeking relief."² *Ibid.*

Our primary task, then, is to consider each of the

² This is not so, however, with respect to § 7 of the Act pertaining to state wardship of a live-born infant. Section 7 applies "where a live born infant results from an attempted abortion which was not performed to save the life or health of the mother." It then provides that the infant "shall be an abandoned ward of the state" and that the mother—and the father, too, if he consented to the abortion—"shall have no parental rights or obligations whatsoever relating to such infant."

The physician-appellants do not contend that this section of the Act imposes any obligation on them or that its operation otherwise injures them in fact. They do not claim any interest in the question of who receives custody that is "sufficiently concrete" to satisfy the "case or controversy" requirement of a federal court's Art. III jurisdiction. *Singleton v. Wulff*, *post*, at 112. Accordingly, the physician-appellants do not have standing to challenge § 7 of the Act.

The District Court did not decide whether Planned Parenthood has standing to challenge the Act, or any portion of it, because of its view that the physician-appellants have standing to challenge the entire Act. 392 F. Supp. 1362, 1366-1367 (1975). We decline to consider here the standing of Planned Parenthood to attack § 7. That question appropriately may be left to the District Court for reconsideration on remand. As a consequence, we do not decide the issue of § 7's constitutionality.

this right "must be considered against important state interests in regulation." *Id.*, at 154.

The Court went on to say that the "pregnant woman cannot be isolated in her privacy," for she "carries an embryo and, later, a fetus." *Id.*, at 159. It was therefore "reasonable and appropriate for a State to decide that at some point in time another interest, that of health of the mother or that of potential human life, becomes sig-

challenged provisions of the new Missouri abortion statute in the particular light of the opinions and decisions in *Roe* and in *Doe*. To this we now turn, with the assistance of helpful briefs from both sides and from some of the *amici*.

A

The definition of viability. Section 2 (2) of the Act defines "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." Appellants claim that this definition violates and conflicts with the discussion of viability in our opinion in *Roe*. 410 U. S., at 160, 163. In particular, appellants object to the failure of the definition to contain any reference to a gestational time period, to its failure to incorporate and reflect the three stages of pregnancy, to the presence of the word "indefinitely," and to the extra burden of regulation imposed. It is suggested that the definition expands the Court's definition of viability, as expressed in *Roe*, and amounts to a legislative determination of what is properly a matter for medical judgment. It is said that the "mere possibility of momentary survival is not the medical standard of viability." Brief for Appellants 67.

In *Roe*, we used the term "viable," properly we thought, to signify the point at which the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid," and presumably capable of "meaningful life outside the mother's womb," 410 U. S., at 160, 163. We noted that this point "is usually placed" at about seven months or 28 weeks, but may occur earlier. *Id.*, at 160.

viable
28
weeks

We agree with the District Court and conclude that the definition of viability in the Act does not conflict with what was said and held in *Roe*. In fact, we believe that

§ 2 (2), even when read in conjunction with § 5 (proscribing an abortion "not necessary to preserve the life or health of the mother . . . unless the attending physician first certifies with reasonable medical certainty that the fetus is not viable"), the constitutionality of which is not explicitly challenged here, reflects an attempt on the part of the Missouri General Assembly to comply with our observations and discussion in *Roe* relating to viability. Appellant Hall, in his deposition, had no particular difficulty with the statutory definition.³ As noted above, we recognized in *Roe* that viability was a matter of medical judgment, skill, and technical ability, and we preserved the flexibility of the term. Section 2 (2) does the same. Indeed, one might argue, as the appellees do, that the presence of the statute's words "continued indefinitely" favor, rather than disfavor, the appellants, for, arguably, the point when life can be "continued indefinitely outside the womb" may well occur later in pregnancy than the point where the fetus is "potentially able to live outside the mother's womb." *Roe v. Wade*, 410 U. S., at 160.

leave
to
physician

In any event, we 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 definition of viability in § 2 (2) merely reflects this fact. The appellees do not contend otherwise, for they insist

³ "[A]lthough I agree with the definition of 'viability,' I think that it must be understood that viability is a very difficult state to assess." Tr. 369.

that the determination of viability rests with the physician in the exercise of his professional judgment.⁴

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. See *Wolfe v. Schroering*, 388 F. Supp. 631, 637 (WD Ky. 1974); *Hodgson v. Anderson*, 378 F. Supp. 1008, 1016 (Minn. 1974), dismissed for want of jurisdiction *sub nom. Spannaus v. Hodgson*, 420 U. S. 903 (1975).⁵

We conclude that the definition in § 2 (2) of the Act does not circumvent the limitations on state regulation outlined in *Roe*. We therefore hold that the Act's definition of "viability" comports with *Roe* and withstands the constitutional attack made upon it in this litigation.

B

The woman's consent. Under § 3 (2) of the Act, a woman, prior to submitting to an abortion during the first 12 weeks of pregnancy, must certify in writing her consent to the procedure and "that her consent is informed and freely given and is not the result of coercion." Appellants argue that this requirement is violative of

*Informed
Consent
- valid*

⁴ "The determination of when the fetus is viable rests, as it should, with the physician, in the exercise of his medical judgment, on a case-by-case basis." Brief for Appellee Danforth 26. "Because viability may vary from patient to patient and with advancements in medical technology, it is essential that physicians make the determination in the exercise of their medical judgment." *Id.*, at 28. "Defendant agrees that 'viability' will vary, that it is a difficult state to assess . . . and that it must be left to the physician's judgment." *Id.*, at 29.

⁵ The Minnesota statute under attack in *Hodgson* provided that a fetus "shall be considered potentially 'viable'" during the second half of its gestation period. Noting that the defendants had presented no evidence of viability at 20 weeks, the three-judge District Court held that that definition of viability was "unreasonable and cannot stand." 378 F. Supp., at 1016.

Roe v. Wade, 410 U. S., at 164-165, by imposing an extra layer and burden of regulation on the abortion decision. See *Doe v. Bolton*, 410 U. S., at 195-200. Appellants also claim that the provision is overbroad and vague.

The District Court's majority relied on the propositions that the decision to terminate a pregnancy, of course, "is often a stressful one," and that the consent requirement of § 3 (2) "insures that the pregnant woman retains control over the discretions of her consulting physician." 392 F. Supp., at 1368, 1369. The majority also felt that the consent requirement "does not single out the abortion procedure, but merely includes it within the category of medical operations for which consent is required." *Id.*, at 1369. The third judge joined the majority in upholding § 3 (2), but added that the written consent requirement was "not burdensome or chilling" and manifested "a legitimate interest of the state that this important decision has in fact been made by the person constitutionally empowered to do so." 392 F. Supp., at 1374. He went on to observe that the requirement "in no way interposes the state or third parties in the decision-making process." *Id.*, at 1375.

We do not disagree with the result reached by the District Court as to § 3 (2). It is true that *Doe* and *Roe* clearly establish that the State may not restrict the decision of the patient and her physician regarding abortion during the first stage of pregnancy. Despite the fact that apparently no other Missouri statute, with the exceptions referred to in n. 6, *supra*, requires a

⁶ Apparently, however, the only other Missouri statutes concerned with consent for general medical or surgical care relate to persons committed to the Missouri State chest hospital, Mo. Rev. Stat. § 199.240 (Supp. 1975), or to mental or correctional institutions, § 105.700 (1969).

patient's prior written consent to a surgical procedure,⁷ the imposition by § 3 (2) of such a requirement for termination of pregnancy even during the first stage, in our view, is not in itself an unconstitutional requirement. The decision to abort, indeed, is an important, and often a stressful one, and it is desirable and imperative that it be made with full knowledge of its nature and consequences. The woman is the one primarily concerned, and her awareness of the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent.

We could not say that a requirement imposed by the State that a prior written consent for any surgery would be unconstitutional. As a consequence, we see no constitutional defect in requiring it only for some types of surgery as, for example, an intracardiac procedure, or where the surgical risk is elevated above a specified mortality level, or, for that matter, for abortions.⁸

C

The spouse's consent. Section 3 (3) requires the prior written consent of the spouse of the woman seeking an abortion during the first 12 weeks of pregnancy, unless

⁷ There is some testimony in the record to the effect that taking from the patient a prior written consent to surgery is the custom. That may be so in some areas of Missouri, but we definitely refrain from characterizing it extremely as "the universal practice of the medical profession," as the appellees do. Brief for Appellee Danforth 32.

⁸ The appellants' vagueness argument centers on the word "informed." One might well wonder, offhand, just what "informed consent" of a patient is. The three Missouri federal judges who composed the three-judge District Court, however, were not concerned, and we are content to accept, as the meaning, the giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession.

additional challenges to § 3 (3) based on vagueness and overbreadth.

D *was in different "notice"*
Parental Consent. Section 3 (4) requires, with respect to the first 12 weeks of pregnancy, where the woman is unmarried and under the age of 18 years, the written consent of a parent or person *in loco parentis* unless, again, "the abortion is certified by a licensed physician as necessary in order to preserve the life of the mother." It is to be observed that only one parent need consent.

The appellees defend the statute in several ways. They point out that the law properly may subject minors to more stringent limitations than are permissible with respect to adults, and they cite, among other cases, *Prince v. Massachusetts*, 321 U. S. 158 (1944), and *McKeiver v. Pennsylvania*, 403 U. S. 528 (1971). Missouri law, it is said, "is replete with provisions reflecting the interest of the state in assuring the welfare of minors," citing statutes relating to a guardian *ad litem* for a court proceeding, to the care of delinquent and neglected children, to child labor, and to compulsory education. Brief for Appellee Danforth 42. Certain decisions are considered by the State to be outside the scope of a minor's ability to act in his own best interest or in the interest of the public, citing statutes proscribing the sale of firearms and deadly weapons to minors without parental consent, and other statutes relating to minors' exposure to certain types of literature, the purchase by pawnbrokers of property from minors, and the sale of cigarettes and alcoholic beverages to minors. It is pointed out that the record contains testimony to the effect that children of tender years (even ages 10 and 11) have sought abortions. Thus, a State's permitting a child to obtain an abortion without the counsel of an adult "who has responsi-

bility or concern for the child would constitute an irresponsible abdication of the State's duty to protect the welfare of minors." *Id.*, at 44. Parental discretion, too, has been protected from unwarranted or unreasonable interference from the State, citing *Meyer v. Nebraska*, 262 U. S. 390 (1923); *Pierce v. Society of Sisters*, 268 U. S. 510 (1925); *Wisconsin v. Yoder*, 406 U. S. 205 (1972). Finally, it is said that § 3 (4) imposes no additional burden on the physician because even prior to the passage of the Act the physician would require parental consent before performing an abortion on a minor.

The appellants, in their turn, emphasize that no other Missouri statute specifically requires the additional consent of a minor's parent for medical or surgical treatment, and that in Missouri a minor legally may consent to medical services for pregnancy (excluding abortion), venereal disease, and drug abuse. Mo. Rev. Stat. §§ 431.061-431.063 (Supp. 1975). The result of § 3 (4), it is said, "is the ultimate supremacy of the parents' desires over those of the minor child, the pregnant patient." Brief for Appellants 93. It is noted that in Missouri a woman under the age of 18 who marries with parental consent does not require parental consent to abort, and yet her contemporary who has chosen not to marry must obtain parental approval.

The District Court majority recognized that, in contrast to § 3 (3), the State's interest in protecting the mutuality of a marriage relationship is not present with respect to § 3 (4). It found "a compelling basis," however, in the State's interest "in safeguarding the authority of the family relationship." 392 F. Supp., at 1370. The dissenting judge observed that one could not seriously argue that a minor must submit to an abortion if her parents insist, and he could not see "why she would not be entitled to the same right of self-determination now

explicitly accorded to adult women, provided she is sufficiently mature to understand the procedure and to make an intelligent assessment of her circumstances with the advice of her physician." *Id.*, at 1376.

Of course, much of what has been said above, with respect to § 3 (3), applies with equal force to § 3 (4). Other courts that have considered the parental-consent issue in the light of *Roe* and *Doe*, have concluded that a statute like § 3 (4) does not withstand constitutional scrutiny. See, e. g., *Poe v. Gerstein*, 517 F. 2d, at 792; *Wolfe v. Schroering*, 388 F. Supp., at 636-637; *Doe v. Rampton*, 366 F. Supp., at 193, 199; *State v. Koome*, 84 Wash. 2d 901, 530 P. 2d 260 (1975).

We agree with appellants and with the courts whose decisions have just been cited that the State may not impose a blanket provision, such as § 3 (4), requiring the consent of a parent or person in loco parentis as a condition for abortion of an unmarried minor during the first 12 weeks of her pregnancy. Just as with the requirement of consent from the spouse, so here, the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy, regardless of the reason for withholding the consent.

Constitutional rights do not mature and come into being magically only when one attains the state-defined age of majority. Minors, as well as adults, are protected by the Constitution and possess constitutional rights. See, e. g., *Breed v. Jones*, 421 U. S. 519 (1975); *Goss v. Lopez*, 419 U. S. 565 (1975); *Tinker v. Des Moines School Dist.*, 393 U. S. 503 (1969); *In re Gault*, 387 U. S. 1 (1967). The Court indeed, however, long has recognized that the State has somewhat broader authority to regulate the activities of children than of adults.

Prince v. Massachusetts, 321 U. S., at 170; *Ginsberg v. New York*, 390 U. S. 629 (1968). It remains, then, to examine whether there is any "significant state interest" in conditioning an abortion on the consent of a parent or person *in loco parentis* that is not present in the case of an adult.

One suggested interest is the safeguarding of the family unit and of parental authority. 392 F. Supp., at 1370. It is difficult, however, to conclude that providing a parent with absolute power to overrule a determination, made by the physician and his minor patient, to terminate the patient's pregnancy will serve to strengthen the family unit. Neither is it likely that such veto power will enhance parental authority or control where the minor and the nonconsenting parent are so fundamentally in conflict and the very existence of the pregnancy already has fractured the family structure. Any independent interest the parent may have in the termination of the minor daughter's pregnancy is no more weighty than the right of privacy of the competent minor mature enough to have become pregnant.

We emphasize that our holding that § 3 (4) is invalid does not suggest that every minor, regardless of age or maturity, may give effective consent for termination of her pregnancy. See *Bellotti v. Baird*, *post*, p. 132. The fault with § 3 (4) is that it imposes a special-consent provision, exercisable by a person other than the woman and her physician, as a prerequisite to a minor's termination of her pregnancy and does so without a sufficient justification for the restriction. It violates the strictures of *Roe* and *Doe*.

E

Saline amniocentesis. Section 9 of the statute prohibits the use of saline amniocentesis, as a method or technique of abortion, after the first 12 weeks of preg-

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE HARRY A. BLACKMUN

May 18, 1983

Re: No. 81-185 - Simopoulos v. Virginia

Dear Lewis:

I very much appreciate what you have done with the uncirculated fourth draft of your opinion in this case. You certainly and most graciously have accommodated most of the concerns expressed in my letter of May 4. I am deeply grateful for all this.

I could, and if necessary would, join your fourth draft in its present form. I must confess, however, that I remain very uncomfortable with the combination of the presence of both footnotes 9-17 and the sentence on page 11 to the effect that the regulations appear to be generally compatible with accepted medical standards. Under your analysis in Akron, this phrase does have constitutional significance; regulations that accord with accepted medical standards carry a presumption of constitutionality. Although the Virginia regulations may well turn out to be constitutional upon closer examination, I do not want to create the impression that we have prejudged the question.

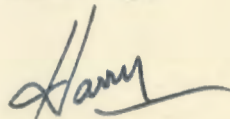
Footnotes 13 and 15 provide an example of the problem. There is nothing wrong with any of the tests mentioned in footnote 13, but it is not at all clear to me that each and every one of those tests is necessary prior to every abortion. Moreover, when coupled with footnote 15's requirement that test results be received before an abortion is performed, the result may be a mandatory waiting period of several days prior to the abortion. (I am always disturbed when people in Washington tell me about how long they must wait for laboratory results. I was spoiled by the Mayo system where results are available either immediately through frozen sections or, in almost all cases, within 24 hours.) I think it is at least open to question whether such a result would be consistent with good medical practice, yet this is what the footnotes and the sentence on page 11 imply.

Would you be willing to compromise by omitting the footnotes and have the sentence on page 11 remain? I could then join with enthusiasm and contentment.

I say again that I am grateful for your sympathetic consideration.

Sincerely,

Justice Powell



pp. 10-12, 14

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Powell
Justice Rehnquist
Justice Stevens
Justice O'Connor

From: **Justice Blackmun**

Circulated: _____

Recirculated: MAY 19 1983

2nd DRAFT

SUPREME COURT OF THE UNITED STATES

Nos. 81-1255 AND 81-1623

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
ET AL., PETITIONERS

81-1255

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL.

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL., PETITIONERS

81-1623

v.

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC., ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE EIGHTH CIRCUIT

[May —, 1983]

JUSTICE BLACKMUN, concurring in part and dissenting in part.

The Court's decision today in *Akron v. Akron Center for Reproductive Health, Inc.*, ante, invalidates the city of Akron's hospitalization requirement and a host of other provisions that infringe on a woman's decision to terminate her pregnancy through abortion. I agree with the Court that Missouri's hospitalization requirement is invalid under the *Akron* analysis, and I join Parts I and II of the Court's opinion in the present cases. I do not agree, however, that the remaining Missouri statutes challenged in these cases satisfy

the constitutional standards set forth in *Akron* and the Court's prior decisions.

I

Missouri law provides that whenever an abortion is performed, a tissue sample must be submitted to a "board eligible or certified pathologist" for a report. Mo. Rev. Stat. § 188.047 (1983). This requirement applies to first trimester abortions as well as to those performed later in pregnancy. Our past decisions establish that the performance of abortions during the first trimester must be left "free of interference by the State." *Akron, ante*, at 12, quoting *Roe v. Wade*, 410 U. S. 113, 163 (1973). As we have noted in *Akron*, this does not mean that every regulation touching upon first-trimester abortions is constitutionally impermissible. But to pass constitutional muster, regulations affecting first-trimester abortions must "have no significant impact on the woman's exercise of her right" and must be "justified by important state health objectives." *Akron, ante*, at 11; see *ante*, at 8.

Missouri's requirement of a pathologist's report is not justified by important health objectives. Although pathology examinations may be "useful and even necessary in some cases," *ante*, at 10, Missouri requires more than a pathology examination and a pathology report; it demands that the examination be performed and the report prepared by a "board eligible or certified pathologist" rather than by the attending physician. Contrary to the Court's assertion, *ante*, at 9, this requirement of a report by a pathologist is not in accord with "generally accepted medical standards." The routine and accepted medical practice is for the attending physician to perform a gross (visual) examination of any tissue removed during an abortion. Only if the physician detects abnormalities is there a need to send a tissue sample to a pathologist. The American College of Obstetricians and Gynecologists (ACOG) does not recommend an examination by a pathologist in every case:

"In the situation of elective termination of pregnancy, the attending physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy must be submitted to a pathologist for gross and microscopic examination.

"... Aspirated tissue should be examined to ensure the presence of villi or fetal parts prior to the patient's release from the facility. If villi or fetal parts are not identified with certainty, the tissue specimen must be sent for further pathologic examination. . . ." ACOG, Standards for Obstetric-Gynecologic Services 52, 54 (1982).¹

Nor does the National Abortion Federation believe that such an examination is necessary:

"All tissue must be examined grossly at the time of the abortion procedure by a physician or trained assistant and the results recorded in the chart. In the absence of visible fetal parts or placenta upon gross examination, obtained tissue may be examined under a low power microscope for the detection of villi. If this examination is inconclusive, the tissue should be sent to the nearest suitable pathology laboratory for microscopic examination." National Abortion Federation Standards 6 (1981) (emphasis deleted).

The Court fails to distinguish between the medical practice

¹See also ACOG, Standards for Obstetric-Gynecologic Services 66 (1982):

"Tissue removed should be submitted to a pathologist for examination. . . . An exception to the practice may be in elective terminations of pregnancy in which definitive embryonic or fetal parts can be identified. In such instances, the physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy must be submitted to a pathologist for gross and microscopic examination."

of performing a "tissue examination," *ante*, at 11, and Missouri's requirement that this examination be performed by a pathologist. As the Court of Appeals pointed out, there was expert testimony at trial that a nonpathologist physician is as capable of performing an adequate gross examination as is a pathologist, and that the "abnormalities which are of concern" are readily detectable by a physician. 655 F. 2d 848, 871, n. 37 (CA8 1981); see App. 135.² While a pathologist may be better able to perform a microscopic examination, Missouri law does not require a microscopic examination unless "fetal parts or placenta are not identified." 13 Mo. Admin. Code § 50-151.030(1) (1981). Thus, the effect of the Missouri statute is to require a pathologist to perform the initial gross examination, which is normally the responsibility of the attending physician and which will often make the pathologist's services unnecessary.

On the record before us, I must conclude that the State has not "met its burden of demonstrating that [the pathologist requirement] further[s] important health-related State concerns." *Akron*, *ante*, at 12. There has been no showing that tissue examinations by a pathologist do more to protect health than examinations by a nonpathologist physician. Moreover, I cannot agree with the Court that Missouri's pathologist requirement has "no significant impact" *ante*, at 8, on a woman's exercise of her right to an abortion. It is undisputed that this requirement may increase the cost of a first-trimester abortion by as much as \$40. See *ante*, at 10, n. 12; 483 F. Supp., at 700, n. 48. Although this increase may seem insignificant from the Court's comfortable perspective, I cannot say that it is equally insignificant to every woman seeking an abortion. For the woman on welfare or the unemployed teenager, this additional cost may well put

²The District Court made no findings on this point, noting only that some witnesses for the State had testified that "pathology should be done" for every abortion. 483 F. Supp. 679, 700, n. 49 (WD Mo. 1980).

the price of an abortion beyond reach.³ Cf. *Harper v. Virginia Board of Elections*, 383 U. S. 663, 668 (1966) (\$1.50 poll tax “excludes those unable to pay”); *Burns v. Ohio*, 360 U. S. 252, 255, 257 (1959) (\$20 docket fee “foreclose[s] access” to appellate review for indigents).

In *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S. 52, 81 (1976), the Court warned that the minor record-keeping requirements upheld in that case “perhaps approach[ed] impermissible limits.” Today in *Akron*, we have struck down restrictions on first-trimester abortions that “may in some cases add to the cost of providing abortions.” *Ante*, at 30; see *ante*, at 31–32. Missouri’s requirement of a pathologist’s report unquestionably adds significantly to the cost of providing abortions, and Missouri has not shown that it serves any substantial health-related purpose. Under these circumstances, I would hold that constitutional limits have been exceeded.

II

In Missouri, an abortion may be performed after viability only if necessary to preserve the life or health of the woman. Mo. Rev. Stat. §188.030.1 (1983). When a post-viability abortion is performed, Missouri law provides that “there [must be] in attendance a [second] physician . . . who shall take control of and provide immediate medical care for a child born as a result of the abortion.” Mo. Rev. Stat. §188.030.3 (1983). The Court recognized in *Roe v. Wade*, 410 U. S., at

³ A \$40 pathologist’s fee may increase the price of a first-trimester abortion by 20% or more. See 655 F. 2d, at 869, n. 35 (cost of first-trimester abortion at Reproductive Health Services is \$170); F. Jaffe, B. Lindheim, and P. Lee, *Abortion Politics: Private Morality and Public Policy* 36 (1981) (cost of first-trimester clinic abortion ranges from approximately \$185 to \$235); Henshaw, *Freestanding Abortion Clinics: Services, Structure, Fees*, 14 *Family Planning Perspectives* 248, 255 (1982) (average cost of first-trimester clinic abortion is \$190); NAF Membership Directory 18–19 (1982/1983) (NAF clinics in Missouri charge \$180 to \$225 for first-trimester abortion).

164-165, that a State's interests in preserving maternal health and protecting the potentiality of human life may justify regulation and even prohibition of post-viability abortions, except those necessary to preserve the life and health of the mother. But regulations governing post-viability abortions, like those at any other stage of pregnancy, must be "tailored to the recognized state interests." *Id.*, at 165; see *H.L. v. Matheson*, 450 U. S. 398, 413 (1981) ("statute plainly serves important state interests, [and] is narrowly drawn to protect only those interests"); *Roe*, 410 U. S., at 155 ("legislative enactments must be narrowly drawn to express only the legitimate state interests at stake").

A

The Court upholds the second physician requirement on the basis that it "furthers the State's compelling interest in protecting the lives of viable fetuses." *Ante*, at 8. While I agree that a second physician indeed may aid in preserving the life of a fetus born alive, this type of aid is possible only when the abortion method used is one that may result in a live birth. Although Missouri ordinarily requires a physician performing a post-viability abortion to use the abortion method most likely to preserve fetal life, this restriction does not apply when this method "would present a greater risk to the life and health of the woman." Mo. Rev. Stat. § 188.030.2 (1983).

The District Court found that the dilatation and evacuation (D&E) method of abortion entails no chance of fetal survival, and that it will nevertheless be the method of choice for some women who need post-viability abortions. In some cases, in other words, maternal health considerations will preclude the use of procedures that might result in a live birth. 483 F. Supp., at 694.⁴ When a D&E abortion is performed, the

⁴The Court of Appeals upheld this factual finding. 665 F. 2d, at 865. As a general rule, we do not review a District Court's factual findings in

second physician can do nothing to further the State's compelling interest in protecting potential life. His presence is superfluous. The second-physician requirement thus is overbroad and "imposes a burden on women in cases where the burden is not justified by any possibility of survival of the fetus." 655 F. 2d, at 865-866.

The Court reasons that the State's interest in preserving potential life "justifies the State in requiring a second physician at *every* third-trimester abortion" because "[w]e . . . cannot assume that *all* third-trimester abortions will be D&E abortions, or that there will be no live births." *Ante*, at 7, n. 7 (emphasis added). But the fact that other methods of post-viability abortions may result in live births cannot justify requiring a second physician to attend an abortion at which the chance of a live birth is nonexistent. The choice of method presumably will be made in advance,⁵ and any need for a second physician disappears when the woman's health requires that the choice be D&E. Because the statute is not tailored to protect the State's legitimate interests, I would hold it invalid.⁶

which the Court of Appeals has concurred. *Branti v. Finkel*, 445 U. S. 507, 512, n. 6 (1980).

⁵In addition to requiring the physician to select the method most likely to preserve fetal life, so long as it presents no greater risk to the pregnant woman, Missouri requires that the physician "certify in writing the available method or techniques considered and the reasons for choosing the method or technique employed." Mo. Rev. Stat. § 188.030.2 (1983). This ensures that the choice of method will be a reasoned one.

⁶The State argues that its second-physician requirement is justified even when D&E is used, because "[i]f the statute specifically excepted D&E procedures, abortionists would be encouraged to use it more frequently to avoid the expense of a second physician, to ensure a dead fetus, to prevent the presence of a second professional to observe malpractice or the choice of a questionable procedure from a safety viewpoint, a fetus-destroying procedure, or to avoid their own awakening to concern for the newborn." Brief for Cross-Petitioners in No. 81-1623, p. 44. The Court rejected this purported justification for a second physician in *Doe v. Bol-*

B

In addition, I would hold that the statute's failure to provide a clear exception for emergency situations renders it unconstitutional. As the Court recognizes, *ante*, at 7, n. 8, an emergency may arise in which delay could be dangerous to the life or health of the woman. A second physician may not always be available in such a situation; yet the statute appears to require one. It states, in unqualified terms, that a post-viability abortion "*shall* be performed . . . *only* when there is in attendance" a second physician who "*shall* take control of" any child born as a result of the abortion, and it imposes certain duties on "the physician *required* by this section to be in attendance." Mo. Rev. Stat. §188.030.3 (emphasis added). By requiring the attendance of a second physician even when the resulting delay may be harmful to the health of the pregnant woman, the statute impermissibly fails to make clear "that the woman's life and health must always prevail over the fetus' life and health when they conflict." *Colautti v. Franklin*, 439 U. S. 379, 400 (1979).

The Court attempts to cure this defect by asserting that the final clause of the statute, requiring the two physicians to "take all reasonable steps . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman," could be construed to permit emergency post-viability abortions without a second physician. *Ante*, at 7, n. 8. This construction is contrary to the plain language of the statute; the clause upon which the Court relies refers to the duties of both physicians during the performance of the abortion, but it in no way suggests that the second physician may be dispensed with.

ton, 410 U. S. 179, 199 (1973): "If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice."

Moreover, since the Court's proposed construction is not binding on the courts of Missouri,⁷ a physician performing an emergency post-viability abortion cannot rely on it with any degree of confidence. The statute thus remains impermissibly vague; it fails to inform the physician whether he may proceed with a post-viability abortion in an emergency, or whether he must wait for a second physician even if the woman's life or health will be further imperiled by the delay. This vagueness may well have a severe chilling effect on the physician who perceives the patient's need for a post-viability abortion. In *Colautti v. Franklin*, we considered a statute that failed to specify whether it "require[d] the physician to make a 'trade-off' between the woman's health and additional percentage points of fetal survival." 439 U. S., at 400. The Court held there that "where conflicting duties of this magnitude are involved, the State, at the least, must proceed with greater precision before it may subject a physician to possible criminal sanctions." *Id.*, at 400-401.⁸ I would apply that reasoning here, and hold Missouri's second-physician requirement invalid on this ground as well.⁹

⁷"Only the [Missouri] courts can supply the requisite construction, since of course 'we lack jurisdiction authoritatively to construe state legislation.'" *Gooding v. Wilson*, 405 U. S. 518, 520 (1972), quoting *United States v. Thirty-seven Photographs*, 402 U. S. 363, 369 (1971).

⁸A physician who fails to comply with Missouri's second-physician requirement faces criminal penalties and the loss of his license. Mo. Rev. Stat. §§ 188.065, 188.075 (1983).

⁹Because I would hold the statute unconstitutional on these grounds, I do not reach the question whether Missouri's second-physician requirement impermissibly interferes with the doctor-patient relationship. I note, however, that Missouri does not require attendance of a second physician at any other medical procedure, including a premature birth. There was testimony at trial that a newborn infant, whether the product of a normal birth or an abortion, ordinarily remains the responsibility of the woman's physician until he turns its care over to another. App. 133; see ACOG, Standards for Obstetric-Gynecologic Services 31 (1982) ("The individual who delivers the baby is responsible for the immediate post-delivery care of the newborn until another person assumes this duty").

This allocation of responsibility makes sense. Consultation and team-

III

Missouri law prohibits the performance of an abortion on an unemancipated minor absent parental consent or a court order. Mo. Rev. Stat. § 188.028 (1983).

A

Until today, the Court has never upheld "a requirement of a consent substitute, either parental or judicial," *ante*, at 11. In *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S., at 74, the Court invalidated a parental consent requirement on the ground that "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient, regardless of the reason for withholding the consent." In *Bellotti v. Baird*, 443 U. S. 622 (1979) (*Bellotti II*), eight Justices agreed that a statute permitting a judicial veto of a mature minor's decision to have an abortion was unconstitutional. See *id.*, at 649–650 (opinion of POWELL, J.); *id.*, at 654–656 (opinion of STEVENS, J.). Although four Justices stated in *Bellotti II* that an appropriately structured judicial consent requirement would be constitutional, *id.*, at 647–648 (opinion of POWELL, J.), this statement was not necessary to the result of the case and did not command a majority. Four other Justices concluded that any judicial-consent statute would suffer from the same flaw the Court identified in *Danforth*: it would give a third party an absolute veto over the decision of the physician and his patient. *Id.*, at 655–656 (opinion of STEVENS, J.).

I continue to adhere to the views expressed by JUSTICE STEVENS in *Bellotti II*:

work are fundamental in medical practice, but in an operating room a patient's life or health may depend on split-second decisions by the physician. If responsibility and control must be shared between two physicians with the lines of authority unclear, precious moments may be lost to the detriment of both woman and child.

Massachusetts

an

"It is inherent in the right to make the abortion decision that the right may be exercised without public scrutiny and in defiance of the contrary opinion of the sovereign or other third parties. . . . As a practical matter, I would suppose that the need to commence judicial proceedings in order to obtain a legal abortion would impose a burden at least as great as, and probably greater than, that imposed on the minor child by the need to obtain the consent of the parent. Moreover, once this burden is met, the only standard provided for the judge's decision is the best interest of the minor. That standard provides little real guidance to the judge, and his decision must necessarily reflect personal and societal values and mores whose enforcement upon the minor—particularly when contrary to her own informed and reasonable decision—is fundamentally at odds with privacy interests underlying the constitutional protection afforded to her decision." 443 U. S., at 655-656 (footnote omitted).

Because Mo. Rev. Stat. § 188.028 permits a parental or judicial veto of a minor's decision to obtain an abortion, I would hold it unconstitutional.

B

Even if I believed that a State could require parental or judicial consent, I could not accept the Court's conclusion that the Missouri consent statute should be upheld. Under Missouri law, a minor who has not obtained parental consent may petition the juvenile court for court consent or the right to self-consent. Section 188.028.2(4) then provides that:

"the court shall for good cause:

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

"(b) Find the abortion to be in the best interests of the minor and give judicial consent to the abortion . . . ; or

"(c) Deny the petition, setting forth the grounds on

which the petition is denied. . . .”

The Court recognizes that this statute “[o]n its face . . . authorizes juvenile courts to choose among any of the alternatives outlined in the section.” *Ante*, at 13 (footnote omitted). The District Court took a similar view, noting that “each of the three [alternatives] is clearly independent of the others, connected in the statute with the disjunctive ‘or.’” The District Court also concluded that “[a]lternative (c) permits the court to ‘deny the petition,’ guided only by the general standard that such action be ‘for good cause.’” 483 F. Supp., at 689. The District Court thus found it “clear . . . that alternative (c) authorizes the juvenile court to deny the minor’s petition for good cause, but does not require a prior finding that the minor is not sufficiently mature and not competent to make a decision regarding abortion independently.” *Ibid*.

If the statute is construed in accordance with its plain language, it would be unconstitutional under the standards set forth in either the opinion of JUSTICE POWELL or the opinion of JUSTICE STEVENS in *Bellotti II*, 443 U. S., at 643–644, 647–648, 652–656. To avoid the necessity of invalidating the statute, the Court applies the maxim that, “[w]here fairly possible, courts should construe a statute to avoid a danger of unconstitutionality.” *Ante*, at 14. The Court thus approves the construction adopted by the Court of Appeals, concluding that a Missouri juvenile court may not “deny a [minor’s] petition ‘for good cause’ unless it first [finds] . . . that the minor was not mature enough to make her own decision.” *Ante*, at 14.

The Court’s maxim of statutory construction may be a wise one for federal courts to follow in discerning the meaning of federal statutes, but it is not one we can impose on state courts interpreting their own law. The interpretation of Missouri law is a matter for the courts of Missouri, and “[t]he majority’s construction of state law is, of course, not bind-

ing on the Missouri courts.” *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S., at 101, n. 4 (opinion of WHITE, J.). A Missouri juvenile court considering a petition brought by a mature minor may therefore conclude, despite this Court’s optimistic assertion to the contrary, that Missouri’s judicial consent statute means exactly what it says: the court may “for good cause . . . [d]eny the petition.”¹⁰

It is certainly possible that the courts of Missouri will agree with this Court and construe Missouri law as the Court does today. But this is a task that must be left to the state courts. We cannot perform it for them. In *Bellotti v. Baird*, 428 U. S. 132 (1976) (*Bellotti I*), the Court held that the District Court should have abstained where “an unconstrued state statute is susceptible of a construction by the state judiciary ‘which might avoid in whole or in part the necessity for federal constitutional adjudication, or at least materially change the nature of the problem.’” *Id.*, at 147, quoting *Harrison v. NAACP*, 360 U. S. 167, 177 (1959); see *Railroad Comm’n v. Pullman Co.*, 312 U. S. 496 (1941). I feel that the District Court should have abstained here as well.¹¹ Although Missouri does not have a certification pro-

¹⁰ This statute was enacted in 1979, after the Court’s decision in *Bellotti v. Baird*, 428 U. S. 132 (1976) (*Bellotti I*), but very shortly before its 1979 decision in *Bellotti II*. The Massachusetts statute held invalid in *Bellotti II*, like the Missouri statute before us today, permitted a court to grant or deny a minor’s petition “for good cause shown.” See *Bellotti II*, 443 U. S., at 625. The Massachusetts Supreme Judicial Court interpreted this language to authorize the withholding of consent “in circumstances where [the court] determines that the best interests of the minor will not be served by an abortion,” even if the minor “is capable of making, and has made, an informed and reasonable decision to have an abortion.” *Id.*, at 630, quoting *Baird v. Attorney General*, 371 Mass. 741, 748, 360 N. E. 2d 288, 293 (1977). The Court does not explain why it expects the Missouri courts to reach a different result.

¹¹ The Court’s interpretation of Missouri law is directly contrary to the interpretation given by the United States District Judge, who has been on the Missouri bench, state or federal, for over 30 years. The District Judge

cedure comparable to the one employed in *Bellotti I*, its rules of procedure provide for expedited review of questions of "general interest or importance." Mo. S. Ct. Rules 83.02, 83.06 (1983). In *Bellotti I*, moreover, we did not "mean to intimate that abstention would be improper . . . were certification not possible." 428 U. S., at 151.¹² In cases where constitutional rights of this magnitude are at stake, we should refrain from speculating on the meaning of Missouri law when an authoritative interpretation may be obtained by other means.

declined to abstain on the basis that "[i]t is clear to this Court that section 188.028 is *not* susceptible to a reasonable construction which would avoid the federal constitutional question controlling in *Bellotti II*." 483 F. Supp., at 690 (emphasis added). This District Judge's interpretation of the statute should indicate that it is at least sufficiently ambiguous to necessitate abstention. Cf. *Bishop v. Wood*, 426 U. S. 341, 345-347 (1976).

¹² While "speed in resolution" of this constitutional challenge remains important, *Bellotti I*, 428 U. S., at 151, it is worthy of note that enforcement of these statutes has been stayed pending the outcome of this litigation. The District Court would have been free to keep its stay in effect, in exercising its power to retain jurisdiction over the constitutional issue. See *England v. Medical Examiners*, 375 U. S. 411 (1964).

footnote omitted

May 20, 1983

81-185 Simopoulos v. Virginia

Dear Harry:

I am pleased by your letter of the 18th because, at long last, we should be able to get a Court together that will adequately protect all of the relevant interests, and also afford guidance that is now lacking.

You are generous to express your willingness to join my fourth draft in its present form. Your strong preference, however, would be to omit footnotes 9-17 that include a more detailed statement of the regulations than the general summary in the text. Although I really do not share your concern, I understand it. Also, I think it is important for both of us to be strongly supportive of a fourth draft. After all, we need three more votes.

Accordingly, if we can obtain the concurrence of Bill Brennan and Thurgood in the opinion, I will remove the eight footnotes.

It will be necessary, of course, for me to persuade the Chief. I think this can be done to assure a Court, though I have not spoken to him.

Would you be willing to talk to Bill Brennan, either alone or with me as you think best?

When John called me on the 18th to say that he will join your Ashcroft dissent, we discussed the status of Simopoulos. He recognizes the importance of trying to have a solid six Court majority, and has agreed to await my fourth draft. In the discussion with John, I summarized very briefly the exchanges you and I have had.

Sincerely,

Justice Blackmun

lfp/ss

May 23, 1983

81-185 Simopoulos v. Virginia

Dear Chief:

This is the 4th draft I am circulating this morning. The copy marked "4th draft" that you saw - and approved - last week had not then been circulated.

I wanted your approval before I showed it to Harry. He has now agreed to "go along". He wanted one change: the deletion of the footnotes that described the Virginia regulations in detail.

I have agreed. The regulations are summarized in the text, with specific reference to the section number of each regulation. The deletion of the more detailed description in the footnotes therefore is really immaterial.

I believe we now can get a Court to affirm - rather than remand as HAB and WJB have insisted until now. My thanks for your cooperation.

Sincerely,

The Chief Justice

lfp/ss



Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE THURGOOD MARSHALL

✓

May 23, 1983

Re: No. 81-185-Simopoulos v. Virginia

Dear Lewis:

Please join me.

Sincerely,

J.M.
T.M.

Justice Powell

cc: The Conference

CHAMBERS OF
JUSTICE LEWIS F. POWELL, JR.

Supreme Court of the United States
Washington, D. C. 20543

*On I had an opportunity to talk to File
the Chief, I
did not sent
this letter.*

May 23, 1983

81-185 Simopoulos v. Virginia

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Sincerely,

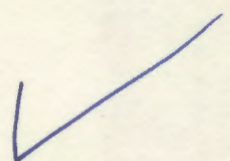
The Chief Justice

lfp/ss

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE WM. J. BRENNAN, JR.

May 23, 1983



Re: No. 81-185
Simopoulos v. Virginia

Dear Lewis,

I deeply appreciate the way you've
accommodated my problems. I am
delighted to join your circulation of
May 23rd.

Sincerely,

A handwritten signature in blue ink that appears to read "Bill".

Justice Powell

Copies to the Conference



Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE HARRY A. BLACKMUN

May 23, 1983

✓

Re: No. 81-185 - Simopoulos v. Virginia

Dear Lewis:

Please join me.

Sincerely,

Justice Powell

cc: The Conference

11-746

Akron file

~~Post~~



Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE HARRY A. BLACKMUN

May 23, 1983

Dear Lewis:

Herewith, for your information, is a copy of the letter I received from the Catholic Bishop at Fargo. This was hand delivered to me when I was at the University at Grand Forks the weekend before last.

Sincerely,

Larry

Justice Powell

Dear Bill:

Thank you for your recent letter and kind remarks on my opinion in this case. I understood your concerns to be similar to those expressed by Harry in his letter of March 8 and by John on March 7. I recognize that vacating and remanding in light of Akron is an option, but am inclined to believe that we should decide the case. There may be some prudential reasons why the issue in this case should be avoided, but, as you note, the case is properly before us on appeal, and the hospitalization issue was argued in briefs and at oral argument. There are also prudential reasons to decide the case: Any remand would leave the law unsettled ~~to some degree~~⁹ as to the validity of requiring that second-trimester abortions be performed in state-licensed outpatient clinics that conform generally to accepted medical practice and requirements. A decision by us in all three of these cases should go far to resolve the existing uncertainties.

I am today circulating a second draft. I have added two footnotes and substantially rewritten another specifically with your concerns in mind. See nn. 5, 6, 7. See also n. 9. I hope these changes will be helpful.

I look forward to hearing whether my work has addressed the problems that you raise.

Sincerely,

L.F.P., Jr.

cc: JUSTICE BLACKMUN

29
31
31

CASE	ISSUE/REQUIREMENT	DECISION BELOW	VOTE
Simopoulos v. Virginia No. 81-185 S.Ct. Va.	Failure to allege or prove lack of maternal necessity	Defendant must raise necessity defensively; State must disprove it.	<i>Aff'm</i> <i>Medical necessity, defense, a concerned by Va Ct. is an affirmative defense</i>
	Failure to prove causation	State proved causation.	<i>Aff'm - friv</i>
	Hospitalization in 2d trimester	Requirement held valid	<i>Aff'm - 1st trimester, no restriction</i> <i>2nd - "clinic" permitted</i>
Planned Parenthood v. Ashcroft No. 81-1255 CA8	Parental Consent (i) Should Court abstain? (ii) Merits	Statute given construction consistent with Bellotti II. & Matheson	<i>no reason to abstain. Cts below reached issue, & construed Mo. statute</i> <i>Aff'm</i> <i>As construed by CA8 to require independent decision-maker</i>
Ashcroft v. Planned Parenthood No. 81-1623	Hospitalization in 2d trimester (i) Hospitals require parental consent to admit minors	Invalidated after remand Hospitalization requirement not invalidated on this basis.	<i>Mo.</i> <i>DC invalidated. CA8 remanded for further findings.</i> <i>Mo. requires all 2nd trimester abortions only in TCAH hospitals. State approved, clinics off as in Va.</i>
	Pathologist must examine tissue samples	Invalid.	<i>In CA8 Aff'm? { may not dissent.</i>
	Second physician for fetus after viability	Invalid.	<i>Discuss - burden is substantial. So is state interest</i>
	Attorneys fees	Awarded in full to PP for work in 1255&1623.	
Akron v. Akron Ctr for Reproductive Health No. 81-746 CA6	Parental Consent (i) Jurisdiction (ii) Merits Parental Notification Informed Consent (i) Severability (ii) Provisions (iii) Attending doctor must counsel personally	Invalid. Valid under Matheson. Invalid Invalid	<i>no party before us has standing. No parent</i> <i>Aff'm - if we reach issue, Juvenile Court must notify.</i> <i>(because of standing)</i> <i>Aff'm - The detailed & slanted info. infringes on patient/physician relationship.</i>
	Waiting Period	Invalid	<i>24 hrs</i> <i>Discuss</i>
	Disposal of Fetal Remains	Invalid	<i>Aff'm</i>
Akron Ctr for Reproductive Health v. Akron No. 81-1172	Hospitalization in 2d trimester	Valid.	<i>CA6, relying on Gary-Northwest (2nd), reluctantly sustained. Reverse - Same as Mo. TCAH hosp. only</i>

* But DC made the findings.

I hope this is legible, but I did have a few post-conference comments to make.

40B

CASE	ISSUE/REQUIREMENT	DECISION BELOW	VOTE
Simopoulos v. Virginia No. 81-185 S.Ct. Va.	Failure to allege or prove lack of maternal necessity	Defendant must raise necessity defensively; State must disprove it.	<u>Affirm</u> - after our conversation, I re-examined the Va. S. Ct.'s opinion: I think it fairly can be read to state that <u>only</u> the medical necessity defense must be invoked by the deft. If other element must be "invoked" by deft. they can be taken care of in later case.
	Failure to prove causation	State proved causation.	<u>Affirm</u> - No problem here
	Hospitalization in 2d trimester	Requirement held valid	<u>Affirm</u> - if the Court reaches this issue, then this case should
Planned Parenthood v. Ashcroft No. 81-1255 CA8	Parental Consent (i) Should Court abstain? (ii) Merits	<i>I do not think this is really an issue here. Although Mo. has not construed its own act, there is no reason not to defer to the CAB's generous construction.</i> Statute given construction consistent with Bellotti II.	<u>Affirm</u> [probably the lead case in the trilogy] - the CAB construed the Mo. statute, as I understand it, consistent w/ your decision in Bellotti II and Matheson. If you see no inconsistency between your view and the CAB's, saying construction, I would affirm.
Ashcroft v. Planned Parenthood No. 81-1623	Hospitalization in 2d trimester (i) Hospitals require parental consent of it to admit minors	Invalidated after remand Hospitalization requirement not invalidated on this basis.	<u>Affirm</u> - if the Court is willing to change test to something more in line w/ strict scrutiny - otherwise, I would Reverse: creates a bright-line
	Pathologist must examine tissue samples	Invalid.	<u>Affirm</u> - close case under strict scrutiny - Reverse under current standards.
	Second physician for fetus after viability	Invalid.	<u>Reverse</u> - in last periods of pregnancy, state's interests are paramount
	Attorneys fees	Awarded in full to PP for work in 1255&1623.	<u>Reverse</u> - Remand for consideration of Hensley v. Eckerhard No. 81-1244
Akron v. Akron Ctr for Reproductive Health No. 81-746 CA6	Parental Consent (i) Jurisdiction (B) (ii) Merits	Invalid.	<u>DIG or Affirm</u> - I still have some problems w/ whether these issues are properly before us, given the parties that appealed to the CAB: the fact that we denied their cert. petn.
	Parental Notification I do not understand this issue to be before us (who would have appealed? cross-petn)	Valid under Matheson.	- if the Court decides it is, I think it is inconsistent w/ your view in Matheson
	Informed Consent (i) Severability (ii) Provisions (iii) Attending doctor must counsel personally	Invalid Invalid.	<u>Affirm</u> - under strict scrutiny, most of this would be invalid - even under current standards, most of this is suspect, although you might be able to uphold the information on pregnancy, but fetal development & public assistance
	Waiting Period	Invalid	<u>Affirm</u>
	Disposal of Fetal Remains	Invalid	<u>Affirm</u> - defer to lower judges on vagueness issue
Akron Ctr for Reproductive Health v. Akron No. 81-1172	Hospitalization in 2d trimester	Valid.	<u>Reverse</u> - if Ct. shifts to more strict scrutiny

Sally Keep in '1a. Case File

Standards of Am. College (A.C.O.G)

p1. Three types of "ambulatory care": office, out patient clinic, or free standing surgical facility.

p54 Abortions

Office or out-patient clinics - 14 weeks

Free standing surgical facility - 18 "

In either case:

1. Special counseling
2. Customary hist., physical, & "indicated lab. procedures"
3. RH factor determination
4. Aspirated tissue examined

p60 Personnel (for all three types of ambulatory facilities)

1. Adequate adm. & prof. personnel
2. Written policies
3. In-service training
4. Free standing surgical facility - a Governing Bd.

p61 Equipment - In Free Standing Surg/Facility
"equivalent to an accredited hospital"

2nd Tru
abortions →

I hope this is legible, but I did have a few post-conference comments to make.

40B

CASE	ISSUE/REQUIREMENT	DECISION BELOW	VOTE
Simopoulos v. Virginia No. 81-185 S.Ct. Va.	Failure to allege or prove lack of maternal necessity	Defendant must raise necessity defensively; State must disprove it.	<u>Affirm</u> - after our conversation, I re-examined the Va. S. Ct.'s opinion; I think it fairly can be read to state that <u>only</u> the medical necessity defense must be invoked by the deft. If other elements must be "invoked" by deft. they can be taken care of in later cases.
	Failure to prove causation	State proved causation.	<u>Affirm</u> - No problem here
	Hospitalization in 2d trimester	Requirement held valid	<u>Affirm</u> - if the Court reaches this issue, then this case should
Planned Parenthood v. Ashcroft No. 81-1255 CAB	Parental Consent (i) Should Court abstain? (ii) Merits	I do not think this is really an issue here. Although Mo. has not construed its own act, there is no reason not to defer to the CAB's generous construction; if later Mo. changes the CAB's construction, or the CAB's construction applies consistently w/ Bellotti, the fed. courts can take Statute given construction consistent with Bellotti II.	<u>Affirm</u> - probably the lead case in the trilogy - the CAB construed the Mo. statute, as I understand it, consistent w/ your decision in Bellotti II and Matheson. If you see no inconsistency between your view and the CAB's, saying construction, I would affirm
Ashcroft v. Planned Parenthood No. 81-1623	Hospitalization in 2d trimester (i) Hospitals require parental consent of it to admit minors	Invalidated after remand Hospitalization requirement not invalidated on this basis.	<u>Affirm</u> - if the Court is willing to change test to something more in line w/ strict scrutiny - otherwise, I would Reverse: create a bright-line
(I could go either way on this one)	Pathologist must examine tissue samples	Invalid.	<u>Affirm</u> - close case under strict scrutiny - Reverse under current standards.
	Second physician for fetus after viability	Invalid.	<u>Reverse</u> - in last periods of pregnancy, state's interests are paramount
	Attorneys fees	Awarded in full to PP for work in 1255&1623.	<u>Reverse</u> - Remand for consideration of Hensley v. Eckerhard No. 81-1244
Akron v. Akron Ctr for Reproductive Health No. 81-746 CA6	§1870.05 Parental Consent (B) (i) Jurisdiction (ii) Merits	Invalid.	<u>DIG or Affirm</u> - I still have some problems w/ whether these issues are properly before us, given the parties that appealed to the CAB: the fact that we denied their cert. petn.
	Parental Notification I do not understand this issue to be before us (who would have appealed? cross-petn)	Valid under Matheson.	- if the Court decides it is I think it is inconsistent w/ your view in Matheson
	§1870.05 Informed Consent (A) (i) Severability (ii) Provisions (iii) Attending doctor must counsel personally	Invalid Invalid.	<u>Affirm</u> - under strict scrutiny, most of this is suspect, although you might be able to uphold the information on pregnancy, risks of fetal development & public assistance
there is a separate section under review for risks of abortion	Waiting Period	Invalid	<u>Affirm</u>
	Disposal of Fetal Remains	Invalid	<u>Affirm</u> - defer to lower judges on vagueness issue
Akron Ctr for Reproductive Health v. Akron No. 81-1172	Hospitalization in 2d trimester	Valid.	<u>Reverse</u> - if Ct. shifts to more strict scrutiny

Sally Keep in '1a. Case File
Standards of Am. College (A.C.O.G)

p1. Three types of "ambulatory care": office, out patient clinic, or free standing surgical facility.

p54 Abortions
Office or out-patient clinic - 14 weeks
Free standing surgical facility - 18 "

In either case:

1. Special counseling
2. Customary hist., physical, & "indicated lab. procedures"
3. RH factor determination
4. Aspirated tissue examined

p60 Personnel (for all three types of ambulatory facilities)

1. Adequate adm. & prof. personnel
2. Written policies
3. In-service training
4. Free standing surgical facility - a Governing Bd.

p61 Equipment - In Free Standing Surg/Facility
"equivalent to an accredited
2nd Tru abortion → hospital"

Va. Regs

My interpretation is that: Part II applies to abortion "clinics" performing 2d-trimester ~~clinics~~ abortions

- Part III (outpatient hospitals performing ^{abortion} abortions only) applies to clinics performing 1st-trimester abortions

- Note especially pp. 10, 16, 18, 20, 29, 31

COMMONWEALTH OF VIRGINIA

DEPARTMENT OF HEALTH

Bureau of Medical and Nursing Facilities Services

Richmond, Virginia

June 30, 1977

Promulgated under Title 32, Chapter 16, Section 32.297 et seq., of the Code of Virginia, 1950 as amended and in conformity with the General Administrative Process Act, Title 9, Chapter 1.1:1, Section 9-6.14:1 et seq.

These are new regulations:

Preliminary Approval by State Board of Health - December 1, 1976.

Public Hearing Held January 26, 1977.

Final Approval by State Board of Health - May 11, 1977.

Effective Date: June 30, 1977

Copies may be obtained from: State Department of Health, Bureau of Medical and Nursing Facilities Services, James Madison Building, 109 Governor Street, Richmond, Virginia 23219.

The following rules and regulations are presented in three parts: Part I, general information and procedures for licensure of outpatient hospitals; Part II, requirements for licensure of outpatient surgical hospitals; and Part III, requirements for licensure of outpatient hospitals performing abortions only.

Part II of these rules and regulations specify minimum organization, operation and construction standards for outpatient surgical hospitals. These facilities are sometimes referred to as "day surgery," "in-and-out surgery" or "surgicenters." The scope of service and types of operative procedures performed in these facilities are usually multidisciplinary. Operational standards and clinical requirements are at a level similar to inpatient surgical facilities.

Part III of these rules and regulations set forth the minimum standards for the organization, operation and physical facility requirements for outpatient abortion hospitals. These facilities are usually referred to as "outpatient abortion clinics." These facilities limit the operative procedures to termination of pregnancy during the first trimester.

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RULES AND REGULATIONS
FOR THE LICENSURE OF
OUTPATIENT SURGICAL HOSPITALS AND
OUTPATIENT HOSPITALS
PERFORMING ABORTIONS ONLY

PART I

GENERAL INFORMATION AND PROCEDURES
FOR EXISTING AND NEW
OUTPATIENT HOSPITALS

PART I: GENERAL INFORMATION AND PROCEDURES

Section 10.0 General Information

10.1 Authority

Title 32, Chapter 16, of the Code of Virginia (1950), as amended, authorizes the Board of Health (hereinafter referred to as Board) to issue licenses to establish, conduct, maintain, and operate hospitals. In order to discharge that duty, the Board is empowered to adopt rules and regulations prescribing minimum standards to promote the safety and ensure proper attention and service to and care of patients of hospitals within the State.

10.2 Purpose

These regulations have been promulgated by the Board for the purpose of defining the minimum standards of operation and construction which shall be permitted in or by licensed outpatient hospitals, and to:

- (a) Guide the Board in its determination of compliance with licensure standards as set forth herein; and
- (b) Assist the owner or his authorized agent in the preparation of an application, architectural drawings and specifications, and other reports.

10.3 Administration

These regulations are administered by the following:

10.3.1 State Board of Health

The Board of Health has responsibility for promulgating, amending, and repealing regulations pertaining to the licensing of hospitals.

10.3.2 State Health Commissioner

The State Health Commissioner (hereinafter referred to as Commissioner) is the executive officer of the State Board of Health with the authority of the Board when it is not in session and subject to such rules and regulations as may be prescribed by the Board.

10.3.3 Bureau of Medical and Nursing Facilities Services

The Bureau of Medical and Nursing Facilities Services (hereinafter referred to as Bureau) of the Department of Health of the Commonwealth of Virginia is designated as the primary reviewing agent of the Board for the purpose of administering these regulations.

10.3.4 Bureau Offices

The Bureau maintains a central office in the City of Richmond with a mailing address of James Madison Building, 109 Governor Street, Richmond, Virginia, 23219.

10.4 Effective Date

These regulations shall be effective on June 30, 1977.

10.5 Extreme Emergency Regulations

If the establishment of an extreme emergency regulation is necessary for the preservation of public health, safety or welfare, the Commissioner may immediately promulgate and adopt the necessary regulation.

10.6 Compliance and Prohibition

These regulations shall apply to "free standing" outpatient hospitals. Such facilities which are operated by and physically attached to a hospital licensed under "Rules and Regulations for the Licensure of General and Special Hospitals," Department of Health, shall be subject to provisions of those regulations.

10.7 Allowable Variance

Upon the finding that the enforcement of one or more of these regulations would be clearly impractical, the Commissioner shall have the authority to waive, either temporarily or permanently the enforcement of one or more of these regulations, provided safety and patient care and service are not adversely affected.

10.8 Severability

If any provision of these regulations or the application thereof to any facility or circumstances shall be held invalid, such invalidity shall not affect the provisions or application of the regulations which can be given effect, and to this end the provisions of the regulations are declared to be severable.

Section 20.0 Definitions

20.1 General

As used in these regulations, the words and terms hereinafter set forth, shall have meanings respectively set forth unless the context clearly requires a different meaning.

20.2 Definitions

20.2.1 Board - The State Board of Health.

OK.

lfp/ss 12/16/82

ABOR1 SALLY-POW

81-1255 Planned Parenthood v. Ashcroft (Missouri)

Conference 12/16/82

CJ absent due to illness.

SS This memorandum ⁵will summarize the votes on the
issues before us. ~~My yellow notes give some - but by no~~
~~means all - of the details.~~

Issue No. 1 - Abstention.

Affirm: 8-0.

Issue No. 2 - Parental Notification and Consent

Divided vote - 4-4.

Why? No? Voting to reverse: WJB, TM, HAB and JPS

Voting to affirm: BRW, LFP, WHR, SO'C

SS (Note: CA8 construed the Missouri statute to
require an independent decision-maker, expressly relying
on my opinions in Bellotti II and Matheson

* * *

81-1623 Ashcroft v. Planned Parenthood

Issue No. 1 - Hospitalization in JCAH Hospitals

Affirmed 5-3 (~~CJ absent~~)

SS (A vote to affirm in this case sustains CA8
holding of invalidity.

Voting to affirm: WJB, TM, HAB, LFP and JPS.

Voting to reverse: BRW, WHR and SO'C

Issue No. 2 - Pathologist's Report

CA8 held this requirement invalid.

Reversed: 6-2 (several tentative).

SS (

Voting to reverse: WJB (tentative), BRW, TM
(tentative), LFP (~~very~~ tentative), WHR, and SO'C.

SS (

Voting to affirm: i.e., invalidate the
requirement. HAB and JPS

SS (

Note: I would not be surprised to see WJB and
TM change their votes on this issue. I also was
tentative.

Issue No. 3 - Second Physician's Opinion Invalidated by

CA8

Reversed 5-3.

SS (

Voting to reverse (to sustain the requirement)
BRW, LFP, WHR, JPS and SO'C.

Voting to affirm: WJB, TM and HAB.

Note: HAB feels strongly about this issue. He thinks that sustaining the second physician requirement is "flatly contrary to Bolton". But Bolton involved only first trimesters. Here the requirement exists only when the fetus is viable and the state's interest is at its strongest.

* * *

Issue No. 4 - Attorney's Fee

All vote to Hold for my opinion in Hensley.

OK

lfp/ss 12/16/82 ABORTION SALLY-POW

81-185 Simopoulous v. Virginia - Conference 12/16/82

CJ absent due to ill~~ness~~. ✓

This memorandum will summarize the votes on the

SS

three issues before us. My yellow notes give some - but

~~my~~ no means all - of the details. ✓

D/S → Issue No. 1 - Burden of Proof on "Necessity"

Affirmed: 8-0.

AS

Issue No. 2 - Sufficiency of Evidence and Causation

Affirmed: 8-0.

Issue No. 3 - Hospitalization

Affirm: ^{ed} 5-3

1

✓

Votes to affirm: WJB (tentative), BRW, LFP,
WHR, and SO'C.

Reverse and remand: TM, HAB and JPS

*Virginia's provision of for
clinical distinguishes this case
from Akron + Ashcroft.*

Master
OK

lfp/ss 12/17/82

ABOR2 SALLY-POW

81-746 Akron v. Akron Center (Conference 12/16/82)

CJ absent due to illness.

SS { This memorandum will summarize the votes on the
three issues before us.

~~Parental~~ Parental Consent

Issue No. 1 ~~Jurisdiction (Standing?)~~

(i) Standing

^ Most of the Justices had not focused on the
issue. WJB saw no standing problem. I rather think that
there is ^a ~~no~~ ^{problem,} standing, but the only vote we took was on the
merits. ~~CA6 invalidated the parental notification and
consent requirement of the ordinance.~~

2 { Affirm: 5-3.

Voting to affirm: WJB, TM, HAB, LFP and JPS

~~Voting to reverse: BRW, WHR and SO'C~~

Issue No. 2 - Parental Consent

(ii) Merits of Parental Consent

CA affirmed the DC decision of invalidity.

We affirmed ⁵⁻³~~6-2~~ (with some questions)

Voting ~~definitely~~ to affirm were WJB, TM, HAB,

and

✓ LFP (if issue is here), and ~~SO'C (I believe)~~.

To reverse: BRW, WHR, SO'C

Issue No. ²~~3~~ - Parental Notification

The DC invalidated, but CA6 reversed - relying on Matheson.

In my view, the issue is not here (see my memo on notice & consent).

any vote here?

→ Issue No. ³~~4~~ - Provisions to Assure Consent is "Informed"

9/10 on merits

✓ We affirmed 5-3

Voting to affirm: BRW, LFP, WHR, JPS, &

To Reverse: WJB, TM, HAB

SO'C

CA6 invalidated all provisions, and we affirmed

6-2.

Voting to affirm: WJB, TM, HAB, LFP, JPS and

SO'C

To Reverse: BRW, WHR.

⁴
Issue No. ~~5~~ - 24 Hour Waiting Period

CA6 held it invalid.

We affirmed 5-3.

Voting to affirm: ~~were~~ WJB, TM, HAB, LFP, and

JPS.

To reverse: BRW, WHR and SO'C

⁵
Issue No. ~~5~~ - Disposal of Fetal Remains

CA6 held invalid.

We affirmed 6-2.

Voting to affirm: WJB, TM, HAB, LFP, JPS and

SO'C

To reverse: BRW and WHR

* * *

81-1172 Akron Center for Reproductive Health v. Akron

The only issue is the requirement for hospitalization in all second trimester cases.

CA6 sustained validity reluctantly, relying on our summary affirmance of the Indiana statute.

We reversed 5-3.

Voting to reverse: WJB, TM, HAB, LFP and JPS

To affirm: BRW, WHR and SO'C

Note: The hospitalization provision in the Akron ordinance is substantially identical with that in

Missouri. Second trimester abortions may not be performed in clinics, even the licensed type like those in Virginia.

Justices, in Fervent Debate, Tackle Abortion Issue Again

By Fred Barbash
Washington Post Staff Writer

Supreme Court Justice Harry A. Blackmun, author of the 1973 decision legalizing abortion, leaned forward, glared down at the solicitor general of the United States and waved the Reagan administration's legal brief asking the court to approve new and stringent restrictions on abortions.

"Mr. Solicitor General, are you asking us to overrule" the abortion decision, he snapped at Solicitor General Rex E. Lee. "It seems to me that you are asking that or you're asking that we overrule *Marbury vs. Madison*," he said sarcastically, referring to the 1803 case that established the court's right to review leg-

islation and declare it unconstitutional.

"Did you personally write this brief?" he said finally, in a tone of disgust.

"Substantial portions," Lee responded tersely.

It was the dramatic high point of three hours of fervent debate yesterday as the Supreme Court began its most comprehensive review of abortion law since its 1973 decision. The justices questioned the lawyers intensely about new medical procedures, counseling, and safety in the thousands of abortion clinics established across the country since their original ruling.

They focused as well on the Con-
See ABORTION, A8, Col. 1



JUSTICE HARRY A. BLACKMUN
... tough questions and a little sarcasm

Justices, Reviewing Abortion Laws

ABORTION, From A1
stitution and the relationship between branches of government.

At issue were laws in Virginia, Missouri and Akron, Ohio, that regulate abortions. Virginia successfully prosecuted a doctor for performing an abortion in his clinic, instead of in a hospital as required by state law.

Missouri enacted a law requiring, among other things, that women be hospitalized for abortions after the second three months of pregnancy and obtain parental or court consent if they are under 18.

Akron, in the most far-reaching legislation, imposed among other things a parental consent requirement for women under 15, a 24-hour "cooling-off period" before an abortion at any stage of pregnancy, and an "informed consent" provision forcing doctors to describe in anatomical detail the appearance of the fetus and to tell patients that it is a "human life from the moment of conception."

None of the justices who asked questions yesterday indicated any inclination to revise substantially the 1973 ruling, *Roe vs. Wade*, as anti-abortion forces had hoped.

In fact, the arguments before the court yesterday revolved around whether the new laws were consistent with *Roe vs. Wade*, which held that most abortions—the ones in the early stages of pregnancy—were a matter of choice between a woman and her doctor.

Akron's lawyer, Alan G. Segedy, said the municipal law, appealed to the Supreme Court after being struck down by a federal appeals court in Ohio, did not rob women of choice.

"The right is not a right to have an abortion," he told the court, "but the right to make a decision: abor-



Lawyer Alan G. Segedy defends Akron law requiring doctors to describe the fetus to wor

tion or childbirth." The Akron law helps women make that choice by giving them the information about the fetus, he said.

"The state has an interest in protecting the woman's freedom of choice whether or not to have an abortion . . . This is not a burdensome law. This is a choice-enhancing law."

The doctor-patient relationship is not disrupted by the Akron ordinance, Segedy added. Rather, the

law creates a doctor-patient relationship in abortion clinics where he maintained that none would exist otherwise.

Segedy urged the court to give states and cities more flexibility to impose restrictions on abortions in the first three months of pregnancy. States should not have to show a "compelling" reason for restrictions, he said.

Stephen Landsman, representing Akron abortion clinics challenging

Asked to Approve Restrictions



By Victor Juhász for the Washington Post
omen seeking abortions: "The right is ... the right to make a decision," he tells court.

the law, pointed out that the ordinance imposes more regulations on women seeking abortions than are imposed on mental patients seeking medical treatment. "It treats women as if they are not to be trusted to know their own minds and to make rational decisions."

"The real purpose of all these statutes," said Frank Susman, representing Planned Parenthood Association of Kansas City, "is to thwart" abortions.

Lawyers defending the hospitalization requirements in all three jurisdictions argued that *Roe vs. Wade* permitted the hospitalization requirements by saying that in the first three months of pregnancy, the state may regulate abortions in order to protect the health of the woman. Hospitals, rather than abortion clinics, are best able to achieve that, they said.

"But there's no law preventing a doctor from doing brain surgery out-

side a hospital, is there," said Justice John Paul Stevens. "A doctor could do that at home, couldn't he," he told Deputy Virginia Attorney General William G. Broaddus.

Missouri Attorney General John Ashcroft said there was a "medical debate" about whether abortions were safer in a hospital or in a clinic in the early period of the second trimester. "When a medical debate rages, I think the state ought to have the ability to err on the side of safety."

The Reagan administration entered the cases as a "friend of the court." Lee told Blackmun that the government was not asking now for a reversal of the 1973 abortion ruling. "That issue must await another day," he said. But he said that in reviewing abortion regulations, the courts should more often defer to legislatures, which are better equipped than courts to make such sensitive policy choices.

"At the end of the day, the decisions must be made by the courts," he acknowledged. "But the courts must be mindful of the choices already made" by those elected by the voters. "Balancing" of competing interests is involved in abortion regulation, Lee said. And legislatures "do it [the balancing] better."

Frank Susman, the lawyer challenging the Missouri law, called Lee's argument a "terrifying thought" that attacks the "very foundations of liberty." It would result in the "bargaining away" of fundamental rights, Susman said. "A hundred and seventy-nine years of constitutional history would appear to fly out the door."

The cases heard yesterday were *Simopoulos vs. Virginia*, *City of Akron vs. Akron Center for Reproductive Health*, and *Planned Parenthood Association of Kansas City vs. Ashcroft*, Attorney General of Missouri *Et Al.*

lfp/ss 12/17/82

MEMO TO FILE

81-746 Akron

There are two sections that tend to be confused:

Section 1870.05(A) requires with respect to women under 18, the giving of 24 hours prior notice to a parent or guardian "unless the abortion is ordered by a court having jurisdiction". (the "notice provision")

Section 1870.05(B) provides, with respect to minors under 15, that written consent must be obtained both from the minor and a parent or guardian unless approval has been obtained from a court having jurisdiction. (the "consent" provision)

The Notice Provision is Not Here

The DC invalidated both the notice and consent provisions. The original defendants (the city, etc.) did not appeal, but intervenors did appeal. Relying on Matheson, and particularly on my concurring opinion, CA6 reversed. Matheson sustained the notice provision because the minor in that case made no claim either that she was mature or that her best interests would not be served by parental notification.

In this case, CA6 noted that the intervenors - the only appealing parties - are "parents of unmarried minor daughters". Neither the maturity nor condition with respect to emancipation of these minors was shown. CA6 accordingly held that the notice provision "is a constitutionally per-

missible regulation insofar as it applies to immature minors who live with their parents, are dependent upon them and are not emancipated by marriage or otherwise". This leaves open situations where the minor is mature or emancipated or where "notice would not be in her best interest".

Accordingly, CA6 reversed the DC. It thus held that §1870.05(A) is facially valid. Apparently no appeal was taken from this decision. Even the brief on behalf of the original plaintiffs (the clinics and the physicians) states in footnote 79, p. 48 (red brief) that §1870.05(A) is "not before this Court".

Consent Provision May Be Here [§1870.05(B)]

CA6 affirmed the decision of the District Court invalidating the consent provision. Again, it was held that no independent decision-maker was provided because juvenile courts - even when they have jurisdiction - are required to notify parents. CA6 relied on Danforth.

On the merits, I would affirm on the basis of my prior opinions.

L.F.P., Jr.

lfp/ss 12/17/82

81-1255 Planned Parenthood v. Ashcroft (Missouri)
Conference 12/16/82

CJ absent due to illness.

This memorandum summarizes the votes on the issues before us.

Issue No. 1 - Abstention.

Affirm: 8-0.

Issue No. 2 - Parental Notification and Consent

Divided vote - 4-4.

Voting to reverse: WJB, TM, HAB and JPS

Voting to affirm: BRW, LFP, WHR, SO'C

Note: CA8 construed the Missouri statute to require an independent decision-maker, expressly relying on my opinion in Bellotti II.

* * *

81-1623 Ashcroft v. Planned Parenthood

Issue No. 1 - Hospitalization in JCAH Hospitals

Affirmed 5-3

A vote to affirm in this case sustains CA8 holding of invalidity.

Voting to affirm: WJB, TM, HAB, LFP and JPS.

Voting to reverse: BRW, WHR and SO'C

Issue No. 2 - Pathologist's Report

CA8 held this requirement invalid.

Reversed: 6-2 (several tentative).

Voting to reverse: WJB (tentative), BRW, TM (tentative), LFP (tentative), WHR, and SO'C.

Voting to affirm: i.e., invalidate the requirement. HAB and JPS

Note: I would not be surprised to see WJB and TM change their votes on this issue. I also was tentative.

Issue No. 3 - Second Physician's Opinion - Invalidated by CA8

Reversed 5-3.

Voting to reverse (to sustain the requirement) BRW, LFP, WHR, JPS and SO'C.

Voting to affirm: WJB, TM and HAB.

Note: HAB feels strongly about this issue. He thinks that sustaining the second physician requirement is "flatly contrary to Bolton". But Bolton involved only first trimesters. Here the requirement exists only when the fetus is viable and the state's interest is at its strongest.

* * *

Issue No. 4 - Attorney's Fee

All vote to Hold for my opinion in Hensley.

lfp/ss 12/17/82

81-746 Akron v. Akron Center (Conference 12/16/82)

CJ absent due to illness.

This memorandum will summarize the votes on the three issues before us.

Issue No. 1 - Parental Consent

(i) Standing: Most of the Justices had not focused on the issue. WJB saw no standing problem. I rather think that there is a standing problem, but the only vote we took was on the merits.

(ii) Merits of Parental Consent:

CA affirmed the DC decision of invalidity.

We affirmed 5-3 (with some questions)

Voting to affirm were WJB, TM, HAB, and LFP (if issue is here).

To reverse: BRW, WHR, SO'C

Issue No. 2 - Parental Notification

The DC invalidated, but CA6 reversed - relying on Matheson.

In my view, the issue is not here. (See my memo on notice and consent).

On merits we affirmed 5-3.

Voting to affirm: BRW, LFP, WHR, JPS and SO'C

To reverse: WJB, TM, HAB

Issue No. 3 - Provisions to Assure Consent is "Informed"

CA6 invalidated all provisions, and we affirmed 6-2.

Voting to affirm: WJB, TM, HAB, LFP, JPS and SO'C

To reverse: BRW, WHR

Issue No. 4 - 24 Hour Waiting Period

CA6 held it invalid.

We affirmed 5-3.

Voting to affirm: WJB, TM, HAB, LFP and JPS.

To reverse: BRW, WHR and SO'C

Issue No. 5 - Disposal of Fetal Remains

CA6 held invalid.

We affirmed 6-2.

Voting to affirm: WJB, TM, HAB, LFP, JPS and SO'C

To reverse: BRW and WHR

* * *

81-1172 Akron Center for Reproductive Health v. Akron

The only issue is the requirement for hospitalization in all second trimester cases.

CA6 sustained validity reluctantly, relying on our summary affirmance of the Indiana statute.

We reversed 5-3.

Voting to reverse: WJB, TM, HAB, LFP and JPS

To affirm: BRW, WHR and SO'C

Note: The hospitalization provision in the Akron ordinance is substantially identical with that in Missouri. Second trimester abortions may not be performed in clinics, even the licensed type like those in Virginia.

lfp/ss 12/17/82

81-185 Simopoulos v. Virginia - Conference 12/16/82

CJ absent due to illness.

This memorandum will summarize the votes on the three issues before us. My yellow notes give some - but by no means all - of the details.

Issue No. 1 - Burden of Proof on "Necessity"

Affirmed: 8-0.

Issue No. 2 - Sufficiency of Evidence and Causation

Affirmed: 8-0.

Issue No. 3 - Hospitalization

Affirmed: 5-3

Votes to affirm: WJB (tentative), BRW, LFP, WHR, and SO'C.

Reverse and remand: TM, HAB and JPS

Virginia's provision for clinics distinguishes this case from Akron and Ashcroft.

December 17, 1982

Abortion Cases

Dear Chief:

In accordance with your request, I now send out to your residence a memorandum that summarizes the voting in these three cases.

I also enclose a memorandum that deals particularly with the confusing questions in the Akron case of "notice" and "consent".

There were so many issues that recording the votes became somewhat speculative. There may be a few mistakes in my notes.

Because of the multiplicity of issues, and also because we were following your form chart primarily, my explanatory notes are too haphazard to be of much assistance. Often we would take a vote with no discussion. In my view, the hospitalization issue is the most important one. We have a Court - including Bill Brennan - to affirm Simopoulos. Unlike the Virginia statute, both Akron and Missouri require all second semester abortions in hospitals, without exception for clinics however adequate.

On questions relating to notice of parents and parental consent, I adhered to views expressed by me in Bellotti II and Matheson. These also are important and recurring issues.

If I can be of any assistance, do not hesitate to call on my.

I do hope you are progressing satisfactorily, and will not strain to return here until you have fully recovered.

Sincerely,

The Chief Justice

lfp/ss

December 17, 1982

Abortion Cases

MEMO TO THE CONFERENCE:

I found the consent and notice provisions of the Akron ordinance confusing, and still do to some extent.

With respect to the consent provision -
§1870.05(B) - I voted to affirm on the merits. There may still be a standing problem for me.

As to the notice provision, I was uncertain as to whether it is before us at all. I am now satisfied that it is not. See the brief on behalf of the original plaintiffs (respondents and cross petitioners brief) at p. 48, footnote 79.

If the Court reaches the merits, I would affirm on the basis of Matheson. CA6 reversed the District Court's holding of invalidity, relying on Matheson. See appendix, p. 12a, 13a.

L.F.P., Jr.

10 Years After the Abortion Decision

By TERRY EASTLAND

Ten years ago this week the Supreme Court ruled that a woman has an almost unrestrictable right to seek an abortion. *Roe v. Wade* began a decade of controversies, the most recent of which arise from congressional attempts to reverse or modify the decision. Whatever one may think of these recent efforts—and I am yet to be persuaded by any of them—and whatever one may think of the morality of abortion, the court's decision 10 years ago was mistaken. That was clear then, and time has only served to emphasize the mistake and to indicate its gravity.

Roe v. Wade boils down to this: A woman has a constitutionally protected right to seek an abortion. It is an absolute right during the first three months of pregnancy. After that, and up to the point of "viability"—which the court defined as the fetus' "capability of meaningful life"—the right may be limited only by the state's interest in protecting the health of the mother. After viability, which the court reckoned to occur at the seven-month mark of a pregnancy, the right may be limited and even proscribed by the state's interest in "the potentiality of human life," unless abortion is necessary to preserve the life or health of the woman.

Note the word "health." Inasmuch as the court, in a companion case to *Roe*, recognized a very broad definition of "health," including the pregnant woman's "emotional well-being," the right to an abortion could easily be exercised in the third trimester of pregnancy. Thus the abortion right announced by the court on Jan. 22, 1973, was virtually unlimited.

Numerous Problems

A wide range of scholars holding both pro- and anti-abortion beliefs quickly pointed out the numerous problems with *Roe v. Wade*. These included mistakes in history, science and law. But the essential difficulty was, as it remains today, that *Roe v. Wade* imposed on the nation a view of the abortion issue lacking constitutional warrant.

A right to abortion obviously can't be found in the Constitution. Neither can it reasonably be concluded from a principled

interpretation of the Constitution. The court thought the right might inhere in the 14th Amendment, but it can lie there only on a reading of individual liberty and the family that has only the slightest legal precedent and flies in the face of American legal and social history.

To be sure, the court did recognize that if the unborn were a person, it would deserve 14th Amendment protection, and the abortion liberty would be significantly circumscribed. But the court combed through the Constitution to conclude that the word "person" in that document nowhere has "pre-natal application." Turning to the experts in medicine, philosophy and theology, the court said that because they could not reach a consensus as to when life be-

Whatever one thinks of the morality of abortion, the Supreme Court's decision 10 years ago was mistaken, and time has only emphasized the gravity of the mistake.

gins, then neither could it, and, thus, neither could the citizens of any state acting through their legislature.

This act of "raw judicial power," as Justice White called it in his vigorous dissent, prevented the states from balancing concern for the mother and concern for the unborn in the many other ways that are clearly possible and which the citizens of the various states then clearly preferred. In 1973, a small number of states permitted abortions of pregnancies involving rape, incest or fetal deformity, and a very few allowed abortions for no reason. All of these states, however, set limits on late-term abortions. No state permitted a right to abortion so expansive as the one protected by the court.

Without clearly adverting to what it surely must have known it was doing, the court gave the green light to abortion for almost any reason, including none at all. *Roe v. Wade* thus was an affront not merely to those who hold that the unborn deserve the fullest protection. It was also an affront to those many Americans who do not consider themselves part of the "pro-life" movement but who deeply believe that abortion involves more serious

ethical considerations than social embarrassment, dislike of children, lost wages, career planning and the "wrong" sex of the unborn child.

Since 1973, the nature of the court's decision has become even clearer. Its essentially legislative character is indicated by the stream of litigants who have gone to the court in 1976, 1977, 1979, 1981 and now again this year asking for clarification and testing the decision's limits. And the fact that it violates the view many people still have of abortion ethics is indicated by the several efforts to hedge the implications of *Roe v. Wade* (such as the Hyde amendment prohibiting federal funding of abortion), some of which have been successful.

With the fetus' status as a human being in limbo, the court said it could not be a constitutionally protected person. The most it would say was that fetuses beyond the 28th week have "potential life"—a curious phrase, inasmuch as some fetuses of even lesser age have had actual life. They have survived outside the womb; miraculously, some have survived despite efforts to abort them.

A case for including the unborn among those covered by the 14th Amendment is at least as plausible as the court's argument that the right to abortion is secured by the Constitution. Protection of the unborn has a more distinguished historical and legal pedigree in this nation than does the liberty to abort. Interestingly, during the latter half of the 19th century, when most states moved to prohibit abortion except when the mother's life was endangered, there was no serious organized opposition arguing for the constitutional right to abortion that the court discovered in 1973. Indeed, women's groups did not oppose the anti-abortion movement.

Even so, the safest conclusion of law and history is that neither the abortion liberty nor the right to life of the unborn is secured beyond doubt by the Constitution.

Faced with this, the court should have deferred to the states and thus to the judgments of citizens as expressed through their legislatures. As Oliver Wendell Holmes once said, wisely, the 14th Amendment does not give the justices "carte blanche to embody [their] economic or moral beliefs in its prohibitions." In *Roe v. Wade*, however, the court read its own moral beliefs into the Constitution to create the abortion liberty and then proceeded to act like a legislature in setting forth the conditions of its exercise.

A Fallible Institution

One of the most serious consequences of the court's decision touches the deepest foundations of our society. Our system of law depends on respect for individual life, a value rooted in the Judeo-Christian ethic. The court's decision in *Roe v. Wade* cannot easily be reconciled with that value. Indeed, it points the way toward a future in which respect for human life becomes, like beauty, merely relative. The court teaches through its decisions, and there is some evidence—one thinks of the "Infant Doe" case in Bloomington last year—to suggest that the people are now more disposed to place relative values on human life.

Today it is fashionable for some to criticize those who say the Supreme Court is wrong. All too frequently defense of a court decision seems to become a statement of the court's infallibility, and too often it is said that the Constitution is what the court says it is. But, as Lincoln once remarked, a decision by the court is not a "thus sayeth the Lord"; the judiciary, like the other two branches of our government, is a fallible institution.

To be sure, it may not be clear what the next step beyond criticism of the court should be—whether legislation, a constitutional amendment, a packing of the court, a withdrawal of jurisdiction—and some steps are wiser than others. But it is certain that whatever step is taken cannot be taken unless those who believe the court was wrong in a given instance speak up when they have the chance. And 10 years ago, in *Roe v. Wade*, the court was wrong—seriously wrong.

Mr. Eastland is editor of the *Virginian-Pilot*.

To Mark & June

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE HARRY A. BLACKMUN

March 8, 1983

Dear Lewis:

Re: Abortion Cases

My writing this letter is presumptuous, but I dare to do so because of experience I have had with the Clerk and the Reporter in the past.

I am in hearty agreement with your treating the Akron case as the primary one. Your three opinions all indicate that the order in which they are to be reported is Akron first, Missouri second, and Simopoulos third. } yes

Numerical order, however, seems to be a routine fact of life here in the Court, and, unless specific and positive instructions are given to Mr. Lind and Mr. Stevas, the case with the lowest number always will be first. This is why Simopoulos was argued first (a mistake in my opinion) at the December session. If you indicate and stress your preference to Henry Lind he will, I am sure, follow it. But, if not, Simopoulos will be reported first and your "post" and "ante" references will be changed.

I certainly shall support you in this minor skirmish.

Sincerely,

Harry

Justice Powell

March 14, 1983

Abortion Cases

Dear Harry:

This is to thank you for your note of March 8 suggesting that Messrs. Lind and Stevas be requested to report these cases in the following order: Akron, Missouri and Simopoulos.

I may well have overlooked the desirability of this.

Sincerely,

Justice Blackmun

lfp/ss

Supreme Court of the United States
Washington, D. C. 20543

CHAMBERS OF
JUSTICE JOHN PAUL STEVENS

Wank -
This seems
OK to me.

May 9, 1983

Re: 81-746 & 81-1172 - City of Akron
v. Akron Center for Repro. Health

Dear Lewis:

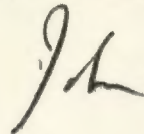
Your new footnote responding to the dissent is effective. You need not change a word to keep me happy, but I have two thoughts to suggest for your consideration:

First, in the third sentence of the second paragraph, would it not be more accurate to say that the dissent's reasoning "would accomplish precisely that result."

Second, in the next to the last sentence in the footnote, I wonder if you might consider a revision along these lines: "In sum, it appears that the dissent would uphold virtually any abortion-inhibiting regulation because every such regulation is rationally related to the State's interest in preserving potential human life. This analysis is wholly incompatible"

As I say, these are just suggestions.

Respectfully,



Justice Powell

Justice
Blackmun
He declined

lfp/ss 06/14/83

81-746 City of Akron v. Akron Center
for Reproductive Health, Inc.

AKRON SALLY-POW

This Term we have considered three cases that present challenges to laws regulating abortions. In Roe v. Wade this Court recognized a woman's constitutional right to choose abortion - subject to the state interests also recognized by the Court. Roe was decided a decade ago. None of our subsequent cases has questioned Roe's authority as a constitutional precedent. We respect the doctrine of stare decisis, and today we reaffirm Roe.

The first of the three cases is here from the Court of Appeals for the Sixth Circuit. This case involves a comprehensive city regulatory ordinance. Its validity was questioned by several abortion clinics and physicians. Five of the ordinance's provisions are at issue here.

The first and most important requires that all second-trimester abortions be performed in an acute care, full service hospital. If valid, it would prevent this surgical procedure from being performed in an outpatient clinic - however well staffed and equipped.

The Court of Appeals held that this hospital requirement is constitutional.

In Roe v. Wade we held that, beginning at approximately the end of the first trimester of pregnancy, a state ^{may}~~may~~ enact abortion regulations that reasonably relate to the preservation and protection of maternal health. It was made clear, however, that a state is not free to adopt regulations that depart from accepted medical practice, and that impose unnecessary burdens on a woman's access to an abortion.

There is convincing evidence - accepted by the American College of Obstetricians and Gynecologists and other medical authorities - that abortions - at least during the first few weeks of the second trimester - can be performed safely in appropriate non-hospital facilities at substantially less cost than in a full hospital.

In light of the record in this case, we think the Akron hospital requirement unnecessarily and unreasonably burdens the woman's right. We therefore reverse the Court of Appeals on this issue.

There are four other provisions of the ^{Akron}~~the~~ ordinance before this Court. They relate to (i) parental consent, (ii) informed consent, (iii) a 24-hour waiting period, and

(iv) disposal of fetal remains. For the reasons stated in our opinion, we agree with the Court of Appeals that each of these provisions also is invalid.

Justice O'Connor has filed a dissenting opinion, joined by Justices White and Rehnquist.

lfp/ss 06/14/83

81-1255 Planned Parenthood Association
of Kansas City, Inc. v. Ashcroft

SPEECH2 SALLY-POW

The second of these cases comes to us on certiorari to the Court of Appeals for the Eighth Circuit. It involves four provisions of a Missouri statute that comprehensively regulates the performance of abortions.

The first of these is a hospital requirement substantially similar to that in Akron. For the reasons stated in that case, we affirm the judgment of the Court of Appeals that the Missouri requirement is invalid.

A second provision requires minors to secure parental or judicial consent before obtaining an abortion. The Court of Appeals sustained the validity of this requirement. We agree and affirm its judgment.

A third provision requires a ~~pa~~/tholgy report for each abortion performed. The Court of Appeals invalidated this requirement. We disagree and reverse.

Finally, a fourth provision requires the presence of a second physician during abortions performed after the fetus has become viable. The Court of Appeals invalidated this provision.

As was made clear in Roe, after viability the state has a compelling interest in preserving the life of a viable fetus. We think the Court of Appeals erred in invalidating the second-physician requirement, and we reverse its judgment.

The views of the Justices, however, have diverged considerably on the issues in this case.

With respect to the several opinions, Parts III, IV, and V of my opinion were joined only by the Chief Justice.

Justice Blackmun has filed an opinion concurring with respect to the hospital requirement, but dissenting on the other three issues. His opinion is joined by Justices Brennan, Marshall, and Stevens.

Justice O'Connor has filed an opinion dissenting from the judgment on the hospitalization issue, but concurring in the judgment on the other three issues. She is joined by Justices White and Rehnquist.

lfp/ss 06/14/83 81-185 Simopulous v. Virginia

SPEECH3 SALLY-POW

This is an appeal from the Supreme Court of Virginia. The appellant is an obstetrician-gynecologist. At his unlicensed clinic, he performed an abortion - by injection of saline solution - on a 17-year-old woman who was approximately 22 weeks pregnant.

Appellant was convicted of violating the Virginia statute requiring that second-trimester abortions be performed in a licensed hospital. The Supreme Court of Virginia affirmed the conviction.

Under Virginia law, the term "hospital" is defined to include outpatient hospitals. Regulations of the Virginia Department of Health provide that second-trimester abortions may be performed in outpatient surgical hospitals licensed by the state. Unlike the City of Akron ordinance and the State of Missouri statute, Virginia does not require that second-trimester abortions be performed in acute-care, full-service hospitals.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.

We have not considered whether the regulations are constitutional in every particular, for appellant declined to challenge them specifically.

We have no reason to doubt, however, that an adequately equipped clinic - upon proper application - could be licensed to perform second-trimester abortions.

We conclude, therefore, that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of further^{ing} the state's compelling interest in protecting the woman's health.

The judgment of the Supreme Court of Virginia is affirmed.

Justice O'Connor, joined by Justices White and Rehnquist, has filed an opinion concurring in part and concurring in the judgment in part. Justice Stevens has filed a dissenting opinion.

lfp/ss 06/14/83

81-1255 Planned Parenthood Association
of Kansas City, Inc. v. Ashcroft

SPEECH2 SALLY-POW

The second of these cases comes us on certiorari to the Court of Appeals for the Eighth Circuit. It involves four provisions of a Missouri statute that comprehensively regulates the performance of abortions.

The first of these is a hospital requirement substantially similar to that of Akron. For the reasons stated in that case, we affirm the judgment of the Court of Appeals that the Missouri requirement is invalid.

A second provision requires a pathology report for each abortion performed. A third provision requires minors to secure prental or judicial consent before obtaining an abortion. The Court of Appeals sustained the validity of both of these requirements. We agree and affirm its judgment.

Finally, a fourth provision requires the presence of a second physician during abortions performed after the fetus has become viable. The Court of Appeals invalidated this provision.

As was made clear in Roe, the state's interest in the woman's health is compelling, but after viability

the state also has a compelling interest in preserving the life of a viable fetus. We think the Court of Appeals erred in invalidating the second-physician requirement, and we reverse its judgment.

The views of the Justices, however, have diverged considerably of the issues in this case. To this point I have announced only the judgment of the Court.

With respect to the several opinions, Parts III, IV and V of my opinion were joined by the Chief Justice.

Justice Blackmun has filed an opinion concurring with respect to the hospital requirement, but dissenting on the other three issues. His opinion is joined by Justices Brennan, Marshall and Stevens.

Justice O'Connor has filed an opinion dissenting from the judgment on the hospitalization issue, but concurring in the judgment on the other three issues. She is joined by Justices White and Rehnquist.

CASE	ISSUE/REQUIREMENT	DECISION BELOW	VOTE
Simopoulos v. Virginia No. 81-185 S.Ct. Va.	Failure to allege or prove lack of maternal necessity	Defendant must raise necessity defensively; State must disprove it.	<u>Affirm</u> - after our conversation, I re-affirmed the Va. S. Ct.'s opinion: I think it fairly can be read to state that <u>only</u> the medical necessity defense must be invoked by the deft. If other elements must be "involved" by deft, they can be taken care of in later
	Failure to prove causation	State proved causation.	<u>Affirm</u> - No problem here
	Hospitalization in 2d trimester	Requirement held valid	<u>Affirm</u> - if the Court reaches this issue, then this case should
Planned Parenthood v. Ashcroft No. 81-1255 CAB	Parental Consent (i) Should Court abstain? (ii) Merits	I do not think this is really an issue here. Although Mo. has not construed its own act, there is no reason not to defer to the CAB's generous construction. Statute given construction consistent with Bellotti II.	<u>Affirm</u> - probably the lead case in the trilogy - the CAB construed the Mo. statute as I understand it, consistent with your decision in Bellotti II & Matheson. If you see no inconsistency between your view and the CAB's siding construction, I would affirm
Ashcroft v. Planned Parenthood No. 81-1623	Hospitalization in 2d trimester (i) Hospitals require parental consent of it to admit minors	If later Mo. changed to the CAB's construction, or if the CAB's construction is inconsistent with Bellotti, the fed. courts can take invalidated after remand Hospitalization requirement not invalidated on this basis.	<u>Affirm</u> - if the Court is willing to change test to something more in line w/ strict scrutiny - otherwise, I would Reverse: creates a bright-line
	Pathologist must examine tissue samples	Invalid.	<u>Affirm</u> - close case under strict scrutiny - <u>Reverse</u> under current standard
	Second physician for fetus after viability	Invalid.	<u>Reverse</u> - in last periods of pregnancy, state's interests are paramount
	Attorneys fees	Awarded in full to PP for work in 1255&1623.	<u>Reverse</u> & Remand for consideration of action 73/Hendley v. Eckerhart No. 81-1255
Akron v. Akron Ctr for Reproductive Health No. 81-746 CA6	§1870. Parental Consent §1870.05 (i) Jurisdiction (B) (ii) Merits	DIG or <u>Affirm</u> - I still have some problems w/ whether these issues are properly before us, given the parties that appealed to the CAB: the fact that we denied their cert. petition	
	Parental Notification I do not understand this issue to be before us (who would have appealed?)	Valid under Matheson.	- if the Court decides it is inconsistent with your view in Matheson
	(A) Informed Consent (i) Severability (ii) Provisions (iii) Attending doctor must counsel personally	Invalid Invalid.	<u>Affirm</u> - under strict scrutiny, most of this would be invalid - even under current standard most of this is suspect, although you might be able to uphold the information on pregnancy
There is a separate section under review for risks of abortion	Waiting Period	Invalid	<u>Affirm</u>
	Disposal of Fetal Remains	Invalid	<u>Affirm</u> - defer to lower judges on vagueness issue
Akron Ctr for Reproductive Health v. Akron No. 81-1172	Hospitalization in 2d trimester	Valid.	<u>Reverse</u> - if Ct. shifts to more strict scrutiny

SIMOP14 SALLY-POW

The regulations applicable to "outpatient abortion clinics" include some provisions explicitly addressed to abortion. In most respects, they are identical to those applicable to "other outpatient surgical hospitals" as defined. See supra, at p. _____, n. ____ and _____. The regulations may be grouped for purposes of discussion into three main categories.

The first grouping relates mainly to organization, management, policies and staffing - matters not presently relevant. These do require personnel and facilities "necessary to meet patient and program needs." §§40.1, 40.3. They require a policy and procedures manual, §43.2,¹² an administrative officer, §40.6, and a

lfp/ss 02/02/83

Rider A, p. 2 (Simopoulos)

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by means of an injection of a saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and she understood that appellant agreed this was all right. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated she had undergone "a surgical procedure" and warned of a "wide range of normal reactions". The sheet also advised that she call the doctor if "heavy bleeding began". Although P.M. does not recall being advised to go to a hospital when labor began, this was specified in the instruction sheet.

* * *

Jim: I have elaborated on the facts a bit, as these are important background to this case. My facts came from the opinion of Virginia Supreme Court. They are not questioned by petitioner's briefs.

1st draft
LFP

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by means of an injection of a saline solution. P.M. told petitioner that she planned to deliver the fetus in a motel, and petitioner agreed that this was all right. Petitioner gave P.M. a "Post-Injection Information" sheet and a perscription for an analgesic that her advised her she had undergone "a surgical procedure" and warned of a "wide range of normal reactions". The sheet also advised her to call the doctor if "heavy bleeding began". Although P.M. does not recall being advised to go to a hospital when labor began, this was specified in the instruction sheet.

Jim: I have elaborated on the facts a bit, as these are important background to this case. My facts came from the opinion of Virginia Supreme Court. They are not questioned by petitioner's briefs.

lfp/ss 02/02/83

Rider A, p. 17 (Simopoulos)

SIMOP17 SALLY-POW

III

Appellant does not attack these regulations as such either in his jurisdictional statement or principal brief. In these, he emphasizes that Virginia requires hospitalization for second trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics and specifically those that may be licensed for abortions. As appellant had not sought a license for his clinic, perhaps he deemed it necessary broadly to equate the Virginia provisions with the hospitalization requirements we have considered in City of Akron and Ashcroft. Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that even if he had applied for a license, it is uncertain whether it would have been granted; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; that Part II of the regulations (see, supra, at _____) do not "cover a surgical facility where second trimester abortions [are] performed"; and that medical evidence rebuts the view that it is "safer to perform trimester

abortions in hospitals". Appellant's reply brief, pp. 9-13. None of these contentions finds support in the prior decisions of this Court, and the Virginia requirements are strikingly different from those we invalidated in City of Akron and Ashcroft. Indeed, it is evident that Virginia has made a thoughtful effort to adopt statutes and regulations compatible with our decisions. We are convinced that the Virginia provisions are reasonably related to and further the state's compelling interest in protecting the health of the mother during the second trimester, and that they do not unduly burden the right of a woman to an abortion.

The requirements of the first and second categories of regulations discussed in Part II-C above have little relevancy in this case. They have not been challenged by appellant beyond his general condemnation of any requirement that second trimester abortions - even those during the 22nd week of pregnancy - be performed in hospitals however defined and whether outpatient or not. In any event, as appears from the recommendations of the ACOG set forth in the margin below, Virginia requirements with respect to the type of facilities, equipment and

personnel are compatible with generally accepted medical standards, and further the state's legitimate interest.

Appellant's argument centers essentially on the patient services requirements of the Virginia regulations. He contends that they do not further the state's interest in the health of the mother. We think they clearly do. The sanitation²⁹ and record keeping standards³⁰ are typical and not unreasonable in detail. The laboratory services support - and often are essential to - the direct medical services performed by the physician and nurse.³¹ The post operative recovery standards also comport with accepted medical practice.³² The equipment requirements for emergency services are minimal³³, and are further prefaced with the "adequate".³⁴

We do not suggest that all of the Virginia requirements are necessary for every second trimester abortion. A state simply cannot adopt regulations that serve every case with the same degree of relevance. Following -- as we must -- Doe and subsequent precedents, we adhere to the trimester periods as providing general guidance for the purpose of state regulation in accordance with medical knowledge and generally accepted standards. The trimester periods are approximations. As we noted in

City of Akron, in light of current medical knowledge and experience - and particularly the use of the saline injection method -- abortions may be performed safely in most cases during the early weeks of the second trimester. But a state's general regulations must be drawn to accommodate reasonable periods of time. Thus, a particular requirement "is not unconstitutional simply because it does not perfectly correspond to the asserted state interest". City of Akron, ____ U.S., at ____.

We therefore conclude, at least on the record before us in this case, that Virginia's regulation of second trimester abortions is reasonably related to and furthers the state's legitimate interest in the health of the mother. We note that Virginia does not require the patient to be hospitalized as an inpatient or that the abortion be performed in a full service general hospital. The Virginia requirements - the statutes and regulations - accommodate medical advances, are in accord generally with accepted medical requirements, and leave the type and timing of the abortion precisely where it belongs -- between the physician and his patient.

Note to Jim and Mark: The foregoing rider, as you will have observed, is a condensed revision of Jim's draft pages 17-23. I would put this discussion in a separate Part III.

The foregoing is by no means a draft to be accepted by you or even by me. Jim can use it as a general guide for putting this Part III into a more finished form.

I will discuss certain points orally with you both.

L.F.P., Jr.

ss

RIDER A

5. ~~That~~ The Supreme Court of Virginia interprets the word "hospital" in §18.2-73 ~~the same~~ as it is defined in §32.1-123.1 is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, ~~which is titled "Health"~~: *many of* *This* *the Title of the Code that contains Virginia's*

The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, see generally, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health. *health laws!*

221 Va., at 1075, 277 S.E.2d, at 204. *ST* There thus is no basis for assuming that the court interpreted "hospital" in §18.2-73 any differently than it is interpreted in title 32.1, and specifically in §32.1-123.1. See n. 6, infra.

Note to Jim: Would it not be better to have Rider B, defining hospitals, precede this note?

RIDER A

5. The Supreme Court of Virginia interprets the word "hospital" in §18.2-73 as it is defined in §32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the Title of the Code that contains many of Virginia's health laws:

The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, see generally, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health.

221 Va., at 1075, 277 S.E.2d, at 204. Thus there is no basis for assuming that the court interpreted "hospital" in §18.2-73 any differently than it is interpreted in title 32.1, and specifically in §32.1-123.1. See n. 6, infra.

→ Note to Jim: Would it not be better to have Rider B, defining hospitals, precede this note?

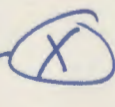
RIDER B

6. Section 32.1-123.1 provides:

"Hospital" means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitoriums and general acute, short-term, long-term, outpatient and maternity hospitals.

The definition of hospital in effect in 1975 when §18.2-73 was enacted is similar, see 1947 Va. Acts, c. 15, §1514-a2, repealed by 1979 Acts, c. 711, specifically including^{ed} at that time "out-patient surgical hospitals (which term shall not include the office or office of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)." See Va. Code §32.298(2) (1973 & Supp. 1978).

RIDER C

7. The regulations were promulgated pursuant to 1947 Va. Acts, c. 15, §1514-a5, repealed by 1979 Acts, c. 711. The State Board of Health gave preliminary approval on December 1, 1976, and a public hearing was held January 26, 1977. At this hearing, Dr. William R. Hill, a member of the Board, presided, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, a Division of Medical Center Hospitals, in Norfolk; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Board apparently made changes in the regulations before giving its final approval on May 11, 1977. The regulations became effective on June 30, 1977. 

of no direct relevance to this case,
4/ Although ~~not particularly relevant here,~~ we note that new but similar regulations now supersede the regulations in effect when

appellant performed the abortion for which he ~~has been~~^{was} prosecuted.
See Department of Health, Rules and Regulations for the Licensure of
Hospitals in Virginia, pt. IV (1982). These new regulations were
promulgated pursuant to Va. Code §§32.1-12, 32.1-127, ~~which were~~
enacted in 1979.

← The abortion for which petitioner was prosecuted was performed on November 10, 1979, some two years and five months after these regulations became effective on June 30, 1977. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said - and indeed ^{appellant} petitioner does not argue - that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

Although of no direct relevance to this case, we note that new but similar regulations

lfp/ss 03/09/82

Rider Y, p. 5 (Simopoulos)

YP5 SALLY-POW

Appellant does not argue that his clinic would meet the requirements of the Virginia statute and regulations; rather, he broadly attacks their validity as applied to second-trimester abortions. Thus, the issue before us is the validity of the Virginia requirements; not whether appellant's clinic and his procedures would have complied with them.

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in City of Akron, ante, at 13, and Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft, ante, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." City of Akron, ante, at 19. The requirements at issue, however, mandated that "all second-trimester abortions must be performed in general, acute-care facilities." Ashcroft, ante, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in City of Akron and Ashcroft are not controlling here.

5/12

sim 12

RIDER B

We need not consider each of the regulations separately. Despite personal knowledge of the regulations at least by the time of his trial,¹⁹ appellant introduced no medical evidence questioning the reasonableness of any of them. This is to be contrasted with the evidence in City of Akron and Ashcroft, where the plaintiffs sought at great length to show that particular requirements as to equipment and services were unreasonable restraints on women seeking second-trimester abortions. Appellant persisted in arguing broadly that Virginia's hospitalization requirements are no different in substance from those we reviewed in the City of Akron and Ashcroft cases.²⁰ Indeed, not until his reply brief in this Court did appellant criticize the regulations apart from Virginia's statutory hospitalization requirement.

lfp/ss 03/14/83

Rider A, Simopoulos

SIMOR SALLY-POW

The most important difference was that the requirements now in Part II of the regulations were applicable to all outpatient clinics, in which abortions could be performed, regardless of the trimester. Thus, no distinction^w as made between first and second trimester abortions with respect to the appropriateness of and need for state regulation. ^{Following these} ~~As a result of the hearings,~~ Part III of the present regulations - relating only to first trimester abortions - was added. It therefore is clear that Virginia has recognized the need for discrete and different types of regulations for the two periods.

RIDER B

The Executive Director of the Virginia Hospital Association stated that "[i]n general, they are a good set of standards and have our support." Id., at 4. The existing abortion clinics were concerned, however, about the imposition of the regulations on existing outpatient abortion clinics doing first-trimester abortions. The clinics acknowledged that during the second trimester "the State may regulate the procedure in the interest of maternal health. This is the law of the land." Id., at 7. But the clinics specifically "propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia." Id., at 26. See also id., at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to regulate outpatient surgical clinics in the State, agreed that such a change was necessary, saying "it would be an irrevocable mistake to allow compromise of the standards for outpatient surgical units to accommodate abortion clinics if they are both to be considered under the same Regulations." Id., at 30. ~~Given these comments, it is not surprising that the Board created~~ Part III, the regulations of which apply only to clinics doing first-trimester abortions. The Board gave its final approval to the regulations before us on ^{June} May 11, 1977.

Following the hearing the Board, ^{added} ~~adopted~~

June - I don't want to give 100% credit to hearings. The Board may have had legal advice also.

RIDER A

The first draft of the regulations was considerably different from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976).

Were these unchanged? Why include I in this sentence
The most important difference was that the requirements now in Parts I and II of the regulations were applicable to all ^{outpatient} ~~abortion~~ clinics, regardless of the trimester in which the procedure was performed.

There was no separate set of regulations for outpatient abortion clinics ^{in which only first trimester abortions are performed} only, such as existed in Part III in the final regulations.

See n. 9, infra.

As a result of the hearings, Part III of the present regulations was added. It therefore is clear that the Virginia has recognized - and provided for - the

lfp/ss 03/14/83

SIM SALLY-POW

81-185 Simopoulos v. Virginia

MEMORANDUM TO THE CONFERENCE:

This refers to Harry's letter of March 8 stating that he will vote to vacate the judgment and remand [this] case for reconsideration in the light of Akron. He suggests that the Virginia regulations were not "really considered by the Supreme Court of Virginia". Bill Brennan has told me that he rather shares Harry's view, and John's letter of March 7 expresses a somewhat similar view, though he is awaiting "further writing".

I recognized, of course, that vacating and remanding is an option available. I adhere strongly to the view, however, that we should decide the case. In my

1244

No. 82-151

No. 81-1782 | No. 81-185

No. 8

should this be said?

view, the issue on which we granted the case is here, and it was argued in briefs and at oral argument.

~~It is true that~~ the primary focus in this case has been, as appellant describes it, on the "mandatory hospitalization requirement of Virginia law". Appellant had good reason to refrain from making the distinction under Virginia law between ^(general) ~~full service~~, acute care "hospitals" and "out-patient surgical hospitals" where second ^A trimester abortions also may be performed.

Appellant did not wish to call our attention to the latter and the implementing regulations as he had made no effort to comply with them. Moreover, appellant has never denied that he knew about the regulations. As I have now made clear in footnotes 6 and 7 in the second draft of my opinion, the regulations were adopted two years and five

months ^(before) ~~prior to~~ the abortion at issue. They were adopted only after public hearings at which several abortions clinics and representatives of the medical profession appeared and testified. The hearings resulted in significant changes being made in the regulations. See n. 7.

It is entirely clear from the Virginia statutes that the term "hospitals" includes outpatient clinics though they are characterized as "outpatient . . .

hospitals". It also is clear that Part II of the

✓ regulations was adopted expressly to accommodate ^{first -} ~~second~~ trimester abortions. ^{and that Part II was meant to regulate second-trimester abortions.} See ⁽ⁿ⁾ fn. 7 and 9. As the [#]

Attorney General of Virginia stated in his brief:

✓ Under Virginia law, a second trimester abortion may be performed in an outpatient surgical

✓ clinic provided that [the] clinic has been inspected and licensed as a hospital by the state". Br. 19.

(Brief for Appellee)

The opinion of the Supreme Court of Virginia, as Harry notes, apart from a reference to the relevant Virginia statutes, did not address the outpatient hospitals separately from general, acute care hospitals.

✓ This is understandable[^] as appellant's position has been a sweeping attack on all "mandatory hospitalization requirements". There certainly is no basis for reversing Simopoulos' conviction. He elected, apparently as a tactic, not to challenge the outpatient regulations on all of Virginia's hospital requirements.

I am not sure I understand this sentence

If we were to remand this case for reconsideration in light of Akron, it would be an unmerited victory for appellant's tactics. Moreover, it

is not clear what the Virginia Supreme Court can do that
 we also cannot do properly. ^(Appellant do not set forth) ~~There is no~~ factual evidence
 in this case with respect to the ^(reasonableness of the) regulations, ^{as} Rather,
^{he makes a}
~~distinguished from appellant's~~ general challenge to the
 validity of all mandatory hospitalization requirements.

The Virginia Supreme Court rejected this challenge, and

its opinion can be read - in light of Virginia law - as

^{any hospitalization of a full service}
 sustaining ~~facially~~ both of the state's hospitalization
 requirements, including ^(both) those ^(that permit) for second trimester
^(in outpatient clinics) abortions as well as ^(requiring the procedure to be performed) for those performed in acute care

hospitals. Akron and Ashcroft settled the issue with

respect to the latter type of hospitals. This leaves, as

the issue before us, whether ~~the~~ mandatory outpatient

hospitals requirements are valid on their face. We would

have a different case if appellant had elected to

bath?

2

challenge - as constitutionally burdensome or otherwise - specific provisions of these requirements.

It is well to bear in mind that this case involves an abortion performed some 20 to 22 weeks after gestation, on the edge of the period of potential viability. Under any view of our prior decisions, including Akron, the interest of the state at this point is compelling. All that my opinion does is to hold that the Virginia regulations "on the record before us" (see pp. ¹⁴~~12~~ and ²⁰~~17~~) are not invalid. We certainly do not decide whether each of the specific regulations would be valid if, for example, they were applied to a D&E abortion quite early in the second trimester.

At the prudential level, there also are rather compelling reasons to decide this case rather than remand

I'd avoid this. I'm troubled by idea that reg might be unconstitutional applied to diff abortions.

it. The latter action would leave the law in Virginia -
and probably in a number of other states - unsettled as to
✓ the validity of requiring that second^Δ trimester abortions
✓ be performed in state^Δ licensed outpatient clinics that
conform generally to accepted medical practice and
requirements.

7.
My recollection is that there were seven or
eight cases pending here that involved the validity of
state regulation of abortions. After consideration at two
or more of our Conferences, we selected for plenary
consideration the three cases now before us. In the
✓ decade since Doe^Δ states have been endeavoring to adjust
their laws and regulations to the new constitutional
requirements. Decisions by us in all three of these cases
should go far to resolve the existing uncertainties.

L.F.P., Jr.

SS

lfp/ss 05/07/83

Simopoulos, p. ~~11~~12 (HAB's revision)

SIM11 SALLY-POW

We need not consider whether Virginia's regulations are constitutional in every particular. Despite personal knowledge of the regulations at least by the time of his trial, [✓]appellant has not attacked them as being insufficiently related to the State's interest in protecting maternal health.¹⁹ His challenge throughout this litigation has been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. In essence, appellant has argued that Virginia's hospitalization requirements are no different in substance from those reviewed in the City of Akron and Ashcroft cases.²⁰ At the same time, however, appellant took the position - both

before the Virginia courts and this Court - that a state licensing requirement for outpatient abortion facilities would be constitutional. See 9 Record 196a, 214a; Brief for Appellant in No. 801107 (Va.S.Ct.), p. 35; Juris. Statement 16; Brief for Appellant 32, 43 n. 75, 46. The clear implication ^{therefore,} of appellant's defense in this case is that the Virginia requirements for outpatient facilities in which second-trimester abortions may be performed are unconstitutional. Yet, not until his reply brief in this Court did he elect to criticize the regulations apart from his broadside attack on the entire Virginia hospitalization requirements.

Given the plain language of the Virginia regulations and the history of their adoption, see notes _____, supra, we see no reason to doubt that an

adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions.

W.F.P.

lfp/ss 05/07/83 Simopoulos, p. 11,12 (HAB's revision)

SIM11 SALLY-POW

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lfp/ss 05/07/83 Simopoulos, p. 11,12 (HAB's revision)

SIM11 SALLY-POW

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Given the plain language of the Virginia regulations and the history of their adoption, see notes _____, supra, we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions.

File

lfp/ss 04/11/83

Rider A, p. 13 (Simopoulos)

SIM13 SALLY-POW

We need not consider each of the regulations separately. Despite personal knowledge of the regulations at least by the time of his trial,¹⁴ appellant introduced no medical evidence questioning the reasonableness of any of the regulations. This is to be contrasted with the evidence in City of Akron and Ashcroft, where the plaintiffs sought at great length to show that particular requirements as to equipment and services were unreasonable restraints on women seeking second-trimester abortions. Rather, appellant persisted in arguing broadly that Virginia's hospitalization requirements are no different in substance from those we reviewed in the Akron and Ashcroft cases. Indeed, not until his reply brief in

this Court did appellant criticize the regulations apart from Virginia's overall requirements.

lfp/ss 03/03/83

Rider A, p. 12 (Simopoulos)

SIMOP12 SALLY-POW

Only the last of these arguments is relevant to the validity of these statutes and regulations, and appellant points to not evidence that supports his sweeping claim of "safety". We have noted above that the Virginia requirements are strikingly different from those we invalidated in City of Akron and Ashcroft. Compliance with the state's requirements will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people. Moreover, ethical physicians are obligated to

*Give
in it State
Board or
Department?*

*Jim - reference to 1947 (pre-Doe) tends
to divert attention from our main point
The ~~to~~ history of § 1514-a5, etc., is clear
enough elsewhere*

RIDER C

*the authority vested
in the State Board of
Health by § 1514-a5.*

7. The regulations were promulgated pursuant to 1947 Va. Acts, c. 15, § 1514-a5, repealed by 1979 Acts, c. 711. The State Board of Health gave preliminary approval on December 1, 1976, and a public hearing was held January 26, 1977. At this hearing, Dr. William R. Hill, a member of the Board, presided, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, a Division of Medical Center Hospitals, in Norfolk; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Board apparently made changes in the regulations before giving its final approval on May 11, 1977. The regulations became effective on June 30, 1977. The abortion for which petitioner was prosecuted was performed on November 10, 1979, some two years and five months after these *the effective date.*

~~regulations became effective.~~ In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said -- and indeed appellant does not argue -- that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

Although of no direct relevance to this case, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§32.1-12, 32.1-127, enacted in 1979.

lfp/ss 11/22/82

MEMO TO FILE

Abortion Cases

As more Amici briefs have been filed than one could read, and as they also inevitably are repetitive, I have focused on several. This memo will identify their positions.

SG's Brief

The SG's brief is filed only in the Akron and Missouri cases, and it does not address the various issues. Rather, it is a brief articulating principles with particular emphasis on the deference due legislative decisions on a subject of social and political controversy. The brief is well written, and uses our decisions skillfully.

The Proper Standard

CA6 (Akron) held that any regulation having a "legally significant impact . . . on a first trimester abortion decision . . . is invalid". The SG asserts this is a new standard not found in our decisions, and would significantly expand the "abortion right".

Our decisions make clear that the "right of personal privacy", held in Roe v. Wade to include the abortion decision, is not an unqualified [right] and must be considered against important state interests in regulation". Roe v. Wade, 410 U.S. at 154. The correct standard, as repeatedly articulated in our cases, is whether the

regulation is "unduly burdensome". Maier v. Roe, 432 U.S. 464, 473-474 (unduly burdensome interference with [the woman's right] to decide whether to terminate her pregnancy); Bellotti I, 428 U.S. 132, 147 (regulation of first trimester abortions "is not unconstitutional unless it unduly burdens the right to seek an abortion"); and repeated in Harris v. McRae, 448 U.S. 297, 314; Beal v. Doe, 432 U.S. 438, 446.

The SG quoted from my opinion in Maier:

"The right in Roe v. Wade can be understood only by considering both the woman's interest and the nature of the state's interference with it. Roe did not declare an unqualified constitutional right to an abortion."

Informed Consent Approved

As an illustration of a regulation held valid by this Court, the SG cites Danforth, 428 U.S. 52, 66-67, where we upheld "informed consent" and record keeping requirements. The consent provision in Danforth required a woman to "certify in writing her consent to the procedure and that her consent is informed and freely given and is not the result of coercion, 428 U.S., at 65 (emphasis added). The SG observes that Danforth noted the strength of the state interest furthered by the informed consent regulation, weighed it against its intrusion upon a woman's unfettered discretion, and concluded that it did not unduly burden the abortion decision.

Substantial Deference Due Legislative Judgment

The greater portion of the SG's brief is a plea for judicial restraint and deference to legislative judgments. He makes the valid argument that the abortion issue has been, and will continue to be, the "focus of great national debate". The sub-issues in the debate are numerous and complex. American citizens are deeply and passionately divided. In a democracy the legislature is the "primary authority" with "responsibility to resolve competing policy views".

As an illustration, the SG notes that "parental entitlement to notification of or participation in an immature daughter's decision that could profoundly affect her life presents competing considerations whose resolution lie at the very core of what legislators are elected to do. See H.L. v. Matheson, 450 U.S., at 408-410.

The SG notes the basic differences between the legislative and judicial branches: first, the superior capacity of a legislature to hold hearings and find facts. Second, legislators - elected by the people - must account periodically to the people for the way they legislate, and this is the heart of our democratic process that assumes a "full and uninhibited discussion of public issues". Finally, legislative decisions can be changed and constitutional ones cannot.

The SG quotes from my opinion in U.S. v. Richardson, 418 U.S., at 188. In footnote 8, p. 13 of his brief, the SG quotes the usual statements with respect to judicial restraint. He relies, for example, on Bickel, The Least Dangerous Branch, p. 15.

Time for the Judiciary to Allow the Legislative Process to Function

It is pointed out that "ten years ago", in Roe, the Court adopted a three-part set of rules with respect to the stages of pregnancy. We left many questions unanswered, and over the intervening decade, litigation has multiplied with the result that the" rules [have] become increasingly intricate and substantially more complicated" Here, the SG cites Matheson, Harris, Bellotti I and II, Colautti v. Franklin, 439 U.S. 379, Maher, Beal and Danforth.

The final plea is that in applying the "undue burden standard", we should accord "substantial deference" to legislative judgment.

L.F.P., Jr.

ss

Abortion Cases - Professors' Brief

Eighty-five professors have joined in a brief by Paul Brest and Susan Appleton that is a well written, but repetitive, argument that - at least for adult women - is strongly pro-abortion. The analytical approach of the brief is straight-forward, and may be consistent with Roe - though possibly inconsistent with some of our subsequent decisions (e.g., Maher and Danforth).

Two-Step Analysis

This is emphasized throughout the brief, and summarized on p. 32 as follows:

"First, a court must examine whether or not the regulation is state action imposing any burden at all on the right to obtain an abortion. The question here is not one of degree but simply whether the regulation affirmatively imposes any legally cognizable burden. If it does not, then the analytical framework developed in Roe does not govern. See Danforth; Maher; McRae. If, however, the regulation imposes any burden on the right recognized in Roe, then as a second step, strict judicial scrutiny must be applied to determine whether that burden is undue--that is, whether it is properly justified by a compelling state interest and sufficiently narrowly tailored to further that goal. See McRae, 468 U.S. at 314; Maher, 432 U.S. at 473-74." p. 32

With respect to the second step, only two state interests have been identified: (i) the compelling character of a state's interest in protecting maternal health only after the first trimester, and the "compelling

character of a state's interest in preserving potential life only after fetal viability", Roe, 410 U.S., at 163-164.

The reason the state's interest in protecting maternal health is said to be compelling only after the first trimester, is that medical testimony establishes that the risk to maternal health during the first trimester is less than at childbirth.

Void All Regulation before the Court

This brief asserts that "all of the regulations now before this Court interfere directly with the right recognized in Roe should be held void". According to the records, they significantly burden the abortion decision and its effectuation by making termination of a pregnancy more onerous, more costly, more time consuming, and - sometimes - more hazardous". Brief, p. 33, 34.

Then, the brief delivers the "knockout", by asserting that "all of the measures applicable to abortions sought by adult women during the first trimester must fall because neither state interests identified in Roe is sufficiently compelling during that stage to support such restrictions". p. 34, 35. Accordingly, all of the first trimester regulations here are "unduly burdensome". Citing McRae, 448 U.S., at 314, Maher, 432 U.S., at 473.

Resort to "Balancing Test" Impermissible

In a subsection commencing at p. 41, the state argues against "resorting to a balancing test or a sliding scale analysis".

Its position is summarized as follows:

"Only the 'compelling state interest' test--applied here and in all fundamental--rights cases--promises adequate protection of fundamental constitutional rights, consistency with this Court's precedents, and elimination of the uncertainty that a variable standard of review resting on ad hoc assessment of burdens generates." 41

Unique Status of Children

In a brief concluding section, the professors concede that children have a unique status. It also emphasizes that children have constitutional rights and quotes at length from Carey, 431 U.S., at 693 (a favorite of the professors, though not an abortion case).

The brief "explicitly refutes" Judge Kennedy's dissenting opinion in Akron in which she argues for a "sliding scale standard of review for all abortion regulations, whether applicable to minors or adults".

The brief identifies (p. 60) the three concerns "uniquely relevant to minors": (i) the vulnerability of children; (ii) their inability to make informed decisions; and (iii) the importance of the parental role in child rearing. Citing my Bellotti opinion, 441 U.S., at 634.

After noting that these special concerns for children do not support a state-granted parental veto (Danforth), "a majority of the Justices would approve a more narrowly drafted statute allowing minors judicially determined to be mature to make their own abortion decisions, while requiring immature minors to obtain a consent substitute, parental permission or judicial authorization" predicated on the minor's best interests. Citing Bellotti, at p. 643-644.

It noted that Matheson approved a parental notification requirement except with respect to mature or emancipated minors or where best interests to the contrary can be shown.

The brief states that a "special standard of review" is appropriate with respect to regulation of minors, but does not define the standard.

* * *

I would like for my clerk to make an independent judgment as to the professors' characterizations of our decisions, particularly with respect to the absolutism of all restrictions - however slight or inherently reasonable - on adult women without meeting the compelling interest standard. My recollection is that there is language in Maher to the contrary, but perhaps I am wrong.

The professors' brief does not address some of the issues that I believe are raised in one of more of these cases. It talks about first trimester abortions by adult

women, and I do not recall that it addresses requirements - such as hospitalization - with respect to second trimester abortions. Although the brief refers to "approximately the end of the first trimester" it does not discuss the position of the American College that physicians should be allowed flexibility to make a judgment as to when a fetus is viable without regard to the number of weeks.

Nor, as I recall, does the brief consider whether appropriately trained persons other than physicians might be allowed to perform abortions during the first trimester, or whether these may be performed in free standing clinics approved by the state.

L.F.P., Jr.

ss

lfp/ss 11/22/82

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CA6 (Akron) held that any regulation having a "legally significant impact . . . on a first trimester abortion decision . . . is invalid". The SG asserts this is a new standard not found in our decisions, and would significantly expand the "abortion right".

Our decisions make clear that the "right of personal privacy", held in Roe v. Wade to include the abortion decision, is not an unqualified [right] and must be considered against important state interests in regulation". Roe v. Wade, 410 U.S. at 154. The correct standard, as repeatedly articulated in our cases, is whether the

regulation is "unduly burdensome". Maher v. Roe, 432 U.S. 464, 473-474 (unduly burdensome interference with [the woman's right] to decide whether to terminate her pregnancy); Bellotti I, 428 U.S. 132, 147 (regulation of first trimester abortions "is not unconstitutional unless it unduly burdens the right to seek an abortion"); and repeated in Harris v. McRae, 448 U.S. 297, 314; Beal v. Doe, 432 U.S. 438, 446.

The SG quoted from my opinion in Maher:

"The right in Roe v. Wade can be understood only by considering both the woman's interest and the nature of the state's interference with it. Roe did not declare an unqualified constitutional right to an abortion."

Informed Consent Approved

As an illustration of a regulation held valid by this Court, the SG cites Danforth, 428 U.S. 52, 66-67, where we upheld "informed consent" and record keeping requirements. The consent provision in Danforth required a woman to "certify in writing her consent to the procedure and that her consent is informed and freely given and is not the result of coercion, 428 U.S., at 65 (emphasis added). The SG observes that Danforth noted the strength of the state interest furthered by the informed consent regulation, weighed it against its intrusion upon a woman's unfettered discretion, and concluded that it did not unduly burden the abortion decision.

Substantial Deference Due Legislative Judgment

The greater portion of the SG's brief is a plea for judicial restraint and deference to legislative judgments. He makes the valid argument that the abortion issue has been, and will continue to be, the "focus of great national debate". The sub-issues in the debate are numerous and complex. American citizens are deeply and passionately divided. In a democracy the legislature is the "primary authority" with "responsibility to resolve competing policy views".

As an illustration, the SG notes that "parental entitlement to notification of or participation in an immature daughter's decision that could profoundly affect her life presents competing considerations whose resolution lie at the very core of what legislators are elected to do. See H.L. v. Matheson, 450 U.S., at 408-410.

The SG notes the basic differences between the legislative and judicial branches: first, the superior capacity of a legislature to hold hearings and find facts. Second, legislators - elected by the people - must account periodically to the people for the way they legislate, and this is the heart of our democratic process that assumes a "full and uninhibited discussion of public issues". Finally, legislative decisions can be changed and constitutional ones cannot.

The SG quotes from my opinion in U.S. v. Richardson, 418 U.S., at 188. In footnote 8, p. 13 of his brief, the SG quotes the usual statements with respect to judicial restraint. He relies, for example, on Bickel, The Least Dangerous Branch, p. 15.

Time for the Judiciary to Allow the Legislative Process to Function

It is pointed out that "ten years ago", in Roe, the Court adopted a three-part set of rules with respect to the stages of pregnancy. We left many questions unanswered, and over the intervening decade, litigation has multiplied with the result that the "rules [have] become increasingly intricate and substantially more complicated" Here, the SG cites Matheson, Harris, Bellotti I and II, Colautti v. Franklin, 439 U.S. 379, Maher, Beal and Danforth.

The final plea is that in applying the "undue burden standard", we should accord "substantial deference" to legislative judgment.

L.F.P., Jr.

lfp/ss 11/22/82

MEMO TO FILE

81-746 and 81-1172 Akron Abortion Cases

The purpose of this memo is to outline the provisions of the sections of the Akron ordinance at issue, together with the holding of CA6.

Section 1870.05(B): The Consent Provision

As to women under 15 years of age, it is a criminal offense for a physician to perform an abortion without first obtaining the "informed written consent" of one of her parents or her legal guardian "in accordance with §1870.06, or having obtained an order from a court having jurisdiction.

The briefs state that the juvenile court is the only one having jurisdiction, and that Ohio law requires all complaints filed in such courts to be served on the minor's parents. Thus, the effect of §1870.05(B) is at least to require notification of parents. For reasons I stated in Bellotti II - and possibly in H.L. v. Matheson, I probably would not approve of this.

There also is a standing question with respect to considering this section of the ordinance. Respondent's brief (p. 45) argued that this section is not properly before the Court because no party with Article III standing appealed to CA6. The only parties who appealed were parents (not the city or city officials) whose interest was unrelated to any specific case.

Section 1870.06(B): Specific Advice Required.

"In order to ensure that the consent" is "informed", physicians are forbidden to perform any abortion until the woman (and one of her parents in the absence of a court order) is advised by her physician on a number of specific matters. See the full provision pp. 6 and 7, petitioner's brief. Included in the required advice is the "unborn child is a human life from the moment of conception"; that the "unborn child may be viable if more than 22 weeks have elapsed; that an abortion is a "major surgical procedure that can result in . . . hemorrhages, perforated uterus, infection, menstrual disturbances, sterility, etc., etc.".

The opinions below, and briefs on the "abortion" side of this case leap on this provision with special fury. So do the briefs on behalf of medical societies. See particularly brief of the American College of Obstetricians and Gynecologists (hereafter the "College"), a well written Wilmer, Cutler brief, at p. 8, et seq. This brief emphasizes the uniqueness of each patient, and the necessity that "a physician must be able to exercise discretion in determining the amount, nature and mode of presentation of the information" for the particular patient and her circumstances.

I am inclined to agree with the foregoing, but construe it to recognize that a physician's advice is

required. This is absent in so many clinics. See Simopoulos.

It is to be noted, in this case, that the District Court found that:

"A patient's contact with the physician who is to perform the abortion procedure usually occurs when she is taken into the operating room. At that time, the physician reviews the patient's medical chart and asks if she has any questions. The doctor then performs a pelvic examination. If [this is negative] . . . the abortion usually will then be performed." App. 46a-47a; also quoted in petitioner's brief p. 8.

Unless CA6 rejected this finding, it appears that one or more of these clinics (there are three of them in this case that together performed 5280 abortions in 1977) provide no real consultative information and advice. See also what happened in Simopoulos.

I would affirm CA6's holding with respect to the invalidity of this section, but make clear - in accordance with the College's brief - that the physician must provide advice in accord with generally accepted practice by qualified physicians.

Section 1870.06(C): Information as to "Particular" Risks.

This section, expanding on the advice required by 1870.06(B) requires that the woman, and one of her parents or guardian be informed of "the particular risks associated with her pregnancy and the abortion technique to be

employed, providing a general description of the medical instructions to be followed subsequent to the abortion.

This also was invalidated by CA6, though the DC sustained its constitutionality. Apparently the debate was over whether the advice should be given by a physician rather than some other person in the clinic. Apart from this, I would think requiring information on the "risks associated" with the abortion need not be included in a statute, although a responsible physician would identify them. The brief of the College indicates that the risks are not as serious as a tonsilectomy or anywhere near as serious as an appendectomy.

Section 1870.07: 24 Hours Delay.

Except in the event of an emergency need for an abortion, this section prohibits this action "until 24 hours have elapsed from the time the pregnant woman, and one of her parents or legal guardian, have signed the consent form required by §1870.06." The physician must certify accordingly.

The DC sustained the 24-hour provision, but CA6 held it unconstitutional for the uninformative reason that it "causes a legally significant impact or consequence on the abortion decision, it therefore cannot be applied to first trimester abortions". CA6 seems to be a bit carried away by inquiring whether a regulation causes a "legally

significant impact or consequence on the abortion decision". This is not a self-evident analysis.

Section 1870.16: Humane Disposal.

Requires that the "remains of the unborn child be disposed of in a humane and sanitary manner". Held unconstitutional by both courts, by the DC on vagueness.

* * *

Respondent's Brief - Second Trimester Abortions.

Respondents in this case are the three clinics in Akron, and a Dr. Bliss. They have filed cross petitions (I am not clear at the moment as to the issues thereof), with a supporting brief prepared by a professor at the Cleveland-Marshall Law School, and lawyers from the ACLU.

The first section of this brief - and apparently the primary interest of respondents - is the limitation on second trimester abortions.

Section 1870.03, according to respondent's brief (I should read the section) requires that every abortion performed subsequent to the end of the first trimester be performed in a hospital. This is defined to mean "a general hospital or special hospital devoted to gynecology or obstetrics which is accredited by the the joint commission on the accreditation of hospitals, or by the American Osteopathic Association. Respondent's brief relies on statistics and evidence to the effect that no arbitrary line can be drawn between the trimesters, and contends that

"early second trimester abortions are safely performed in outpatient clinics". It is stated that only 17% of the public hospitals, and 34% of the private hospitals, do abortions at all. And at the time of trial "second trimester abortions were not available in hospitals in Akron", with the result that "ambulatory facilities" have been developed to meet this special need, and that over 70% of all abortions were performed in free standing clinics.

The College's brief, somewhat more restrained, argued that the limitation on all secondary trimester abortions is unconstitutionally "overbroad". Apparently recognizing that there is language in Roe v. Wade that supports a holding of validity, the College brief emphasizes language in Wade that talks of "present medical knowledge", and reads our cases as having "declined to permit the states to establish a specific point of presumptive viability", rather it is said that this Court has deliberately "left the [compelling] point flexible for anticipated advancements in medical skill". Citing Colauti v. Franklin, 439 U.S., at 387, with a see also to Roe, 410 U.S., at 159-161; and Danforth, 428 U.S., at 61, 64.

The College brief argues that since Roe "medical knowledge has progressed dramatically". In this connection, the College's brief states that the increased safety of abortions after the first trimester results from the "widespread adoption of dialation and evacuation (D&E)", now

an accepted technique for second trimester abortions". Br. 21.

It is argued also that "most second trimester abortions are as safe as or safer than childbirth has led to a change in the views of many physicians regarding the advisability of hospitalization for all second trimester abortions". Br. 23. The College refers to its "Standards for Obstetric-Gynecological Services", as stating:

"[In] a hospital based or in a free standing ambulatory surgical facility, or in an outpatient clinic meeting criteria required for a free standing surgical facility, abortions should be limited generally to 18 weeks from the last menstrual period". Br. 23, 24.

In footnote 65, p. 24, the College's standards are set forth for "free standing surgical facilities":

"ACOG, Standard for Obstetric-Gynecologic Services 54 (5th ed. 1982) ("ACOG Standards"). ACOG's standards for 'free-standing surgical facilities' recommended that they 'be licensed to conform to requirements of state or federal legislation' and 'maintain the same surgical, anesthetic, and personal standards as recommended for hospitals.' Id. at 52. 'Surgical procedures may be performed in those facilities under general or regional block anesthesia when it is expected that the postoperative recovery will permit discharge on the same day. There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication.'

I am tentatively inclined to agree with the College. This still leaves the question (that I have not

seen briefed thoroughly, whether the physician must determine that viability has not commenced before any abortion may be performed except to preserve the life of the mother.

L.F.P., Jr.

lfp/ss 11/22/82

MEMO TO FILE

81-1255 and 81-1623 Planned Parenthood v. Ashcroft

Planned Parenthood, a clinic (Reproduction Health Services), and a couple of doctors, sought injunctive and declaratory relief against the Missouri abortion statute as revised following Danforth. It is not easy to identify the "winner", although this state prevailed on what appear to be most of the major issues. This memo, dictated only to aid my memory will review - summarily - the opinion of CA8 by Chief Judge Lay. In doing so, I follow by subject matter CA8's disposition of the issues.*

I. Second Trimester Hospitalization Requirement.

Section 188.025 requires that second and third trimester abortions be performed in a hospital. The DC had invalidated this requirement. It had noted that the D&E

*At the beginning, CA8 summarizes its disposition of the District Court's opinion, affirming in part and reversing in part. A-56-57.

method was available in Missouri in only one hospital. Moreover, the DC noted that no hospital would admit a woman under 18 without parental consent, and therefore parents were given the power to veto minor women's decisions with respect to second and third trimester abortions.

Parental Consent for Hospitalization

CA8 noted that, unlike the statute in Danforth, the new statute does not require parental consent (is this true even for immature minors?). In rejecting the DC's position, CA8 noted that the unavailability of hospitals was not state action, but was the action of "private entities". Moreover, CA8 thought that the DC's position would "force reevaluation of every health-based second trimester regulation", and that the state interest was both concern for the mother's health and viability of the fetus.

Because of inadequate findings by the District Court, CA8 remanded on the hospitalization requirement. It noted that "the central issue is the relative safety of nonhospitalized D&E and hospitalized methods". In concluding this portion of its opinion, CA8 said:

"In sum, we find that the district court failed to properly analyze the hospitalization requirement. On remand, it should first determine if the regulation creates substantial interference with and imposes a direct burden on the woman's decision to have an abortion. If it does, the district court should evaluate whether the hospitalization requirement is justified by a compelling state interest; i.e., whether it is reasonably related to the woman's health. Missouri bears the burden of justifying the restriction." A-66

II. Parental or Court Consent for Minors.

This section makes it a crime to perform an abortion on a minor (under age 18) unless (i) the physician has obtained written consent of the minor and one parent or guardian; or (ii) the minor is emancipated and the physician has informed consent; or (iii) the minor has been granted the right to self-consent to the abortion by a court order, obtained by procedure prescribed in the statute; or (iv) the minor has been granted consent by court order. See brief of respondents cross petitioners, p. 5.

CA8 began its discussion of this issue by quoting the paragraph from my Bellotti II opinion that outlined requirements with respect to consent.

The DC had invalidated this provision because it was viewed as allowing a state court unbridled discretion. Also the statute had not dealt with emancipation properly. CA8 construed §188.028 differently. It ruled that a court could not deny the minor's petition unless it found that "the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interests". These are my Bellotti II requirements. CA8 buttressed its holding in this respect by reliance on H.L. v. Matheson. See A68-69.

In discussing Matheson CA8 noted that it had gone off on a "standing" issue. But here the plaintiff was not a young woman seeking abortion. Rather, they were corporations and physicians seeking to provide abortion

services, and that these plaintiffs had shown that some of their respective patients included mature minors.

Interestingly, the plaintiffs in this case (the primary petitioners who lost on major points below) argue that CA8 had no authority to interpret the statute as it did, contending that the plain language was otherwise.

CA8 then noted that this case presented "the case left open in Matheson: whether it is constitutionally permissible to require mature or 'best interest' minors to notify their parents prior to a court hearing in which they seek judicial consent". A70 Again relying on my Bellotti II opinion, CA8 states that it "advances persuasive reasons for concluding that parental notice is unduly burdensome in cases involving mature or 'best interest' minors." 443 U.S., at 642-648.

Planned Parenthood challenged several other provisions of §188.028. These do not appear substantial to me - at least at present. The usual vagueness argument is made. It also is said that the procedure does not assure anonymity. Despite these arguments, CA8 concluded that "the judicial consent provision" is constitutional. But CA8 agreed with Planned Parenthood that "the notice provisions found in subsection 188.028.2(2) are impermissible and must be set aside."

In sum, the judicial consent, construed, was sustained, but - in accord with Bellotti II, the requirement of parental notification was invalidated.

III. Restrictions on Abortion After Viability (A73)

CA8 first reversed the DCs holding that all of these restrictions were void for vagueness. I do not think we granted cert on the vagueness issue.

Second Doctor Requirement

CA8 affirmed the DC's decision that this unduly burdened the woman's right. The state agreed that there was a financial burden, but argued that under Harris and Maher that this was a private rather than public matter. I agree with CA8 that these cases were misconstrued by Missouri. Thus, there certainly was a state imposed burden that could be justified only by a showing of compelling state interest.

The interest relied upon by the state was the importance of making sure, where a second trimester abortion is performed, that the fetus will not survive. CA8 affirmed the DC in concluding that the state failed to show that a second doctor's opinion was necessary.

CA8 discussed the D&E procedure, and the conflict of Dr. Crist's testimony with that of all other doctors.*

*My recollection is that Dr. Crist was a party in the Akron case. He testified that he used D&E successfully on women pregnant as much as 28 weeks. His testimony was contradicted by every other physician, the prevailing view being that a fetus could not survive D&E abortion. I'd like to find some way to check up on Dr. Crist. My guess is that he is a professional witness.

IV. Informed Consent

Danforth held that a state may require "informed consent" even in the first trimester. Danforth, 428 U.S., at 64-67. But Danforth limited this as follows:

"The giving of information to the patient as to just what would be done as to its consequences [may be required]. To ascribe more meaning than this might well confine the attending physician in an undesired and uncomfortable straightjacket in the practice of his profession." At 67.

Section 188.039.2(3) goes well beyond Danforth. It requires that the woman be informed of the "probable anatomical and psychological characteristics of the unborn child", and subsection (4) provides that she must be informed of "the immediate and long range physical dangers of abortion and psychological trauma".

The DC held this unduly burdensome, and CA8 affirmed.

In so doing, CA8 said that the DC properly concluded that "the abortion decision is one to be made by a woman and her physician", and that the state's interest is adequately served when the woman's decision is made with "full knowledge of its nature and consequences". Danforth, 428 U.S., at 67.

A Physician Must Advise

Section 188.039.1 requires that the "attending physician" inform the woman of the information specified in the statute. Both the DC and CA8 sustained this requirement, despite the argument of Planned Parenthood that

nonphysicians are capable of informing the patient, and that requiring the physician to do it creates scheduling problems and increased costs. My tentative view is that a qualified person other than a physician could give this information. I think a state could require the licensing of such persons, such as practical nurses are licensed.*

V. Pathological Reports

Section 188.047 requires that sample of the tissue removed must be submitted to a certified pathologist, who must file a report with the state division of health.

CA8 invalidated this provision, holding that the decision whether to obtain pathological reports should be left to the physician. CA8 noted that Missouri "does not require submission of tissue to a pathologist following other medical procedures". A94

*In the subsection discussing advice by the physician (p. A91), CA8 refers to the 48 hours waiting period prescribed. It appears to sustain this as valid, although the discussion at this point in the opinion is very brief.

In invalidating this requirement, CA8 reiterated that "Missouri law requires that all abortions be performed by physicians". A96*

* * *

CA8's opinion is long and rambling, and not altogether clear. I hope we can find some way to prevent courts from having to make the multiplicity of judgments such as those addressed by the DC and CA8 in this case.

L.F.P., Jr.

ss

*CA8's opinion is so long I may have missed it, but I find no full discussion of the requirement that only physicians may perform first trimester abortions. My guess is that the Court will hold specially trained persons other than physicians may be competent to perform first trimester abortions.

Abortion Cases - Professors' Brief

Eighty-five professors have joined in a brief by Paul Brest and Susan Appleton that is a well written, but repetitive, argument that - at least for adult women - is strongly pro-abortion. The analytical approach of the brief is straight-forward, and may be consistent with Roe - though possibly inconsistent with some of our subsequent decisions (e.g., Maher and Danforth).

Two-Step Analysis

This is emphasized throughout the brief, and summarized on p. 32 as follows:

"First, a court must examine whether or not the regulation is state action imposing any burden at all on the right to obtain an abortion. The question here is not one of degree but simply whether the regulation affirmatively imposes any legally cognizable burden. If it does not, then the analytical framework developed in Roe does not govern. See Danforth; Maher; McRae. If, however, the regulation imposes any burden on the right recognized in Roe, then as a second step, strict judicial scrutiny must be applied to determine whether that burden is undue--that is, whether it is properly justified by a compelling state interest and sufficiently narrowly tailored to further that goal. See McRae, 468 U.S. at 314; Maher, 432 U.S. at 473-74." p. 32

With respect to the second step, only two state interests have been identified: (i) the compelling character of a state's interest in protecting maternal health only after the first trimester, and the "compelling

character of a state's interest in preserving potential life only after fetal viability", Roe, 410 U.S., at 163-164.

The reason the state's interest in protecting maternal health is said to be compelling only after the first trimester, is that medical testimony establishes that the risk to maternal health during the first trimester is less than at childbirth.

Void All Regulation before the Court

This brief asserts that "all of the regulations now before this Court interfere directly with the right recognized in Roe should be held void". According to the records, they significantly burden the abortion decision and its effectuation by making termination of a pregnancy more onerous, more costly, more time consuming, and - sometimes - more hazardous". Brief, p. 33, 34.

Then, the brief delivers the "knockout", by asserting that "all of the measures applicable to abortions sought by adult women during the first trimester must fall because neither state interests identified in Roe is sufficiently compelling during that stage to support such restrictions". p. 34, 35. Accordingly, all of the first trimester regulations here are "unduly burdensome". Citing McRae, 448 U.S., at 314, Maher, 432 U.S., at 473.

Resort to "Balancing Test" Impermissible

In a subsection commencing at p. 41, the state argues against "resorting to a balancing test or a sliding scale analysis".

Its position is summarized as follows:

"Only the 'compelling state interest' test--applied here and in all fundamental--rights cases--promises adequate protection of fundamental constitutional rights, consistency with this Court's precedents, and elimination of the uncertainty that a variable standard of review resting on ad hoc assessment of burdens generates." 41

Unique Status of Children

In a brief concluding section, the professors concede that children have a unique status. It also emphasizes that children have constitutional rights and quotes at length from Carey, 431 U.S., at 693 (a favorite of the professors, though not an abortion case).

The brief "explicitly refutes" Judge Kennedy's dissenting opinion in Akron in which she argues for a "sliding scale standard of review for all abortion regulations, whether applicable to minors or adults".

The brief identifies (p. 60) the three concerns "uniquely relevant to minors": (i) the vulnerability of children; (ii) their inability to make informed decisions; and (iii) the importance of the parental role in child rearing. Citing my Bellotti opinion, 441 U.S., at 634.

After noting that these special concerns for children do not support a state-granted parental veto (Danforth), "a majority of the Justices would approve a more narrowly drafted statute allowing minors judicially determined to be mature to make their own abortion decisions, while requiring immature minors to obtain a consent substitute, parental permission or judicial authorization" predicated on the minor's best interests. Citing Bellotti, at p. 643-644.

It noted that Matheson approved a parental notification requirement except with respect to mature or emancipated minors or where best interests to the contrary can be shown.

The brief states that a "special standard of review" is appropriate with respect to regulation of minors, but does not define the standard.

* * *

I would like for my clerk to make an independent judgment as to the professors' characterizations of our decisions, particularly with respect to the absolutism of all restrictions - however slight or inherently reasonable - on adult women without meeting the compelling interest standard. My recollection is that there is language in Maier to the contrary, but perhaps I am wrong.

The professors' brief does not address some of the issues that I believe are raised in one of more of these cases. It talks about first trimester abortions by adult

women, and I do not recall that it addresses requirements - such as hospitalization - with respect to second trimester abortions. Although the brief refers to "approximately the end of the first trimester" it does not discuss the position of the American College that physicians should be allowed flexibility to make a judgment as to when a fetus is viable without regard to the number of weeks.

Nor, as I recall, does the brief consider whether appropriately trained persons other than physicians might be allowed to perform abortions during the first trimester, or whether these may be performed in free standing clinics approved by the state.

L.F.P., Jr.

ss

1fp/ss 11/23/82

MEMORANDUM

TO: Jim

DATE: Nov. 22, 1982

FROM: Lewis F. Powell, Jr.

Abortion Cases

I have now read the briefs you were good enough to select for me, including also the brief by the American College of Obstetricians and Gynecologists. As I am sure you have found, the number of issues in these cases is a bit overwhelming. I have not tried to sort out which ones we granted, or whether we took them across the board.

A primary objective of the Court at this time, as I see it, is to enunciate principles or standards that would afford clearer guidance to state legislatures and limit the flow of litigation into the Courts. The professors' brief with respect to the major issues, suggests rather positive standards, and emphasizes the undesirability of "balancing". These have appeal, but they also probably permit abortions for adult women during the first trimester quite literally "at will". In view of the fees charged (see the Virginia case), there always will be licensed physicians who will make enormous profits out of what have been described as "abortion mills". I am not at all sure the professors' brief fairly states some of our holdings. Perhaps the SG goes too far the other way.

I now summarize, Jim, tentative views on several of the major issues in these cases:

Informed Consent Requirement

Danforth recognized that this is not an undue burden per se. The Akron provision is unduly burdensome because it imposes extensive requirements as to exactly what a physician must advise the woman as a predicate to her "informed" consent.

As to the consent requirement with respect to minors who are neither mature nor emancipated, I joined Matheson in holding that parental consent of at least one parent is a valid requirement except where the minor is mature or emancipated or an independent decision-maker finds that a non-consented abortion is in the best interests of the minor. In Akron, apparently Ohio law would require the juvenile court to notify the parents. Under my opinions in Bellotti II and Matheson, this would be invalid.

24 Hours Delay (Akron) / 48 Hours (Missouri)

Although I do not recall (without checking) a court decision on this issue, I doubt that an arbitrary delay - even with an emergency provision - would meet our standards. This normally can be left to the physician, provided there is some assurance that the physician will adequately inform the woman. With respect to immature minors, there should be time to assure informed consent. We have never considered the extent of a doctor's responsibility in determining whether a minor is mature. I suppose a state validly could require with respect to minors

of tender age (under 15) that an independent decision maker determine maturity and best interest issues. Such a requirement inevitably would produce some delay.

Second Trimester Abortions

My recollection is that Roe drew no bright line, referring only to approximate stages in the development of a fetus. In Akron, respondents argue that "early second trimester abortions are safely performed [even in] outpatient clinics, and CA6 apparently would invalidate any "arbitrary line between trimesters".

The American College seems to agree, relying on the argument that "medical knowledge [since Doe] has progressed dramatically", particularly in the use of D&E procedures. Yet, the evidence in the Missouri case persuaded CA8 (and possibly the DC also) that D&E procedure invariably destroys the fetus. Thus, in view of the compelling state interest once viability exists a state lawfully could insist that the decision as to viability be made by a physician.

As the College brief relies on "current medical knowledge", it would appear that it agrees a qualified physician is the only person likely to possess such knowledge, and therefore the viability decision cannot be delegated to a less qualified person.

Free Standing Clinics

A major issue, in view of the extensive use of clinics and the apparent unavailability of hospitals willing to do abortions, is what sort of facilities - if any - would be lawful.

I am favorably inclined toward the views in the amicus brief of the College. See pages 23, 24. I particularly like footnote 65 on p. 24 that describes the College's standards for "free standing surgical facilities" as requiring them to "maintain the same surgical, anesthetic, personal (maybe this is personnel) standards as recommended for hospitals." Clearly, I would think, clinics should be regulated and approved by state law, and periodically inspected.

It is not clear whether the College would require this type of clinic for first trimester abortions. The record - or perhaps one of the briefs - has the full text of the College's standard as to abortions. Take a look, and identify (or xerox) anything helpful.

* * *

Jim, I have dictated the foregoing summary of tentative views. When we go into Conference on three cases, involving three different sets of regulations, it will be helpful to have a somewhat similar summary from you, identifying the issue and the case. Where we differ, we can reconcile these prior to Conference.

L.F.P., Jr.

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FROM: Lewis F. Powell, Jr.

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Danforth recognized that this is not an undue burden per se. The Akron provision is unduly burdensome because it imposes extensive requirements as to exactly what a physician must advise the woman as a predicate to her "informed" consent.

As to the consent requirement with respect to minors who are neither mature nor emancipated, I joined Matheson in holding that parental consent of at least one parent is a valid requirement except where the minor is mature or emancipated or an independent decision-maker finds that a non-consented abortion is in the best interests of the minor. In Akron, apparently Ohio law would require the juvenile court to notify the parents. Under my opinions in Bellotti II and Matheson, this would be invalid.

24 Hours Delay (Akron) / 48 Hours (Missouri)

Although I do not recall (without checking) a court decision on this issue, I doubt that an arbitrary delay - even with an emergency provision - would meet our standards. This normally can be left to the physician, provided there is some assurance that the physician will adequately inform the woman. With respect to immature minors, there should be time to assure informed consent. We have never considered the extent of a doctor's responsibility in determining whether a minor is mature. I suppose a state validly could require with respect to minors

3.
of tender age (under 15) that an independent decision maker determine maturity and best interest issues. Such a requirement inevitably would produce some delay.

Second Trimester Abortions

My recollection is that Roe drew no bright line, referring only to approximate stages in the development of a fetus. In Akron, respondents argue that "early second trimester abortions are safely performed [even in] outpatient clinics, and CA6 apparently would invalidate any "arbitrary line between trimesters".

The American College seems to agree, relying on the argument that "medical knowledge [since Doe] has progressed dramatically", particularly in the use of D&E procedures. Yet, the evidence in the Missouri case persuaded CA8 (and possibly the DC also) that D&E procedure invariably destroys the fetus. Thus, in view of the compelling state interest once viability exists a state lawfully could insist that the decision as to viability be made by a physician.

As the College brief relies on "current medical knowledge", it would appear that it agrees a qualified physician is the only person likely to possess such knowledge, and therefore the viability decision cannot be delegated to a less qualified person.

Free Standing Clinics

A major issue, in view of the extensive use of clinics and the apparent unavailability of hospitals willing to do abortions, is what sort of facilities - if any - would be lawful.

I am favorably inclined toward the views in the amicus brief of the College. See pages 23, 24. I particularly like footnote 65 on p. 24 that describes the College's standards for "free standing surgical facilities" as requiring them to "maintain the same surgical, anesthetic, personal (maybe this is personnel) standards as recommended for hospitals." Clearly, I would think, clinics should be regulated and approved by state law, and periodically inspected.

It is not clear whether the College would require this type of clinic for first trimester abortions. The record - or perhaps one of the briefs - has the full text of the College's standard as to abortions. Take a look, and identify (or xerox) anything helpful.

* * *

Jim, I have dictated the foregoing summary of tentative views. When we go into Conference on three cases, involving three different sets of regulations, it will be helpful to have a somewhat similar summary from you, identifying the issue and the case. Where we differ, we can reconcile these prior to Conference.

L.F.P., Jr.

L.F.P.
Reviewed
2/2/83

job 02/01/83

FIRST DRAFT: Simopoulos v. Virginia, No. 81-185

JUSTICE POWELL delivered the opinion of the Court.

The principal issue here is whether Virginia's mandatory hospitalization requirement for second-trimester abortions is constitutional.

I

appellant

Petitioner is a practicing obstetrician-gynecologist.

His practice in November, 1979 consisted of office

practice in Woodbridge, Virginia, hospital practice at

four local hospitals or surgery centers, and ~~office~~

practice at his clinic in Falls Church, known as the

American Women's Clinic. The clinic has an operating

room, operating-room lighting, and facilities for

resuscitation and emergency treatment of

cardiac/respiratory arrest. Replacement and stabilization

fluids are on hand. Petitioner ^{customarily} admits performing first-

trimester abortions at his clinic. During the time

relevant to this case, the clinic was not certified or

licensed in any way, nor had petitioner sought any

certification. *of it.* Petitioner is a well trained physician, and is certified to be ~~personally~~ qualified in ob/gyn by the American Board of Obstetrics & Gynecology.

Jan -
This is
an Appeal.
I leave to
you, changing
the
terminology
of the
case
to make
it better
to appellant.

certification.

P.M. was seventeen years old when she ^{went} came to petitioner's clinic on November 8 and 10, 1979. She told

petitioner that she was about 22 weeks pregnant.

Examination by petitioner confirmed that
Petitioner testified that he encouraged her to confide

with her parents and discussed with her the alternative of continuing the pregnancy to term. She did ^{return} go home, but never advised her parents.

Ruler A
Two days later, P.M. returned for a saline injection, *that* which petitioner administered in the clinic operation *room* facility. Although P.M. *does not* was unable to recall being instructed to meet petitioner at any hospital when the labor began, there was testimony that petitioner provided written post-injection instructions as to when to report to the hospital emergency room.

P.M. then went to a motel and M. aborted her fetus in *the* her motel bathroom forty-eight hours after the saline injection. Alone, she left the fetus, follow-up instructions, and pain medication at the motel. Her boyfriend took her home. Police found the fetus later that day and opened an investigation.¹

Footnote(s) 1 will appear on following pages.

Petitioner was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of a licensed hospital and was convicted by a Judge of the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia reviewed his case and, in a unanimous decision, affirmed his conviction. Simopoulos v. Commonwealth, 221 Va. 1059, 277 S.E.2d 194 (1981). This appeal followed. We now affirm.

II

¹Except as permitted by statute, persons performing an abortion are guilty of a felony under Virginia law and subject to mandatory license revocation. Va. Code §§18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). See Simopoulos v. Virginia State Board of Medicine, 644 F.2d 321, 322-323 (CA4 1981).

²The indictment alleges a violation of Va. Code §18.2-71, which provides:

Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony.

In the four following sections the Virginia Code sets forth exceptions to this statute: there is no criminal liability (i) if the abortion is performed within the first trimester, §18.2-72; (ii) if the abortion is performed in a licensed hospital in the second trimester, §18.2-73; (iii) if necessary to save the woman's life, §18.2-74.1; and (iv) during the third trimester under certain circumstances, §18.2-74.1. The indictment here alleged a violation of §18.2-71 and expressly negated any defenses of hospitalization under §18.2-73 and any first-trimester defense under §18.2-72. The indictment did not, however, rebut the other defenses.

II

Petitioner contends that the Virginia^s statutory¹ hospital requirement sharply restricts the availability of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions.³ He also argues that the Virginia

require
³Petitioner raises two issues on his appeal that do not ~~deserve~~ extended treatment. His first contention is that Va. Code §18.2-71 was unconstitutionally applied to him, because lack of medical necessity for the abortion was not alleged in the indictment, not addressed in the prosecution's case, and not^{not} mentioned by the trier of fact. Petitioner contends that this failure creates two constitutional issues: (i) whether the State failed to meet its burden of alleging necessity in the indictment, as required by United States v. Vuitch, 402 U.S. 62 (1971); and (ii) whether the prosecution failed to meet its burden of persuasion, as required by Patterson v. New York, 432 U.S. 197 (1977).

The authoritative construction of §18.2-71 by the Supreme Court of Virginia makes it clear that, at least with regard to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt until petitioner invoked medical necessity as a defense. See 221 Va., at 1069, 277 S.E.2d, at 200. Petitioner's reliance on Vuitch thus is misplaced, because the Virginia statute, as construed by the state court, does not require that the State allege lack of medical necessity; the District of Columbia statute in Vuitch, as construed by this Court, did require the prosecution to so allege. See 403 U.S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See Engle v. Isaac, 102 S.Ct. 1558, 1567-1568 & n. 20 (1982); Mullaney v. Wilbur, 421 U.S. 684, 701-703 nn. 28, 30, 31 (1975). Thus, we agree with the state court that the prosecution did not bear the burden of alleging or proving lack of medical necessity in this case because petitioner failed to invoke the defense.

In - This is unnecessary
 Petitioner also contends that the Supreme Court of Virginia erred in upholding his conviction because the prosecution failed to prove that his acts in fact caused the demise of the fetus. In the State's case, there is evidence that (i) P.M. went to petitioner specifically for an abortion and that she advised him that she was twenty-two weeks pregnant, App. 264, 268; (ii) two days later petitioner injected P.M. with a saline solution without complication, id., at 271; (iii) after the procedure was performed he told P.M. that the fetus would be destroyed, id., at 296; (iv) she then went to a motel and stayed two

Footnote continued on next page.

In view of the undisputed facts proved at trial, summarized above, this contention is frivolous. See opinion of Sup Ct. of Va., 221 Va 1059

requirement ^{results in} ~~creates~~ negative health consequences and, as applied to him and the abortions that he performs in his well-equipped ^{non-licensed} ~~non-hospital~~ clinic, does not "measurably contribut[e] to the ... purposes which the State advances as justification for the restriction." Carey v. Population Services International, 431 U.S. 678, 702 (1977) (WHITE, J., concurring in part and concurring in the result).

We need not pause long here to consider the standard of review, for we have set it out at length today in City of Akron v. Akron Center for Reproductive Health, Inc., U.S. _____. Although the Court found in Roe v. Wade, 410

U.S. 113 (1973), the woman's right to ^{make the abortion} ~~decide to abort~~ to ^{decision is} be a fundamental right, we rejected the notion that a

woman has an absolute right to an abortion without any

interference from the State. We consistently have

recognized, and we reaffirm today, that, "since a State

days, id., at 273-277; (v) that she did not take any medication but the pain pills that petitioner had prescribed, id., at 286; (vi) P.M. went into labor at the motel, id., at 276-277; and (vii) the fetus was born dead and was of the approximate gestational age of five and one-half months, id., at 232-233, 236. We believe this evidence is sufficient to support a finding that petitioner caused the abortion and demise of the fetus.

Join -
repeal
their
sentence
as you
can with
Roe's language

has a legitimate concern with the health of women who undergo abortions, 'a State may properly assert important interests in safeguarding health [and] in maintaining medical standards.'" City of Akron, ____ U.S., at (quoting Roe, 410 U.S., at 154). As JUSTICE BLACKMUM stated for the Court in Roe:

The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise.

410 U.S., at 150. The issue here is whether the Virginia hospitalization requirement is reasonably related to the promotion of the Commonwealth's compelling interest in maternal health and safety.⁴

A

Before examining the medical basis for Virginia's hospitalization requirement, it is ~~essential~~^{helpful} to understand

⁴Petitioner also argues that the State has no compelling interest in imposing criminal penalties on the performance of safe non-hospital abortions in the second trimester and that criminal penalties to enforce total hospitalization is not a narrowly drawn requirement. Similar arguments in prior cases have not been persuasive.

~~first~~ the nature of that requirement. As a general proposition, physicians' offices are not regulated under Virginia law.⁵ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va.

Code §18.2-73 (1982). The Virginia abortion statute ^{itself} does not ~~define~~ "hospital," but ~~§32.1-123.1~~ defines "hospital" to include "outpatient ... hospitals." Section 20.2.11 of

There is
formed in
§32.1-123.1
that

⁵A physician's office is explicitly excluded from the hospital licensing statutes and regulations, unless the office is used principally for performing surgery. See Va. Code §32.1-124(5). Surgery is not defined. Petitioner contends that whether his facility principally performs surgery is a question of fact that has not been resolved and that it is ~~thus far from clear~~ whether his clinic may be licensed as a "hospital." He notes that, after he went to trial, he requested a certificate of need, but was informed by the Office of the Attorney General that his "office-clinic cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Petitioner 3a, 4a. Petitioner did not seek any license before his indictment, ~~however, thus the factual issue~~ whether his ~~particular~~ facility would qualify as a hospital is irrelevant ~~to our determination.~~ ^{under Va law}

uncertain

Petitioner also notes that the Commonwealth does not argue that he should have procured a hospital license under Part III of the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia to perform first-trimester abortions and that, until now, the Commonwealth has considered the Falls Church facility to be a physician's office beyond the reach of the hospital licensure regulations. The legality of petitioner's actions in performing other abortions at the clinic, and the constitutionality of Virginia's first-trimester abortion clinic regulations, is not before us, however.

Jim - This
seems
unnecessary
to me. Why
not omit?

Jim - Earlier in this draft we have said
Petitioner's clinic was not "certified." Shouldn't
we use "license" consistently?

the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) (hereinafter Rules) defines outpatient hospital in pertinent part as "[i]nstitutions ... which primarily provide facilities for the performance of surgical procedures on outpatients"⁶ and expressly includes "outpatient abortion clinics."⁷ Thus, under Virginia law, a second-trimester abortion may be performed in an outpatient surgical clinic provided that clinic has been licensed as a hospital by the Commonwealth.

It is readily apparent that Virginia's second-

⁶Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital ... unless such hospital ... is licensed as provided in this article." See also Rules §30.1 (similar provision specifically for outpatient hospitals).

⁷"Outpatient abortion clinics" refers specifically to those facilities meeting the minimum standards of Part III of the Rules, see Rules, at i, §62.1.2 of which provides that "[a]ny procedure performed to terminate a pregnancy shall be performed prior to the end of the first trimester (12th week amenorrhea)." Petitioner argues from this that outpatient hospitals that provide abortion services cannot provide second-trimester abortions. A more plausible reading, however, is that Part III sets minimum standards for first-trimester abortion clinics, with part II setting minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, i. e., §§43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services. Moreover, the Commonwealth's counsel at oral argument represented that facilities licensed pursuant to Part II legally could perform second-trimester abortions. See Tr. of Oral Arg. 33.

may

8. We herein ^{usually} prefer, in accord with Virginia regulations, ~~to use the term~~ "outpatient hospital" at issue as an "out-patient abortion clinic" or an "outpatient 'clinic'".

If you agree to new "U.S." leave it to you to conform next of opinion.

Jim - There may be some advocacy merit in using "clinic". Add this as a note.

trimester hospitalization requirement is significantly different from those that we invalidated today in City of Akron and Planned Parenthood Association v. Ashcroft, U.S. _____. In those cases, the laws at issue "require[d] all second-trimester abortions to be performed in general, acute-care facilities." Id., at _____. We found that such a requirement, by preventing the performance of D&E abortions in ^{appropriate} nonhospital settings, "imposed a heavy, and ~~entirely~~ unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." City of Akron, ____ U.S., at _____. The Court therefore held invalid the laws there as ~~clearly~~ unreasonable and as ^{reasonably} not furthering the states' interest in maternal health.

One of the most important factors in our analysis in City of Akron was the medical fact that "D&E abortions may be performed as safely in an outpatient clinic as in a hospital." ____ U.S., at _____. ^{In contrast,} The Virginia ^{provision, statutes and regulations} hospitalization requirement, however, does not require that [all] second-trimester abortions be performed exclusively in acute-care, general hospitals. Under

Just -
take
"entirely"
out of
Akron
also.

In this
the only
relevant
part of
the
Akron
quote?
~~quote~~

regulations,
 Virginia's ~~Rules~~, outpatient clinics may qualify for
 licens^{ing}~~ure~~ as hospitals in which second trimester abortions
 lawfully may be performed. Thus, our ~~determinations~~ *decisions* in
City of Akron and Ashcroft are not controlling here, and
~~we must analyze the reasonableness of Virginia's~~
~~requirements separately.~~

B

We do not dispute petitioner's contention that the
 Virginia hospital regulations impose some burden on the
 right to privacy. No doubt there are some costs incurred
 in complying with the challenged regulations and there
 will be some fewer qualified facilities available for
 second-trimester abortions.⁸ We nonetheless conclude that
 Virginia's hospital requirement for second-trimester

⁸Petitioner suggests that the hospitalization
 requirement is not reasonably related to the
 Commonwealth's health interest because it effectively
 leaves the Commonwealth's pregnant women at the mercy of
 local hospital governing boards that may prohibit the
 procedure altogether or require parental consent in the
 case of minors. Cf. Tr. of Oral Arg. 57 (finding no
 evidence that an outpatient surgical facility in Virginia
 has ever performed a second-trimester abortion).
 Petitioner points to no evidence in the record, however,
 that a qualified outpatient surgical center has been
 denied a hospital license, and without such evidence, we
 do not think his argument is relevant to the issue
 presented here--whether the state licensing regulations
 are reasonably related the Commonwealth's compelling
 interests.

*Jim -
 The word
 "licensure"
 is not
 in my
 dictionary.
 I prefer
 "licensing"
 unless I
 am wrong.*

*Jim -
 I prefer
 not to
 make
 concessions
 - at least
 at beginning
 of an argument*

*Jim -
 Don't
 initially
 go w/ ev.
 on this.
 I used
 by dissent,
 we can
 reply.*

Jim - Roe is a bit ambiguous as to when the interest becomes "compelling". The term is used both for 2nd & 3rd trimester. Has any post-Roe case used "compelling" w/r to 2nd trimester? If so, cite it. 11.

abortion is not unconstitutional.

for H Our decisions have established First, we reaffirm our prior holdings that the State

interest in protecting maternal health becomes compelling at approximately the beginning of the second-trimester.

See City of Akron, ___ U.S., at ___; Roe, 410 U.S., at

✓ ³ 164. Second-trimester abortions ^{particularly in the latter weeks,} may give rise to serious

complications,⁹ and in the later weeks of pregnancy

especially, ^{of abortion significantly} certain methods ^{inevitably} increase the

risks.¹⁰ Although the increasingly common use and

relative safety of the dilatation and evacuation method

(D&E), see City of Akron, ___ U.S., at ___, may make the

need for particular equipment in and designs of a facility

⁹Between 1972 and 1978, 79 women undergoing second-trimester abortions in this country died as a result of the abortion procedure. See Centers for Disease Control, Abortion Surveillance, at 48 (1980).

¹⁰For example, the majority of second-trimester abortions after the sixteenth week of gestation are performed by means of intrauterine instillation of saline, see Grimes & Cates, The Brief for Hypertonic Saline, 15 Contemporary Ob/Gyn 29, 30 (1980), even though the rate of death for abortions done by instillation procedures are greater than for D&E, see also ACOG Technical Bulletin No. 37, Hypertonic Saline Amnio-Infusion I (1976) (mortality rate of 18 per 100,000 women); Cates, et al., The Risk of Dying from Legal Abortion in the United States, 1972-1975, 15 Int'l J. Gynaecol. Obstet. 172, 175 (1977). Less serious complications include hypertremia, fever, retained placenta, hemorrhage, premature rupture of the membranes, immediate labor, disseminated intravascular coagulation (DIC), cervicovaginal laceration, failed amniocentesis, failed labor, and sepsis. See ACOG Technical Bulletin No. 37, supra, at 2-3.

Jim -
I can't
help on
this, & I'll
not have
an opportunity
to read the
literature.
HAB has
read it!

facilities used for second trimester abortion

12.

~~commented that the~~
less compelling, they have not eliminated the need for
reasonable standards. D&E, despite its ^{comparative} safety, may cause
complications,¹¹ and States have a legitimate interest in
ensuring that ~~clinics~~ ^{appropriate} meet some ~~minimum~~ standards for
prevention, detection, and treatment of those
complications. That interest is compelling throughout the
second-trimester, and the State may, "from and after the
end of the first trimester, adopt standards for licensing
all facilities where abortions may be performed so long as
those standards are legitimately related to the objective
the State seeks to accomplish." Doe v. Bolton, 410 U.S.
179, 194-195 (1973) (emphasis added).

^{invariable}
TH One reason that acute-care, general
hospitalization does not enhance the safety of D&E
abortions is that a major cause of complications--
infection--does not arise until 24 to 72 hours after the
procedure has taken place, by which time the woman will
have been discharged from either a hospital or a clinic.
See Ashcroft, 664 F.2d 687, 690 n. 6 (CA8 1981), rev'd in
part & aff'd in part, ___ U.S. ___ (1983). That fact,
however, does not alleviate the need for standards
designed to prevent infection. The other leading cause of
death and complications in D&E abortion patients is
hemorrhage, which can be prevented, detected, and treated
during or soon after the procedure. See Cates & Grimes,
Deaths from Second Trimester Abortion by Dilatation and
Evacuation: Causes, Prevention, Facilities, 58 Obstetrics
& Gynecology 401, 403 (1981) (also showing one death from
cardiovascular collapse from toxic reaction to
paracervical anesthesia). Other potential complications
of this procedure are uterine perforation and cervical
tears, which are significantly increased in comparison to
other second-trimester procedures. See ACOG Technical
Bulletin No. 56, at 78 (1979).

Cate
Roe also
p. 163 +
elsewhere it
appropriate

Jim -
Only
this part
is responsive
to Note 11's
call. Put
it first.
I'm uncertain
whether the
first part of this
note belongs here
here. I + you & mark
think this is helpful, make
it a separate ff, &
change first sentence or two
as I have indicated. With
these changes, it is
probably helpful

The medical profession ^{has sought} ~~does not~~ seek an exemption
 from licensing requirements for facilities that provide
 abortion services. The standards of the American College
 of Obstetricians and Gynecologists (ACOG) provide that
 "[a]mbulatory care facilities providing abortion services
 should meet the same standards of care as those
 recommended for other surgical procedures performed in the
 physician's office and outpatient clinic or the free-
 standing and hospital-based ambulatory setting." ACOG,
 Standards for Obstetric-Gynecologic Services 54 (5th ed.
 1982) (hereinafter Standards). The profession ~~clearly~~
 acknowledges the State's role in promulgating and policing
 those standards: "Free-standing or hospital-based
 ambulatory surgical facilities should be licensed to
 conform to requirements of state or federal legislation.
 Such facilities should maintain the same surgical,
 anesthetic, and personnel standards as recommended for
 hospitals." Id., at 54. The issue here is whether
 Virginia's licensing requirements ~~are~~ reasonable
~~restraints~~, ^{and} furthering the state's compelling interest
 without unduly burdening ^{the right of a woman} ~~women's right~~ to an abortion.

give:
 lets not
 call them
 "restraints!"

Good
 name

Jim - I reviewed
this up &
had to do a
review!

~~The regulations~~
are identical to
those applicable
to "other" out-
patient hospitals
as defined.

14.

If the regulations applicable to "out-patient
~~regulations~~ abortion clinics"

Rider
A

The rules can be roughly grouped for purposes of
discussion into three main categories.

The first grouping relates to organization,
management, policies, procedures, and staffing. Some
sections resemble the requirements for a corporation in
that they call for some governing authority, §§40.1, 40.3
(governing body shall provide facilities, personnel, and
resources "necessary to meet patient and program needs"),
an administrative officer, §40.6, disclosure of ownership,
§40.2, by-laws, §40.5, and a policy and procedures manual,

Don't
say
this!

§43.2.¹² A licensed physician^{who} must supervise clinical
services and perform surgical procedures, §42.1 and a
registered nurse^{to} shall be on duty at all times while the
facility is in use, §42.2.

The second category of requirements outlines
construction standards for new hospitals, and additions

¹²The manual must describe emergency and elective
procedures that may be performed at the facility, §41.2.1;
the anesthesia that may be used, §42.2.2; the criteria and
procedure for admissions and discharge, §41.2.4; written
informed consent, §41.2.4; and procedures for housekeeping
and infection control, §41.2.5.

Jim -
See my
memo on
this A

and alterations to existing ones.¹³ The Rules require the facility to provide a brief narrative of requirements and information relating to the fulfillment of the institution's objectives, §50.1.1, and provide that

"deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," §50.2.1.

Guidance is given on parking, safety and fire codes, zoning, site, and location.¹⁴ There are also construction requirements, which set forth standards for the public areas,¹⁵ clinical areas, laboratory and radiology

¹³Section 50.7.1 permits conversion only of buildings that can be remodeled to meet the requirements of the State Uniform Building Code, but, when the licensing agency finds the special requirements of Part II would be impractical, it may waive the enforcement of those requirements, provided patient care and safety to life from fire is not adversely affected.

¹⁴See Rules §50.6.1 (building must "conform to state and local codes, zoning and building ordinances, and the State Uniform Building Code requirements applicable to type of occupancy"); id., §50.8.1 ("The site shall meet local zoning regulations."); id., §50.8.4 (sanitation, water supply, sewage, and disposal facilities must comply with applicable state and local codes and ordinances); and id., §50.8.5 (adequate fire protection).

¹⁵See, e. g., Rules §52.1.2 (room may serve more than one function); id., §52.1.4 (lobby area must have space for one friend or family member per patient and must provide public toilets, a public telephone, a water fountain, and wheelchair storage); id., §52.1.6 (private space for counseling if program requires it); id., §52.1.7 (nourishment room optional).

from ~~the~~ this
applies
to all of
the
requirements,
it is
important
enough to
emphasize
- as it
provides
flexibility

Far too
much
detail.
Omit all
or most
of this
now, but
save
a copy
of this
draft for
possible need
when dissent
hit us.

services,¹⁶ and general building.

The most important group of ^{regulations} standards for our purposes relates to patient care services. ~~The bulk of~~

^{Primarily what state} ~~the standards discuss~~ the requirements for various

services that the facility may offer, such as

anesthesia,¹⁷ laboratory,¹⁸ and pathology.¹⁹ Some

^{of the requirement relate to} ~~standards govern~~ sanitation, laundry, and the physical

plant. See, e. g., Rules §§ 43.2, 43.10, 43.12.6. There

are also guidelines on medical records, §43.7, pre-

¹⁶These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. See Rules §52.3.1.

¹⁷See, e. g., Rules §43.1.1 (service must be directed by licensed physician); id., §43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁸Each patient admitted must receive "appropriate routine" laboratory testing. See Rules §43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, §64.1.3, and where medically indicated, serologic testing for syphilis and a Papanicolaou smear, §64.1.4.

¹⁹Section 43.6.3 requires that all tissue shall be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of §64.2.4 (must be submitted "for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See Ashcroft, U.S., at ____.

operative admission,²⁰ and post-operative recovery.²¹

Finally, the Rules mandates some emergency services and evacuation planning.²²

~~We carefully have reviewed these regulations and are~~

²⁰Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time must be allowed between initial examination and initiation of any procedure to permit review of laboratory tests. See id., §43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. See id., §43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods." Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, it remains true that "it is for the woman, in conjunction with her physician, to decide what considerations are relevant to [her] decision." See City of Ashcroft, ___ U.S., at ___.

²¹Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. See Rules §§43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. See id., §§43.9.3, 43.9.4.

²²See Rules §43.4.1 (written evacuation plan); id., §43.5.1 (shall maintain "adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); id., §43.5.2 (requiring a written agreement ensuring ambulance service to a licensed general hospital). Section 43.5.3 provides:

A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times.

Jim -
Doesn't
this mean
delay of
at least
24 hrs?
What does
this do
to our
above
holding

A

convinced that they are reasonably related to the

provision of abortion services during the second

trimester. The first category of requirements need little

discussion.²³ States have a legitimate interest in

regulating organizations as organizations within their

jurisdiction, and organizations primarily devoted to

providing abortion services are no different.²⁴ Virginia

requires little more or different than it does from other

associations and groups holding out their services for a

fee.²⁵

Onerous Construction or renovation requirements can

²³The ACOG's standards discuss much of Virginia's concerns about proper management and policies under the appropriate heading of "Quality Assurance." See Standards, supra, at 55 ("Each physician's office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished."). Like Virginia's narrative requirement, see supra, at ___, the ACOG's standards suggest that the "outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnosis, appropriateness of use of laboratory and other services, and other outcome of care." Standards, supra, at 55-56.

²⁴The ACOG advises that each ambulatory body should have a "governing body" that has the final authority and responsibility for the appointment of the medical staff. Id., at 60. Cf. supra, at ___. It also states that "[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically." Id., at 60.

²⁵See, e. g., Va. Const. art. IV, §14(17) (power to create private corporations).

[to be written]

But the
Regs do
not
require
incorporation.

Associations
also are
regulated - but medical
partnerships
do not have
this type of
organization. Don't
Regs define who
or what is being
regulated

discourage doctors from providing outpatient facilities,

~~and they must be carefully scrutinized.~~ The requirements

here, however, merely require the ^{clinic} facility to follow some

general design²⁶ and provide basic equipment.²⁷ The

safety standards for the most part merely refer to local

codes,²⁸ and many are not specific requirements, requiring

only that the facility be adequate for the services

²⁶The ACOG recommends that even physicians' offices and clinics provide at least a patient reception room, consultation room, at least two examining rooms, a utility room, and storage. See Standards, supra, at 57-59. The standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evaluation, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See id., at 61. The ACOG details the equipment to be found in the various rooms and areas. See id., at 57-58, 61.

²⁷The ACOG lists the equipment that a clinic's examining room should contain, including instruments for vaginal and rectal examinations, obtaining cultures and smears, and diagnostic studies and operative procedures. See id., at 57. When local anesthesia is used, the clinic or doctor's office should have emergency resuscitation equipment, including positive pressure oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. See ibid. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. See id., at 61.

²⁸See n. 14, supra. The ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. See Standards, supra, at 58, 61. Specific plans should be developed to evacuate patients in case of an emergency. See id., at 59, 62. Procedures should also be made for emergency transfers to a nearby hospital. See id. at 58, 62.

Jim -
Can we
correctly
say that
Va's Reg's
imposes
requirements
on ambulatory
clinics
substantially
similar
to those
recommended
by ACOG?
If no,
put this
in Text
at an
appropriate
place. We need
some basis of
comparison
other than our
unskilled
judgment!

offered. Cf. Standards, at 51 ("Procedures should be limited to those that can be performed safely with available medications and equipment and for which the participating personnel are trained."). The medical

profession seeks no immunity from local building laws, and the Virginia Rules ~~are simply an admission of~~ ^{reflect} that fact.

Our ^{primary} ~~greatest~~ concern is with the patient services requirement, for they ~~are the ones that~~ most clearly relate to health, yet may be unreasonable when considered as conditions for abortion procedures. The sanitation²⁹ and recordkeeping standards³⁰ are typical and not unreasonable in detail. The laboratory services ~~are~~

²⁹Infection can be a serious complication with any abortion procedure. See nn. 10 & 11, supra. Significant portions of the Virginia Regulations are designed to assure that outpatient surgical hospitals practice stringent infection control, including sterile processing, appropriate waste disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Va. Reg. §§41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. The ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies. See Standards, supra, at 58, 62.

³⁰The Virginia record keeping requirements are ~~very~~ similar to those detailed by the ACOG, see Standards, supra, at 54-55, 59-60, and we have found such requirements, "if not abused or overdone," impose a legally insignificant burden on the Roe right. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 81 (1976).

This seems
out of
place here.
The preceding
quote refers
to "procedures"

21.
21. *from - "tailored" is a law review word
that all of us use too much*

support - and often are essential to -- the
~~tailored to the provision of medical services,~~³¹ and the
post-operative recovery standards follows ~~common~~^{accepted} medical
practice.³² The equipment requirements for emergency
services are minimal³³ and are further prefaced with the
word "adequate."³⁴

We are impressed by the means Virginia has ~~tailored~~^{prescribed}
to assure that they further the state interest.
its requirements to ends that it seeks to meet. This is

³¹The risks of hemorrhage, are reduced by requiring an outpatient surgical hospital to make hemoglobin or hematocrit determinations before initiating instillation. See Standards, supra, at 59 ("The laboratory data should include hemoglobin or hematocrit, urinalysis").

³²Anesthesia complications are alleviated by requiring a physician to be present for monitoring functions during the administration of anesthetics and in the recovery period. See Standards, supra, at 53. Less serious complications can be monitored by the registered nurse on duty. See ibid. ("During the recovery period, the patient should be under continuous observation by a qualified member of the health care team."). The required one-hour recovery period is intended to permit detection of these problems. See Kerenyi, Mandelman & Sherman, Five Thousand Consecutive Saline Inductions, 116 Am. J. Obstet. & Gynecol. 593 (1973); Standards, supra, at 53; App. 37 (defense witness concedes waiting period necessary).

³³The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See Cates & Grimes, supra n. 11, at 407 (even for nonhospital facilities providing D&E, "arrangements for emergency care should be established with hospitals near the nonhospital facility").

Appellant's ³⁴~~Our judgment finds comfort in the fact that~~
petitioner's ~~well-equipped~~^{support} operating room contains
practically ~~all of~~^{indeed much more than} the
emergency services equipment required by the Commonwealth.
The record indicates that it has excellent lighting, wall
outlets for oxygen, suction apparatus, resuscitation
equipment, a defibrillator, an EKG machine, IV fluids,
complete anesthesia equipment, and drugs to be used in
emergencies. See App. 21-22, 375-376. *Appellant's*

~~facts~~^{by their} *make no contention, however,*
that his office facilities, or personnel
or care conform to the other requirements
for an out-patient abortion clinic.

especially so given that, in the regulation of abortion^s services, a particular ^{requirement} ~~regulation~~ "is not unconstitutional simply because it does not perfectly correspond to the asserted State interest." City of Akron, ____ U.S., at ____ . We find the correspondence here reasonable to pass constitutional muster.³⁵

We believe that the hospitalization requirement contained in §18.2-73 is nothing more than statutory recognition of the medical fact that second-trimester abortions may require certain technological support not necessary in the relatively safer first-trimester abortions.³⁶ The statute does not require that the

³⁵We indicated in City of Akron that the ACOG recommends that abortions performed in a physician's office or outpatient clinic be limited to fourteen-weeks gestation, but it indicates that abortions may be performed safely in a hospital-based or in a free-standing ambulatory facility until eighteen weeks gestations. See City of Akron, ____ U.S. ____ (citing Standards, supra, at 52). Virginia's Rules easily correspond to the ACOG requirements for a free-standing clinic and thus are reasonably related to the State's compelling interest in maternal health and safety for the period after fourteen weeks. But we are also impressed by the fact that, even though the Rules apply to two weeks in which abortions could be performed safely in a doctor's office or a clinic, they do not impose requirements that significantly deviate from those that ACOG would require of a well-equipped office or clinic performing thirteenth and fourteenth week abortions. See nn. 23-30. We think that Virginia has done well to tailor its requirements to promote the ends that it seeks.

³⁶Petitioner argues that Part III of the Rules, covering first-trimester abortion clinics requires the
Footnote continued on next page.

patient be hospitalized as an inpatient or that the abortion be performed in a full-scale general hospital.

The Virginia hospitalization requirement, in conjunction with the Rules and Regulations for the Licensure of Out-Patient Hospitals in Virginia, accommodates medical advances and leaves the type and timing of the abortion precisely where it belongs--between the physician and his patient. Petitioner's failure to avail himself of the hospital licensure provisions does not make the Commonwealth's minimal hospitalization requirement unconstitutional.³⁷

same services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Rules §63.1.1(b), §63.3, §§64.2.5(a)-(m). Petitioner argues that, given these extensive regulations for first-trimester abortion hospitals, the only way to require more technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the state's compelling interest in maternal health and safety.

³⁷Petitioner argues that, even if he could have obtained an outpatient hospital license to provide second-trimester abortions at his Falls Church office, he would also be required to obtain a certificate of public need. See Va. Code §32.1-102.1. He contends that this arduous process consumes several months and requires that a public hearing be held. See id., §32.1-102.6.A. It is not at all clear that an outpatient surgical center would need a certificate. See id., §32.1-102.1.6(a); §32.2-102.2.; see Rules §§30.5. In any case, the statute itself does not indicate the process is particularly difficult, and in the absence of any record evidence, we are unwilling to assume that this licensing procedure will actually burden women's

Footnote continued on next page.

Omit in
over
first
draft

III

Roe clearly permits States to impose some reasonable health requirements on second-trimester abortions to insure protection of a woman's physical health. Although there has been impressive advancements in medical science since 1973, eliminating in some circumstances the need for caution that the medical community was then expressing, the same medical community does not advise that any or all second-trimester procedures are so safe that this Court should eradicate all health regulations guiding their effectuation. We ^{hold}~~believe~~ that Virginia's requirement that such abortions must be performed in properly equipped outpatient clinics is reasonably related to the Commonwealth's compelling interest in maternal health and safety.

IV

We hold that Virginia's second-trimester hospitalization requirement is constitutional. The judgment of the Supreme Court of Virginia therefore is

right to decide to have an abortion.

Affirmed.

JUSTICE POWELL delivered the opinion of the Court.

The principal issue here is whether Virginia's mandatory hospitalization requirement for second-trimester abortions is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. His practice in November, 1979 consisted of office practice in Woodbridge, Virginia, hospital practice at four local hospitals or surgery centers, and practice at his clinic in Falls Church. The Falls Church clinic has an operating room, operating-room lighting, and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a seventeen-year old, high school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately twenty-two weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confide with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the doctor if "heavy" bleeding began. Although P.M. does not recall being advised to go to a hospital when labor began, this was listed in the instruction sheet. Id., at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom forty-eight hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion

¹Except as permitted by statute, persons performing an abortion are guilty of a felony under Virginia law and subject to mandatory license revocation. Va. Code §§18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). The felony is punishable by a sentence of two to ten years in prison. Va. Code §18.2-10(d).

²The indictment alleges a violation of Va. Code §18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony."

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during the second trimester of pregnancy outside of a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia reviewed appellant's case and unanimously affirmed his conviction.

Simopoulos v. Commonwealth, 221 Va. 1059, 277 S.E.2d 194 (1981).

This appeal followed. We noted probable jurisdiction, ___ U.S. ___, and now affirm.

II

Appellant broadly attacks Virginia's hospitalization requirements.³ He contends that they sharply restrict the

In the four following sections the Virginia Code sets forth exceptions to this statute: there is no criminal liability (i) if the abortion is performed within the first trimester, §18.2-72; (ii) if the abortion is performed in a licensed hospital in the second trimester, §18.2-73; (iii) if necessary to save the woman's life, §18.2-74.1; and (iv) during the third trimester under certain circumstances, §18.2-74.1. The indictment here alleged a violation of §18.2-71 and expressly negated any defenses of hospitalization under §18.2-73 and any first-trimester defense under §18.2-72. The indictment did not, however, rebut the other defenses.

³Questions raised particularly with respect to Virginia's outpatient surgical clinics are considered in Part III, infra. Appellant also raises two issues on his appeal that do not require extended treatment. He first contends that Va. Code §18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, nor mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by United States v. Vuitch, 402 U.S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by Patterson v. New York, 432 U.S. 197 (1977).

The authoritative construction of §18.2-71 by the Supreme Court of Virginia makes it clear that, at least with regard to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt until appellant invoked medical necessity as a defense.

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availability of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions. He also argues that the Virginia requirements result in negative health consequences and, as applied to him and the abortions he performs in his well-equipped non-licensed clinic, do not "measurably contribut[e] to the ... purposes which the State advances as justification for the restriction." Carey v. Population Services International, 431 U.S. 678, 702 (1977) (WHITE, J., concurring in part and concurring in the result).

We need not pause long here to consider the guiding principles, for we have set them out at length today in City of Akron v. Akron Center for Reproductive Health, Inc., ante, p. _____. In Roe v. Wade, 410 U.S. 113 (1973), the Court held that the Fourteenth Amendment's concept of personal liberty was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy," id., at 153. We rejected, however, the notion that a woman has an absolute right to an abortion. We consistently have recognized and reaffirm today

See 221 Va., at 1069, 277 S.E.2d, at 200. Appellant's reliance on Vuitch thus is misplaced. The Virginia statute, as construed by the state court, does not require that the State allege lack of medical necessity; the District of Columbia statute in Vuitch, as construed by this Court, required the prosecution to make this allegation. See 402 U.S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See Engle v. Isaac, ____ U.S. ____, and n. 20 (1982); Mullaney v. Wilbur, 421 U.S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is frivolous. See 221 Va., at 1069-1070, 277 S.E.2d, at 200-201.

that, "because a State has a legitimate concern with the health of women who undergo abortions, 'a State may properly assert important interests in safeguarding health [and] in maintaining medical standards.'" City of Akron, ante, at 10 (quoting Roe, 410 U.S., at 154). This "important and legitimate interest in the health of the mother" becomes "'compelling' ... at approximately the end of the first trimester," Roe, 410 U.S., at 163, and is compelling throughout the remainder of the pregnancy.

The State's interest in the health of the pregnant woman includes an interest in the safety of facilities that perform abortions. As the Court stated in Roe:

"The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise." 410 U.S., at 150.

To protect this compelling interest, the State may, "from and after the end of the first trimester, adopt standards for licensing all facilities where abortions may be performed so long as those standards are legitimately related to the objective the State seeks to accomplish." Doe v. Bolton, 410 U.S. 179, 194-195 (1973) (emphasis added). Specifically, the State may regulate "as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like." Roe, 410 U.S., at 163.

It is in furtherance of this compelling interest in maternal health that Virginia has enacted its hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under Virginia law.⁴ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code §18.2-73 (1982). The Virginia abortion statute itself does not contain the definition of the term "hospital." This definition is found in Va. Code §32.1-123.1, which defines "hospital" to include "outpatient ... hospitals." Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁵ defines

⁴A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code §32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that, after he performed the abortion on P.M., he requested a certificate of need, see also id., §32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek any license before he performed the abortion at issue here. Thus, without record evidence whether appellant's facility qualifies as a surgical outpatient clinic and that he was denied a hospital license, whether the Falls Church facility would qualify under Virginia law is irrelevant to our determination in this case. See n. 7, infra (noting State's interpretation of the Virginia regulations).

⁵The regulations were promulgated pursuant to 1947 Va. Acts, c. 15, §1514-a5, repealed by 1979 Acts, c. 711. Although
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outpatient hospital in pertinent part as "[i]nstitutions ... which primarily provide facilities for the performance of surgical procedures on outpatients"⁶ and provides that second-trimester abortions may be performed in these clinics.⁷ Thus, under Virginia law, a second-trimester abortion may be performed in an outpatient surgical clinic⁸ provided that clinic has been licensed as a "hospital" by the State.

It is readily apparent that Virginia's second-trimester

not relevant to our determination here, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he has been prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982).

⁶Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital ... unless such hospital ... is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) §30.1 (similar provision specifically governing outpatient surgical clinics).

⁷Part II of the regulations sets minimum standards for outpatient surgical clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

"Outpatient abortion clinics" refers specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. "These facilities limit the operative procedures to termination of pregnancy during the first trimester." *Ibid.* See *id.*, §62.1.2 ("Any procedure performed to terminate a pregnancy shall be performed prior to the end of the first trimester (12th week amenorrhea).").

⁸We herein usually refer to the outpatient "hospitals" in Virginia that legally may perform second-trimester abortions as "outpatient surgical clinics."

hospitalization requirement is significantly different from those at issue in City of Akron, ante, p. 13, and Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, ante, p. ____.

In those cases, the regulations required "all second-trimester abortions [to] be performed in general, acute-care facilities." Ashcroft, ante, at ____.

We found that such a requirement, by preventing the use of the dilatation and evacuation method (D&E) of performing abortions in appropriate nonhospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." City of Akron, ante, at 20.

The Court held these laws invalid because they did not reasonably further the States' interest in maternal health.

One of the most important factors in our analysis in City of Akron was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." Ante, at 19.

In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in acute-care, general hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for licensing as hospitals in which second trimester abortions lawfully may be performed. Thus, our decisions in City of Akron and Ashcroft are not controlling here.

B

Second-trimester abortions may give rise to serious complications,⁹ and certain procedures significantly increase the

Footnote(s) 9 will appear on following pages.

risks.¹⁰ Although the increasingly common use and relative safety of the D&E method, see City of Akron, ante, at ___, may make the need for particular equipment in and designs of a facility less compelling, the need for reasonable regulations has not been eliminated. D&E, despite its relative safety early in the second trimester, still may cause complications.¹¹

⁹Between 1972 and 1978, at least 67 women undergoing second-trimester abortions in this country died as a result of the abortion procedure. See Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: Annual Summary 1978, at 48 (1980). See also Cadesky, Ravinsky & Lyons, Dilation and Evacuation: A Preferred Method of Midtrimester Abortion, 129 Am. J. Obstet. Gynecol. 329, 331 (1981) (6.9% complication rate for second-trimester D&E abortions; 55% complication rate for second-trimester prostaglandin instillation).

¹⁰For example, the majority of second-trimester abortions after the sixteenth week of gestation are performed by means of intrauterine instillation of saline, see Grimes & Cates, The Brief for Hypertonic Saline, 15 Contemporary Ob/Gyn 29, 30 (1980), even though there is on the whole a greater death rate for instillation abortions than there is for D&E. See also Cates, et al., The Risk of Dying from Legal Abortion in the United States, 1972-1975, 15 Int'l J. Gynaecol. Obstet. 172, 175 (1977). For identification of less serious complications, see American College of Obstetricians and Gynecologists (ACOG), Technical Bulletin No. 37, Hypertonic Saline Amnio-Infusion 1, 2-3 (1976) (now replaced by ACOG Technical Bulletin No. 56, Methods of Midtrimester Abortion 75 (1979)).

¹¹A leading cause of death and complications in D&E abortion patients is hemorrhage, see Cates & Grimes, Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities, 58 Obstetrics & Gynecology 401, 401-402 (1981), that can be prevented, detected, and treated during or soon after the procedure. Other potential complications of this procedure are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, supra n. 10, at 78.

A major potential complication for all abortion techniques--infection--does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. See Ashcroft, 664 F.2d

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The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). Those standards need not be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982) (hereinafter ACOG Standards). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

Although the State's interest in licensing medical facilities

687, 690 n. 6 (CA8 1981), rev'd in part & aff'd in part, *ante*, p. . Thus the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

is compelling, the State's discretion to regulate on this basis does not "permit it to adopt abortion regulations that depart from sound medical practice." City of Akron, ante, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' Doe, 410 U.S., at 195." City of Akron, ante, at 12. The issue here is whether Virginia's licensing requirements for outpatient surgical clinics performing second-trimester abortions are reasonable means of furthering the State's compelling interest in the woman's health.

C

The Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia. Those regulations may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing--matters not particularly relevant. These require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) §40.3; see also §40.1. They also require a policy and procedures manual, §43.2¹², an administrative officer, §40.6, a licensed physician who

¹²The manual must describe emergency and elective procedures that may be performed at the facility, §41.2.1; the anesthesia that may be used, §41.2.2; the criteria and procedures for admissions and discharge, §41.2.4; written informed consent, §41.2.4; and procedures for housekeeping and infection control,

Footnote continued on next page.

must supervise clinical services and perform surgical procedures, §42.1, and a registered nurse to be on duty at all times while the facility is in use, §42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," §50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹³ and general building.¹⁴

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹⁵ laboratory,¹⁶ and pathology.¹⁷ Some of the

§41.2.5.

¹³These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) §52.3.1.

¹⁴The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹⁵See, e. g., Va. Regs. (Outpatient Hospitals) §43.1.1 (service must be directed by licensed physician); id., §43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁶Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) §43.6.1. Outpatient surgical clinics providing abortion services

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Footnote(s) 17 will appear on following pages.

requirements relate to sanitation, laundry, and the physical plant. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, §43.7, pre-operative admission,¹⁸ and post-operative recovery.¹⁹ Finally, the regulations mandate some emergency services and evacuation

also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, §64.1.3, and where medically indicated, serologic testing for syphilis and a Papanicolaou smear, §64.1.4.

¹⁷Section 43.6.3 requires that all tissue shall be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of §64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See Ashcroft, ante, at ____.

¹⁸Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. Id., §43.8.3. In an outpatient surgical clinic providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. Id., §43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods." (emphasis added) Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, it is, unlike in City of Akron, for the woman, in conjunction with her physician, to decide what considerations are relevant to her decision. See ante, at 27-28.

¹⁹Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. Id., §§43.9.3, 43.9.4. For a discussion of similar standards by various medical organizations, see n 32, infra.

planning.²⁰

III

Appellant does not attack expressly these regulations in his jurisdictional statement or in his principal brief. In those, he emphasizes that Virginia requires hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics that may perform second-trimester abortions. As appellant had not sought a license for his clinic, he appears to argue that the Virginia hospitalization requirements are comparable to those we have considered in City of Akron and Ashcroft.

Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that, even if he had applied for a license, it is uncertain whether it would have been granted; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; that Part II of the regulations does not

²⁰See Va. Regs. (Outpatient Hospitals) §43.4.1 (written evacuation plan); id., §43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); id., §43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and

which has a physician in the hospital and available for emergency service at all times."

cover an outpatient surgical facility where second trimester abortions are performed, but see n. 8, supra; and that medical evidence rebuts the view "that it is safer to perform second trimester abortions in hospitals." Reply Brief for Appellant 1. None of these contentions finds support in this Court's prior opinions, and the Virginia requirements are strikingly different from those we invalidated in City of Akron and Ashcroft. Indeed, it is evident that Virginia has adopted statutes and regulations compatible with our decisions. We are convinced that the Virginia provisions are reasonably related to and further the State's compelling interest in protecting the health of the pregnant woman during the second trimester.²¹

The requirements of the first²² and second categories²³ of

²¹No doubt there are costs incurred in complying with Virginia's requirements, but these are not burdens that necessarily invalidate the regulations. As an empirical matter, we have no reason to believe these costs will result in fewer appropriate facilities for performing second-trimester abortions. Ethical physicians are obligated to provide facilities consistent with the standards set by their profession. And appellant has not identified any significant differences between professional standards and the Virginia requirements.

²²ACOG's standards discuss many of Virginia's concerns about proper management and policies under the appropriate heading of "Quality Assurance." See ACOG Standards, supra, at 55 ("Each physician's office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished."). Like Virginia's "narrative" requirement, Va. Regs. (Outpatient Hospitals) §§50.1.1, 50.2.1, ACOG's standards suggest that the "outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnoses, appropriateness of use of laboratory and other services, and outcome of care." ACOG Standards, supra, at 55-56. See National Abortion Federation (NAF), National Abortion Federation Standards 11 (1981) (hereinafter NAF Standards) (requiring written descriptions of procedures and

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Footnote(s) 23 will appear on following pages.

regulations discussed in Part II-C above have little relevance to

policies in each area of care). Cf. Brief of the APHA as Amicus Curiae 29 n. 6. (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

ACOG also advises that each ambulatory body should have a "governing body" that has the final authority and responsibility for the appointment of the medical staff, ACOG Standards, supra, at 60; cf. Va. Regs. (Outpatient Hospitals) §40.3, and that "[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically," ACOG Standards, supra, at 60. Cf. NAF Standards, supra, at 12 (responsibilities of chief administrative officer); Planned Parenthood of Metropolitan Washington, D.C., Inc., 1980 Guidelines for Operation, Maintenance and Evaluation of First Trimester Outpatient Abortion Facilities 1 (hereinafter "Planned Parenthood Guidelines") (duties of administrator).

²³This second category of Virginia regulations is consistent with those set forth by ACOG. ACOG recommends that even physicians' offices provide at least a patient reception room, consultation room, two examining rooms, a utility room, and storage. ACOG Standards, supra, at 56-58. Cf. Planned Parenthood Guidelines, supra n. 22, at 1-3 (detailing extensive physical requirements for first-trimester abortion clinics). ACOG's standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evaluation, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See ACOG Standards, supra, at 61. Cf. S. Neubardt & H. Schulman, Techniques of Abortion 110-111 (2d ed. 1977) (similar list of facilities needed for model abortion care unit).

ACOG details the equipment to be found in the various rooms and areas. ACOG Standards, supra, at 57-58, 61. Cf. APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980) (hereinafter "APHA Guide") (any abortion facility should have "[a]n operating table, or conventional gynecologic examining table with accessories, located in a room which is adequately lighted and ventilated and meets all other environmental standards for surgical procedures"); Planned Parenthood Guidelines, supra, at 2. A doctor's examining room should contain instruments for vaginal examinations, supplies for obtaining cultures and smears, and equipment for diagnostic studies and operative procedures. ACOG Standards, supra, at 57. Cf. Planned Parenthood Guidelines, supra, at 2. When local anesthesia is used, the clinic or doctor's office should have emergency resuscitation equipment, including positive pressure

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this case. They have not been challenged by appellant beyond his general condemnation of any requirement that second-trimester abortions--even those during the twenty-second week of pregnancy--be performed in hospitals, however defined and whether outpatient or not. In any event, as appears from the recommendations of ACOG and the American Public Health Association (APHA) set forth in the margin, see nn. 22, 23 & 24, Virginia's requirements, although more detailed with respect to specific facilities,²⁴ equipment, and personnel than the ACOG and APHA standards, are compatible with generally accepted medical standards and do not unreasonably burden the abortion decision.

Our concern centers on the patient services requirements of the Virginia regulations and whether they further the State's interest in the health and safety of the pregnant woman. We think they clearly do. Again, we have compared them to the standards used by

oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. ACOG Standards, supra, at 57. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. Id., at 61. Cf. APHA Guide, supra, at 655 (requiring oxygen, and equipment for artificial ventilation and resuscitation); NAF Standards, supra n. 22, at 9 (requiring all facilities performing second-trimester abortions to have resuscitation bag, oxygen, and defibrillator if general anesthesia is administered); Planned Parenthood Guidelines, supra, at 2 (even first-trimester abortion clinics should have parenteral fluids, resuscitation equipment, and oxygen).

²⁴ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. ACOG Standards, supra, at 58, 61. Specific plans should be developed to evacuate patients in case of an emergency. Id., at 59, 62. Cf. NAF Standards, supra n. 22, at 8, 11; Planned Parenthood Guidelines, supra n. 22, at 10.

ACOG and APHA, and we are impressed with the scrupulousness with which Virginia has drawn regulations reasonably related to its interest in protecting the pregnant woman's health. The sanitation²⁵ and record-keeping standards²⁶ are typical and not

²⁵Infection can be a serious complication with any abortion procedure. See nn. 11 & 12, supra. Significant portions of the Virginia regulations are designed to assure that outpatient surgical clinics take appropriate steps to control infection, including sterile processing, appropriate waste disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Va. Regs. (Outpatient Hospitals) §§41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies. ACOG Standards, supra, at 58, 62. APHA Guide, supra n. 23, at 655; NAF Standards, supra n. 22, at 7 ("Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure"); Planned Parenthood Guidelines, supra n. 22, at 2.

²⁶The Virginia record-keeping requirements are similar to those detailed by ACOG for a physician's office, ACOG Standards, supra, at 54-55, 59-60, which require at the initial visit a comprehensive data base including information on reason for visit, menstrual history, obstetric history, gynecologic history, sexual history, past medical and surgical history, current medications, allergies, social history, and family history. For ambulatory surgical facilities, ACOG recommends that the patient's record contain sufficient information to justify the preoperative diagnosis and the operative procedure, and should at least contain patient identification data, history and physical examination, provisional diagnosis, diagnostic and therapeutic orders, surgeons' and nurses' notes, laboratory data, operative consent, operative report, anesthesia report, tissue report, medications record, and discharge summary and instructions. Id., at 59. See also id., at 60 ("On the day of surgery a preanesthetic evaluation, including an interval history, medical record review, and a heart and lung examination should be performed by a physician and the findings should be noted in the record."). We have found such requirements, "if not abused or overdone," impose a legally insignificant burden on the Roe right. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 81 (1976). We do not think Virginia's requirements are excessive. Cf. APHA Guide, supra n. 23, at 655-656 (recommended reporting requirements); Planned Parenthood

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unreasonable in detail. The laboratory services²⁷ support--and often are essential to--the direct medical services²⁸ performed by the physician²⁹ and nurse.³⁰ The post-operative recovery

Guidelines, supra n. 22, at 13 (record-keeping and reporting requirements).

²⁷The risk of hemorrhage is reduced by requiring an outpatient surgical clinic to make hemoglobin or hematocrit determinations before initiating instillation. See ACOG Standards, supra, at 59 ("The laboratory data should include hemoglobin or hematocrit, urinalysis, and, in certain selected patients, other studies such as a chest x-ray, electrocardiogram, and electrolytes."). See also APHA Guide, supra n. 23, at 654 ("Appropriate laboratory procedures must include determination of hematocrit and Rh factor in every case. The value of other laboratory procedures will depend upon the population served; these may include sickle cell testing; endocervical and anal culture for gonorrhea; urinalysis; serologic testing for syphilis; and, when indicated cytologic screening for cancer."); NAF Standards, supra n. 22, at 7 ("Rh-immune globulin must be explained and administered to Rh-negative patients."); Planned Parenthood Guidelines, supra n. 22, at 8 (requiring lab facilities to be available on premises for pregnancy tests, urine protein and sugar, hematocrit or hemoglobin determination, and Rh typing).

²⁸See ACOG Standards, supra, at 59 ("The appropriate records should be completed and laboratory data recorded prior to surgery.") (emphasis added). ACOG also recommends that "[t]he physician should strive to identify pre-existing or concurrent illness, medications, and adverse drug reactions that may have a bearing on the operative procedure or anesthesia. All records should be reviewed before any surgery is performed." Id., at 60 (emphasis added). APHA Guide, supra n. 23, at 654; Planned Parenthood Guidelines, supra n. 22, at 8.

²⁹For example, the ACOG requires careful laboratory work before anesthesia is administered, and even then, it must be given only by or under the supervision of a doctor: "Any ambulatory surgical unit that utilizes general, epidural, or spinal anesthesia should do so under the direction of an anesthesiologist. These anesthetics should be administered by a qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation must be available." ACOG Standards, supra, at 53. Cf. APHA

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standards³¹ also comport with accepted medical practice.³² The

Guide, supra n. 23, at 655; Planned Parenthood Guidelines, supra n. 22, at 10.

³⁰The ACOG Standards do not specifically require nurses for physicians' offices or for ambulatory surgical facilities, but note: "The efficient operation of an ambulatory surgical facility requires adequate staffing with administrative and professional personnel. The assignment of personnel should be based on the number of patients, patient profiles, type of procedures, and facility design." ACOG Standards, supra, at 60. Cf. id., at 56 ("Administrative and professional personnel requirements will vary considerably in each physician's office and outpatient clinic depending on the patient load, pattern of practice, and type of facility."); Planned Parenthood Guidelines, supra n. 22, at 7 (nurses); id., at 7-8 (head laboratory technician); id., at 9 ("It is strongly recommended that three staff persons be present in the procedure room: the operating physician, the physician's assistant and a counselor to assist the patient.").

³¹See n. 19, supra.

³²Complications resulting from anesthesia are alleviated by requiring a physician to be present during the recovery period. See ACOG Standards, supra, at 53 ("The supervising anesthesiologist, or another physician qualified in cardiopulmonary resuscitation, should be present in the ambulatory surgical facility until all surgical patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the back-up hospital."); Planned Parenthood Guidelines, supra n. 22, at 11; see also APHA Guide, supra n. 23, at 655 ("[I]t will be necessary to periodically observe the temperature, pulse rate, blood pressure, and the amount of bleeding. In addition, the abdomen should be examined for evidence of intra-abdominal bleeding or injury."). Less serious complications can be monitored by the registered nurse on duty. See ACOG Standards, supra, at 53 ("During the recovery period, the patient should be under continuous observation by a qualified member of the health care team. This person should maintain a complete record of the patient's general condition including vital signs, blood loss, and occurrence of complications."); NAF Standards, supra n. 22, at 6 ("The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area."); Planned Parenthood Guidelines, supra, at 11. The required one-hour recovery period is intended to permit detection of these complications. See APHA Guide, supra, at 655 (requiring post-operative observations "over a period of two or more hours, depending upon the type of anesthesia used"); Kerenyi, Mandelman

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equipment requirements for emergency services are minimal³³ and are further prefaced with the word "adequate."³⁴

We do not suggest that all of the Virginia requirements are necessary for every second-trimester abortion. But a State simply cannot adopt regulations that serve every case with the same degree of relevance; "a State necessarily must have some latitude in adopting regulations of general applicability in this sensitive area." City of Akron, ante at 16. Although a State's general licensing regulations must be drawn to further the State's interests in women's health for all reasonable periods of time within the second-trimester, a particular requirement "is not unconstitutional

& Sherman, Five Thousand Consecutive Saline Inductions, 116 Am. J. Obstet. & Gynecol. 593, 597 (1973); ACOG Standards, supra, at 53; App. 37 (defense expert witness concedes waiting period desirable).

³³The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See APHA Guide, supra n. 23, at 655; ACOG Standards, supra, at 52 ("There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication."); id., at 58, 62; Cates & Grimes, supra n. 11, at 407 (even for nonhospital facilities providing D&E, "arrangements for emergency care should be established with hospitals near the nonhospital facility"); NAF Standards, supra n. 22, at 7; Planned Parenthood Guidelines, supra n. 22, at 10 ("Each facility must have a functioning arrangement for emergency transport to a local accredited hospital.").

³⁴Appellant's operating room contains practically all of the emergency services equipment required by the State. The record indicates that it has excellent lighting, wall outlets for oxygen, suction apparatus, resuscitation equipment, a defibrillator, an EKG machine, intravenous fluids, and complete anesthesia equipment. App. 21-22, 375-376. Although appellant sought a "certificate of need" from the Virginia Bureau of Resources Development, see n. 4, supra, he makes no contention that his office's facilities, personnel, or care conform fully to the requirements for an outpatient surgical clinic.

simply because it does not correspond perfectly to the asserted state interest" every day of the trimester. Ante, at 20.

We therefore conclude, at least on the record before us in this case, that Virginia's regulations concerning second-trimester abortions are reasonably related to and further the State's compelling interest in "protecting the woman's own health and safety." Roe, 410 U.S., at 150.³⁵ As we emphasized in Roe, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." Ibid. Unlike Akron in City of Akron or Missouri in Ashcroft, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements--the statutes and the regulations--accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong--between the physician and the patient.

IV

We hold that Virginia's requirement that second-trimester

³⁵Appellant argues that Part III of the regulations, covering first-trimester abortion clinics requires the same services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§63.1.1(b), §63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require more technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the state's compelling interest.

abortions be performed in properly equipped outpatient clinics is constitutional. The judgment of the Supreme Court of Virginia

therefore is

Affirmed.

I will continue to work on inserting
ACOG quotes into the foot-
notes in Part III.

Have a good vacation.

DOB

LFD
Reviewed
2/4-5/83

Sinopoulos v. Virginia, No. 81-185

JUSTICE POWELL delivered the opinion of the Court.

The principal issue here is whether Virginia's
mandatory hospitalization requirement for second-trimester
abortions is constitutional.

I

Appellant is a practicing obstetrician-gynecologist
certified by the American Board of Obstetrics and
Gynecology. His practice in November, 1979 consisted of
office practice in Woodbridge, Virginia, hospital practice
at four local hospitals or surgery centers, and practice
at his clinic in Falls Church, known as the American
Women's Clinic. The clinic has an operating room,
operating-room lighting, and facilities for resuscitation
and emergency treatment of cardiac/respiratory arrest.
Replacement and stabilization fluids are on hand.
Appellant customarily performs first-trimester abortions
at his clinic. During the time relevant to this case, the
clinic was not licensed, in any way, nor had appellant

sought any license for it.

P.M. was a seventeen-year old, high school student when she went to appellant's clinic on November 8, 1979.

She was unmarried, and told appellant that she was about twenty-two weeks pregnant. She requested an abortion and

did not want her parents to know. Examination by

appellant confirmed that P.M. was five months pregnant, ^{well into the second trimester,} 1

Appellant testified that he encouraged her to confide with

her parents and discussed with her the alternative of

continuing the pregnancy to term. She did return home,

but never advised her parents.

Two days later, P.M. returned to the clinic with her

✓ "boy friend." The abortion was performed by ~~means~~ of an

injection of a saline solution. P.M. told appellant that

she planned to deliver the fetus in a motel, and she

understood that ~~appellant~~ ^{he} agreed this was all right.

Appellant gave P.M. a prescription for an analgesic and a

"Post-Injection Information" sheet that stated she had

undergone "a surgical procedure" and warned of a "wide

range of normal reactions." The sheet also advised that

she call the doctor if "heavy" bleeding began. Although

5 1/2 mos.?

P.M. does not recall being advised to go to a hospital when labor began, this was specified in the instruction sheet.

P.M. ~~then~~ ^{alone} went to a motel and aborted her fetus in the motel bathroom forty-eight hours after the saline injection. ~~Alone~~ ¹ She left the fetus, follow-up instructions, and pain medication at the motel. Her boyfriend took her home. Police found the fetus later that day and opened an investigation.¹

Appellant was indicted² for unlawfully performing an

¹Except as permitted by statute, persons performing an abortion are guilty of a felony under Virginia law and subject to mandatory license revocation. Va. Code §§18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). See Simopoulos v. Virginia State Board of Medicine, 644 F.2d 321, 322-323 (CA4 1981).

²The indictment alleges a violation of Va. Code §18.2-71, which provides:

Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony.

In the four following sections the Virginia Code sets forth exceptions to this statute: there is no criminal liability (i) if the abortion is performed within the first trimester, §18.2-72; (ii) if the abortion is performed in a licensed hospital in the second trimester, §18.2-73; (iii) if necessary to save the woman's life, §18.2-74.1; and (iv) during the third trimester under certain circumstances, §18.2-74.1. The indictment here alleged a violation of §18.2-71 and expressly negated any defenses of hospitalization under §18.2-73 and any first-

Footnote continued on next page.

*Just - what
was this
case about?*

abortion during the second trimester of pregnancy outside of a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia reviewed appellant's case and, in a unanimous decision, affirmed his conviction. Simopoulos v. Commonwealth, 221 Va. 1059, 277 S.E.2d 194 (1981). This appeal followed. We now affirm.

II

Appellant ^{broadly attacks} ~~contends~~ that Virginia's ^{hospitalization} hospital requirement ^{5.} ~~He contends that they~~ sharply restricts the availability of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions.³ He also argues that the Virginia

^{particularly} trimester defense under §18.2-72. The indictment did not, however, rebut the other defenses.

^{also} Appellant ³ raises two issues on his appeal that do not require extended treatment. He first contends that Va. Code §18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, nor mentioned by the trier of fact. Appellant contends that this failure creates two constitutional issues: (i) whether the State failed to meet its burden of alleging necessity in the indictment, as required by United States v. Vuitch, 402 U.S. 62 (1971); and (ii) whether the prosecution failed to meet its burden of persuasion, as required by Patterson v. New York, 432 U.S. 197 (1977).

The authoritative construction of §18.2-71 by the Supreme Court of Virginia makes it clear that, at least with regard to the defense of medical necessity, the prosecution was not obligated to prove lack of medical

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*Sim -
This II
mentions
only two of
appellant's
contentions.*

*Questions
raised with
respect to
Virginia's
outpatient
surgical
clinics
are
considered
in Part III,
infra.*

requirement⁵ results in negative health consequences and, as applied to him and the abortions that he performs in his well-equipped non-licensed clinic, does not "measurably contribut[e] to the ... purposes which the State advances as justification for the restriction." Carey v. Population Services International, 431 U.S. 678, 702 (1977) (WHITE, J., concurring in part and concurring in the result).

We need not pause long here to consider the standard of review, for we have set it out at length today in City of Akron v. Akron Center for Reproductive Health, Inc.,

^{Amke at} U.S. _____. ~~Although the Court found~~ In Roe v. Wade, 410 U.S. 113 (1973), ^{the Court held that} the Fourteenth Amendment's concept of

necessity beyond a reasonable doubt until appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S.E.2d, at 200. Appellant's reliance on Vuitch thus is misplaced, because the Virginia statute, as construed by the state court, does not require that the State allege lack of medical necessity; the District of Columbia statute in Vuitch, as construed by this Court, did require the prosecution to so allege. See 403 U.S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See Engle v. Isaac, 102 S.Ct. 1558, 1567-1568 & n. 20 (1982); Mullaney v. Wilbur, 421 U.S. 684, 701-703 nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the demise of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is frivolous. See 221 Va., at 1069-1070, 277 S.E.2d, at 200-201.

personal liberty ^{was} "broad enough to encompass a woman's decision whether or not to terminate her pregnancy," id., at 153. ^{however,} We rejected ¹ the notion that a woman has an absolute right to an abortion without any interference from the State. We consistently have recognized, and ~~we~~ reaffirm today ¹ that ¹ "since a State has a legitimate concern with the health of women who undergo abortions, 'a State may properly assert important interests in safeguarding health [and] in maintaining medical standards.'" City of Akron, ____ U.S., at ____ (quoting Roe, 410 U.S., at 154). As ~~JUSTICE BLACKMUN~~ ^{stated} ~~stated for~~ the Court ¹ in Roe:

The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise.

410 U.S., at 150. ¹ The issue here is whether the Virginia hospitalization requirement is reasonably related to the promotion of the Commonwealth's compelling interest in maternal health and safety.⁴

Footnote(s) 4 will appear on following pages.

Jim - I would add here the quote from Roe that state's interest is compelling from 2nd trimester. We ~~now~~ use this quote in Akron & Cincinnati.

Jim - As we repeat this on p 13 in different language, I'd omit the sentence here and reframe language on p 13.

A

Before examining the medical basis for Virginia's hospitalization requirement, it is helpful to understand the nature of that requirement. As a general proposition, physicians' offices are not regulated under Virginia law.⁵ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code §18.2-73 (1982). The Virginia abortion statute

⁴Appellant also argues that the State has no compelling interest in imposing criminal penalties on the performance of safe nonhospital abortions in the second trimester and that criminal penalties to enforce ~~total~~ hospitalization is not a narrowly drawn requirement. Similar arguments in prior cases have not been persuasive.

⁵A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. See Va. Code §32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that, after he performed the abortion on P.M., he requested a certificate of need, but was informed by the Office of the Attorney General that his "office-clinic cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek any license before he performed the abortion at issue here. Thus, whether his facility would qualify under Virginia law is irrelevant to our determination.

itself does not contain the definition of the term "hospital." This is found ⁱⁿ §32.1-123.1, ^{that} which defines "hospital" to include "outpatient ... hospitals." Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) (^{"regulations"} ~~hereinafter~~ Rules) defines outpatient hospital in pertinent part as "[i]nstitutions ... which primarily provide facilities for the performance of surgical procedures on outpatients"⁶ and expressly includes "outpatient abortion clinics."⁷ Thus, under Virginia law, a second-trimester abortion may be performed

⁶Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital ... unless such hospital ... is licensed as provided in this article." See also Rules §30.1 (similar provision specifically for outpatient surgical clinics).

⁷"Outpatient abortion clinics" refers specifically to those facilities meeting the minimum standards of Part III of the Rules, see Rules, at i, §62.1.2 of which provides that "[a]ny procedure performed to terminate a pregnancy shall be performed prior to the end of the first trimester (12th week amenorrhea)." Appellant argues from this that outpatient surgical clinics that provide abortion services cannot ^{provide} second-trimester abortions. A more plausible reading, however, is that Part III sets minimum standards for first-trimester abortion clinics, with part II setting minimum standards for outpatient surgical clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, i. e., §§43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services. Moreover, the Commonwealth's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. See Tr. of Oral Arg. 33.

In most places, we simply say "regulations".

be licensed to perform

in an outpatient surgical clinic⁸ provided that clinic has been licensed as a "hospital" by the Commonwealth.

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those that we invalidated today in City of

~~Akron and Planned Parenthood Association v. Ashcroft,~~

U.S. ____. In those cases, the laws at issue "require[d]

all second-trimester abortions to be performed in general,

acute-care facilities." Id., at _____. We found that such

a requirement, by preventing ^{the use of the dilation and evacuation method} ~~the performance~~ of (D&E)

^{of performing} abortions in appropriate nonhospital settings, "imposed a

heavy, and unnecessary, burden on women's access to a

relatively inexpensive, otherwise accessible, and safe

abortion procedure." City of Akron, ____ U.S., at ____.

The Court therefore held invalid the laws there as not

reasonably furthering the states' interest in maternal

health.

One of the most important factors in our analysis in

⁸We herein usually refer to the outpatient "hospitals" in Virginia that legally may perform second-trimester abortions as "outpatient surgical clinics."

Jim -
check with
Reporter's
office as
to how we
refer to
these cases.
All these
should be
provided
together

Should not
we identify
D & E.

*Jim + Mark:
We should
discuss
whether to
say "early
weeks" or
say
approximately
to 14 (16?)
weeks?*

City of Akron was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." ____ U.S., at _____. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in acute-care, general hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for licensing as hospitals in which second trimester abortions lawfully may be performed. Thus, our decisions in City of Akron and Ashcroft are not controlling here.

B

As noted above,
^ ~~Our decisions have established that~~ the State's interest in protecting maternal health becomes compelling at approximately the beginning of the second-trimester. See City of Akron, ____ U.S., at ____; Roe, 410 U.S., at 163. Second-trimester abortions may give rise to serious complications,⁹ and certain procedures significantly

⁹Between 1972 and 1978, 79 women undergoing second-trimester abortions in this country died as a result of the abortion procedure. See Centers for Disease Control, Abortion Surveillance, at 48 (1980).

increase the risks.¹⁰ Although the increasingly common use and relative safety of the ~~dilatation and evacuation~~ ^{D & E} method (~~D&E~~), see City of Akron, ___ U.S., at ___, may make the need for particular equipment in and designs of a facility less compelling, ~~they have~~ ^{this method has} not eliminated the need for reasonable ^{regulatory} standards. D&E, despite its ^{relative} ~~comparative~~ safety, may cause complications¹¹ and States

10 For example, the majority of second-trimester abortions after the sixteenth week of gestation is performed by means of intrauterine instillation of saline, see Grimes & Cates, The Brief for Hypertonic Saline, 15 Contemporary Ob/Gyn 29, 30 (1980), even though the rate of death for abortions done by instillation procedures is overall greater than for D&E. See also ACOG Technical Bulletin No. 37, Hypertonic Saline Amnio-Infusion I (1976) (mortality rate of 18 per 100,000 women); Cates, et al., The Risk of Dying from Legal Abortion in the United States, 1972-1975, 15 Int'l J. Gynaecol. Obstet. 172, 175 (1977). Less serious complications include hypertremia, fever, retained placenta, hemorrhage, premature rupture of the membranes, immediate labor, disseminated intravascular coagulation (DIC), cervicovaginal laceration, failed amniocentesis, failed labor, and sepsis. See ACOG Technical Bulletin No. 37, supra, at 2-3.

11 A leading cause of death and complications in D&E abortion patients is hemorrhage, which can be prevented, detected, and treated during or soon after the procedure. See Cates & Grimes, Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities, 58 Obstetrics & Gynecology 401, 403 (1981). Other potential complications of this procedure are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, Methods of Midtrimester Abortion, at 78 (1979).

A major potential complication for all abortion techniques--infection--does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman will have been discharged from any facility, see Ashcroft, 664 F.2d 687, 690 n. 6 (CA8 1981), rev'd in part & aff'd in part, ___ U.S. ___ (1983), thus the safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

You - I'm impressed,
but lacking these
horrors - of which I
know nothing - secure
unnecessary. In these
three cars together we
have a lot of this

usually

relative

Therefore

^ have a legitimate interest in ensuring that facilities used for second-trimester abortions meet appropriate standards for prevention, detection, and treatment of those complications. That interest is compelling throughout the second-trimester, and the State may, "from and after the end of the first trimester, adopt standards for licensing all facilities where abortions may be performed so long as those standards are ^[reasonably] legitimately related to the objective the State seeks to accomplish." Doe v. Bolton, 410 U.S. 179, 194-195 (1973) (emphasis added). Specifically, the State may regulate "as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like." Roe, 410 U.S., at 163.

The medical profession has not sought an exemption from licensing requirements for facilities that provide abortion services. The standards of the American College of Obstetricians and Gynecologists (ACOG) provide that "[a]mbulatory care facilities providing abortion services

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should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." ACOG, Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982) (hereinafter Standards). The profession clearly acknowledges the State's role in promulgating and policing those standards: "Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation. Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." Id., at 54. The issue here is whether Virginia's licensing requirements reasonably further the State's compelling interest ^{in maternal health,} ~~without unduly burdening the~~ right of a woman to an abortion.

Does Rule
Book
capitalize
"state"?

Jim: Mark
thinks we should
avoid "undue" or
qualification
of "burden".
We should
agree on
a way to
state this
issue in these
three cases & use it
uniformly. Roe has
been criticized
for use of different
formulations.

C

The regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia. Those

regulations may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization,¹² management, policies, procedures, and staffing--matters not presently relevant. These do require personnel and facilities "necessary to meet patient and program needs." Rules §§40.1, 40.3. They also require a policy and procedures manual, §43.2¹³, an administrative officer, §40.6, a licensed physician who must supervise clinical services and perform surgical procedures, §42.1, and a registered nurse to be on duty at all times while the facility is in use, §42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the

¹²The regulations seem to allow the owners, to decide what economic arrangement--i. e., corporation, partnership, association--is appropriate. See Rules §40.2.

¹³The manual must describe emergency and elective procedures that may be performed at the facility, §41.2.1; the anesthesia that may be used, §42.2.2; the criteria and procedures for admissions and discharge, §41.2.4; written informed consent, §41.2.4; and procedures for housekeeping and infection control, §41.2.5.

*to select
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of legal
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or sole proprietorship.

minimum requirements have been fulfilled," §50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁴ and general building.¹⁵

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹⁶ laboratory,¹⁷ and pathology.¹⁸ Some of the requirements relate to

¹⁴These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. See Rules §52.3.1.

¹⁵The regulations ~~also~~⁶ contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Rules §§50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹⁶See, e. g., Rules §43.1.1 (service must be directed by licensed physician); id., §43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁷Each patient admitted must receive "appropriate routine" laboratory testing. See Rules §43.6.1. Outpatient surgical clinics providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, §64.1.3, and where medically indicated, serologic testing for syphilis and a Papanicolaou smear, §64.1.4.

¹⁸Section 43.6.3 requires that all tissue shall be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of §64.2.4 (must be submitted "for histological examination by a pathologist in all cases where gross examination by the attending physician does

Footnote continued on next page.

sanitation, laundry, and the physical plant. See, e. g., Rules §§ 43.2, 43.10, 43.12.6. There are also guidelines on medical records, §43.7, pre-operative admission,¹⁹ and post-operative recovery.²⁰ Finally, the Rules mandates some emergency services and evacuation planning.²¹

not confirm presence of fetal parts"). See Ashcroft, U.S., at ____.

¹⁹Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time must be allowed between initial examination and initiation of any procedure to permit review of laboratory tests. See id., §43.8.3. In an outpatient surgical clinic providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. See id., §43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods." Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, it remains true that "it is for the woman, in conjunction with her physician, to decide what considerations are relevant to [her] decision." See City of Ashcroft, ____ U.S., at ____.

²⁰Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. See Rules §§43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. See id., §§43.9.3, 43.9.4.

²¹See Rules §43.4.1 (written evacuation plan); id., §43.5.1 (shall maintain "adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); id., §43.5.2 (requiring a written agreement ensuring ambulance service to a licensed general hospital). Section 43.5.3 provides:

A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical anesthesia, clinical

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III

Appellant does not attack these regulations as such either in his jurisdictional statement or in his principal brief. In those, he emphasizes that Virginia requires hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics that may perform second-trimester abortions. As appellant had not sought a license for his clinic, ~~perhaps~~ ^{apparently} he deemed it ~~to argue that~~ ^{necessary} broadly to equate the Virginia provisions with ~~the~~ ^{are comparable to those} hospitalization requirements we have considered in City of Akron and Ashcroft.

Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that, even if he had applied for a license, it is uncertain whether it would have been granted; that Virginia courts have had no opportunity to construe the "licensing statutes and ^{regulations} regulations"; that Part II of the Rules do not cover an

laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times.

outpatient surgical facility where second trimester abortions are performed, but see n. 7, supra; and that medical evidence rebuts the view that it is "safer to perform trimester abortions in hospitals." Reply Brief for Appellant 9-13. None of these contentions finds support in this Court's prior opinions, and the Virginia requirements are strikingly different from those we invalidated in City of Akron and Ashcroft. Indeed, it is evident that Virginia has made a thoughtful effort to adopt statutes and regulations compatible with our decisions. We are convinced that the Virginia provisions are reasonably related to and further the State's compelling interest in protecting the health of the pregnant woman during the second trimester, and that they do not ~~unduly~~ *unnecessarily* burden her right to an abortion.²²

22 No doubt there are ~~some~~ ^{incurred} costs ~~incurred~~ in complying with Virginia's hospitalization requirements, but ~~the burdens accompanying state abortion regulation do not necessarily make the regulations infirm. The burdens here, for example, are unlikely to discourage women from undergoing a safe second-trimester abortion. As an empirical matter, we do not believe that there will be fewer appropriate facilities available for second-trimester abortions than without the regulations. Doctors are obligated to provide facilities consistent with the standards set by their profession, and because we conclude that Virginia's regulations reasonably correspond to those set by medical organizations, any differences do not impose unreasonable burdens.~~

And Appellant has not identified any significant differences ^{between} ~~from~~ professional standards ^{and} the Virginia requirements.

The requirements of the first²³ and second categories²⁴ of regulations discussed in Part II-C above

²³The ACOG's standards discuss much of Virginia's concerns about proper management and policies under the appropriate heading of "Quality Assurance." See Standards, supra, at 55 ("Each physician's office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished."). Like Virginia's narrative requirement, see Rules §§50.1.1, 50.2.1, the ACOG's standards suggest that the "outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnosis, appropriateness of use of laboratory and other services, and other outcome of care." Standards, supra, at 55-56. See National Abortion Federation, Standards 11 (1981) (hereinafter NAF Standards) (requiring written descriptions of procedures and policies in each area of care).

The ACOG also advises that each ambulatory body should have a "governing body" that has the final authority and responsibility for the appointment of the medical staff, id., at 60; cf. Rules §40.3, and that "[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically." Id., at 60. Cf. NAF Standards, supra, at 12 (detailing responsibilities of chief administrative officer).

²⁴The ACOG recommends that even physicians' offices provide at least a patient reception room, consultation room, two examining rooms, a utility room, and storage. See Standards, supra, at 57-59. Its standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evaluation, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See id., at 61.

The ACOG details the equipment to be found in the various rooms and areas. See id., at 57-58, 61. A doctor's examining room should contain instruments for vaginal and rectal examinations, obtaining cultures and smears, and diagnostic studies and operative procedures. See id., at 57. When local anesthesia is used, the clinic or doctor's office should have emergency resuscitation equipment, including positive pressure oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. See ibid. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. See id., at 61. Cf. NAF Standards, supra n. 23, at 9 (requiring all facilities performing second-trimester abortions to have

Footnote continued on next page.

have little relevancy in this case. They have not been challenged by appellant beyond his general condemnation of any requirement that second-trimester abortions--even those during the twenty-second week of pregnancy--be performed in hospitals, however defined and whether outpatient or not. In any event, as appears from the recommendations of the ACOG and National Abortion Federation (NAF)²⁵ set forth in the margin below, see nn. 23, 24 & 26, Virginia's requirements with respect to the facilities,²⁶ equipment, and personnel are compatible with generally accepted medical standards, and further the State's legitimate interest.

*Jim -
This is the
solid
ground
of this
opinion.
We should
ask ~~ourselves~~
ourselves
whether
others
Chambers
reasonably
can
challenge
this*

Appellant's argument centers essentially on the patient services requirements of the Virginia regulations.

resuscitation bag, oxygen, and defibrillator if general anesthesia is administered).

²⁵See n.23, supra. See Brief of the American Public Health Association as Amicus Curiae 29 n. 6 in Nos. 81-185, 81-746 & 81-1172 (supporting the NAF Standards for nonhospital abortion facilities as constituting "minimum standards").

²⁶The ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. See Standards, supra, at 58, 61. Specific plans should be developed to evacuate patients in case of an emergency. See id., at 59, 62. See also NAF Standards, supra n. 23, at 8, 11.

He contends that they do not further the State's interest in the helth^a of the pregnant woman. We think they clearly¹ do. The sanitation²⁷ and record-keeping standards²⁸ are typical and not unreasonable in detail. The laboratory services support--and often are essential to--the direct medical services performed by the physician and nurse.²⁹ The post-operative recovery standards also comport with accepted medical practice.³⁰ The equipment requirements

²⁷Infection can be a serious complication with any abortion procedure. See nn. 10 & 11, supra. Significant portions of the Virginia Rules are designed to assure that outpatient surgical clinics practice ~~stringent~~ infection control, including sterile processing, appropriate waste disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Rules §§41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. The ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies. See Standards, supra, at 58, 62. See also NAF Standards, supra n. 23, at 7.

²⁸The Virginia record-keeping requirements are ~~very~~ similar to those detailed by the ACOG, see Standards, supra, at 54-55, 59-60, and we have found such requirements, "if not abused or overdone," impose a legally insignificant burden on the Roe right. See Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52, 81 (1976).

²⁹The risks of hemorrhage are reduced by requiring an outpatient surgical clinic to make hemoglobin or hematocrit determinations before initiating instillation. See Standards, supra, at 59 ("The laboratory data should include hemoglobin or hematocrit, urinalysis"). See also NAF Standards, supra n. 23, at 7 ("Rh-immune globulin must be explained and administered to Rh-negative patients.").

³⁰Anesthesia complications are alleviated by requiring a physician to be present for monitoring functions during the administration of anesthetics and in

Footnote continued on next page.

for emergency services are minimal³¹ and are further prefaced with the word "adequate."³²

We do not suggest that all of the Virginia requirements are necessary for every second-trimester abortion. A State simply cannot adopt regulations that serve every case with the same degree of relevance. Following, as we must, Roe and subsequent precedents, we adhere to the trimester periods as providing general

the recovery period. See Standards, supra, at 53. Less serious complications can be monitored by the registered nurse on duty. See ibid. ("During the recovery period, the patient should be under continuous observation by a qualified member of the health care team."); NAF Standards, supra n. 23, at 6 ("The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area."). The required one-hour recovery period is intended to permit detection of these problems. See Kerenyi, Mandelman & Sherman, Five Thousand Consecutive Saline Inductions, 116 Am. J. Obstet. & Gynecol. 593 (1973); Standards, supra, at 53; App. 37 (defense witness concedes waiting period necessary).

³¹The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See ACOG Standards, supra, at 58, 62; Cates & Grimes, supra n. 11, at 407 (even for nonhospital facilities providing D&E, "arrangements for emergency care should be established with hospitals near the nonhospital facility"); NAF Standards, supra n. 23, at 7.

³²Appellant's operating room contains practically all of the emergency services equipment required by the Commonwealth. The record indicates that it has excellent lighting, wall outlets for oxygen, suction apparatus, resuscitation equipment, a defibrillator, an EKG machine, IV fluids, complete anesthesia equipment, and drugs to be used in emergencies. See App. 21-22, 375-376. Appellant makes no contention, however, that his office's facilities, personnel, or care conform to the other requirements for an outpatient surgical clinic.

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guidance as to the validity of state abortion regulations in accord with medical knowledge and generally accepted standards. Although a State's general licensing regulations must be drawn to further the State's interests in women's health and safety for all reasonable periods of time within the second-trimester, a particular requirement "is not unconstitutional simply because it does not perfectly correspond to the asserted state interest" every day of the trimester. City of Akron, ____ U.S., at ____.³³

We therefore conclude, at least on the record before us in this case, that Virginia's regulations of second-trimester abortions are reasonably related to and further

³³We indicated, ^{noted} in City of Akron that the ACOG recommends that abortions performed in a physician's office or outpatient clinic be limited to fourteen-weeks gestation, but it indicates that abortions may be performed safely in a hospital-based or in a free-standing ambulatory facility until eighteen-weeks gestation. See City of Akron, ____ U.S. ____ (citing Standards, supra, at 52). Virginia's Rules easily correspond to the ACOG requirements for a free-standing clinic and thus are reasonably related to the State's compelling interest in maternal health and safety for the period after fourteen weeks. But we are also impressed by the fact that, even though the Rules apply to two weeks in which abortions could be performed safely in a doctor's office or a clinic, they do not impose requirements that significantly deviate from those that ACOG would require of a well-equipped office or clinic performing thirteenth and fourteenth week abortions. See nn. 23-24, 26-31. See also NAF Standards, supra n. 23, at 5-7. We think that Virginia has done well to draw its requirements to promote the ends that it seeks.

Jim -
I do not
think the
difference
as to what
applies to
14 + 18 weeks
is at all
clear from
this note.

Does ACOG
recommend
that abortions
after 14 weeks
be performed in
a surgical clinic
though it recognizes that
abortion may be OK up to 18 weeks?

And are we talking about Va's 1st
trimester Rules?

24 x
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the State's ^{compelling} legitimate interest in the health and safety
of pregnant women.³⁴ We emphasize again that Virginia
does not require the patient to be hospitalized as an
inpatient or that the abortion be performed in a full-
service general hospital. Rather, the ^{State's} Virginia
requirements--the statutes and the regulations--
accommodate medical requirements, and leave the method and
timing of the abortion precisely where they belong--
between the physician and his patient.

Jim -
There is a
weak
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IV
^{expressly}
Roe clearly permits States to impose some reasonable
health requirements on second-trimester abortions to
insure protection of a woman's ^{physical} health and safety.
Although there ^{have} been impressive advancements in medical
science since 1973, eliminating in some circumstances the

³⁴Appellant argues that Part III of the Rules, covering first-trimester abortion clinics requires, the same services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Rules §63.1.1(b), §63.3, §§64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require more technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the state's compelling interest, in maternal health and safety.

need for caution that the medical community was then
 expressing, the same medical community does not advise
 that any or all second-trimester procedures are so safe
 that this Court should eradicate all health regulations
 guiding their effectuation. ¶ We hold that Virginia's

requirement that ^{second trimester} such abortions ~~must~~ be performed in
 properly equipped outpatient clinics is ^{constitutional.} reasonably related
 to the Commonwealth's compelling interest in maternal
 health and safety.

^{IV}
~~We hold that~~
 Virginia's second-trimester ~~hospitalization~~
 requirement is constitutional. The judgment of the
 Supreme Court of Virginia therefore is

Affirmed.

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FEB 28 1981

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

LJP
2/28

From: **Justice Powell**

Circulated: _____

Recirculated: _____

CHAMBERS DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[March —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

The principal issue here is whether Virginia's mandatory hospitalization requirement for second-trimester abortions is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. His practice in November, 1979 consisted of office practice in Woodbridge, Virginia, hospital practice at four local hospitals or surgery centers, and practice at his clinic in Falls Church. The Falls Church clinic has an operating room, operating-room lighting, and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a seventeen-year old, high school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately twenty-two weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confide with her parents and discussed with her

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footnotes
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reasonableness
of the Va Regs
(i.e. p 10 et
seq)*

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pages.*

*Generally,
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looks
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the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the doctor if "heavy" bleeding began. Although P.M. does not recall being advised to go to a hospital when labor began, this was listed in the instruction sheet. *Id.*, at 200.

*physician
included*

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom forty-eight hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). The felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony."

In the four following sections the Virginia Code sets forth exceptions to this statute: there is no criminal liability (i) if the abortion is performed within the first trimester, § 18.2-72; (ii) if the abortion is performed in a

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a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia reviewed appellant's case and unanimously affirmed his conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, U. S. —, and now affirm.

II

Appellant broadly attacks Virginia's hospitalization requirements.³ He contends that they sharply restrict the

licensed hospital in the second trimester, § 18.2-73; (iii) if necessary to save the woman's life, § 18.2-74.1; and (iv) during the third trimester under certain circumstances, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defenses of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

³ Questions raised particularly with respect to Virginia's outpatient surgical clinics are considered in Part III, *infra*. Appellant also raises two issues on his appeal that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, nor mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with ~~regard~~ to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced. The Virginia statute, as construed by the state court, does not require that the State allege lack of medical necessity; the District of Columbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, U. S. —, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28,

respect

availability of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions. He also argues that the Virginia requirements result in negative health consequences and, as applied to him and the abortions he performs in his well-equipped non-licensed clinic, do not "measurably contribut[e] to the . . . purposes which the State advances as justification for the restriction." *Carey v. Population Services International*, 431 U. S. 678, 702 (1977) (WHITE, J., concurring in part and concurring in the result).

We need not pause long here to consider the guiding principles, for we have set them out at length today in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —. In *Roe v. Wade*, 410 U. S. 113 (1973), the Court held that the Fourteenth Amendment's concept of personal liberty was "broad enough to encompass a woman's decision whether or not to terminate her pregnancy," *id.*, at 153. We rejected, however, the notion that a woman has an absolute right to an abortion. We consistently have recognized and reaffirm today that, "because a State has a legitimate concern with the health of women who undergo abortions, 'a State may properly assert important interests in safeguarding health [and] in maintaining medical standards.'" *City of Akron*, ante, at 10 (quoting *Roe*, 410 U. S., at 154). This "important and legitimate interest in the health of the mother" becomes "'compelling' . . . at approximately the end of the first trimester," *Roe*, 410 U. S., at 163, and is compelling throughout the remainder of the pregnancy.

The State's interest in the health of the pregnant woman includes an interest in the ~~safety of facilities~~ that perform abortions. As the Court stated in *Roe*:

30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is frivolous. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

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"The State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient. This interest obviously extends at least to the performing physician and his staff, to the facilities involved, to the availability of after-care, and to adequate provision for any complication or emergency that might arise." 410 U. S., at 150.

To protect this compelling interest, the State may, "from and after the end of the first trimester, adopt standards for licensing *all* facilities where abortions may be performed so long as those standards are legitimately related to the objective the State seeks to accomplish." *Doe v. Bolton*, 410 U. S. 179, 194-195 (1973) (emphasis added). Specifically, the State may regulate "as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; as to the licensing of the facility; and the like." *Roe*, 410 U. S., at 163.

A

It is in furtherance of this compelling interest in maternal health that Virginia has enacted its hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under Virginia law.⁴ Virginia law does not, however, per-

⁴A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that, *after* he performed the abortion on P.M., he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek any license before he performed the abortion at issue here. Thus, without

mit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not contain the definition of the term "hospital." This definition is found in Va. Code § 32.1-123.1, which defines "hospital" to include "outpatient . . . hospitals." Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁵ defines outpatient hospital in pertinent part as "[i]nstitutions . . . which primarily provide facilities for the performance of surgical procedures on outpatients"⁶ and provides that second-trimester abortions may be performed in these clinics.⁷ Thus, under Virginia law, a second-trimester

record evidence whether appellant's facility qualifies as a surgical outpatient clinic *and* that he was denied a hospital license, whether the Falls Church facility would qualify under Virginia law is irrelevant to our determination in this case. See n. 7, *infra* (noting State's interpretation of the Virginia regulations).

⁵The regulations were promulgated pursuant to 1947 Va. Acts, c. 15, § 1514-a5, repealed by 1979 Acts, c. 711. Although not relevant to our determination here, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he has been prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982).

⁶Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁷Part II of the regulations sets minimum standards for outpatient surgical clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

abortion may be performed in an outpatient surgical clinic³ provided that clinic has been licensed as a "hospital" by the State.

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron, ante*, p. 13, and *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, ante*, p. —. In those cases, the regulations required "all second-trimester abortions [to] be performed in general, acute-care facilities." *Ashcroft, ante*, at —. We found that such a requirement, by preventing the use of the dilation and evacuation method (D&E) of performing abortions in appropriate nonhospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron, ante*, at 20. The Court held these laws invalid because they did not reasonably further the States' interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in acute-care, general hospitals. Under Virginia's regulations, outpatient surgical clinics may

"Outpatient abortion clinics" refers specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. "These facilities limit the operative procedures to termination of pregnancy during the first trimester." *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy shall be performed prior to the end of the first trimester (12th week amenorrhea).").

³ We herein usually refer to the outpatient "hospitals" in Virginia that legally may perform second-trimester abortions as "outpatient surgical clinics."

qualify for licensing as hospitals in which second trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

B

Second-trimester abortions may give rise to serious complications,⁹ and certain procedures significantly increase the risks.¹⁰ Although the increasingly common use and relative safety of the D&E method, see *City of Akron*, ante, at —, may make the need for particular equipment in and designs of a facility less compelling, the need for reasonable regulations has not been eliminated. D&E, despite its relative safety early in the second trimester, still may cause complications.¹¹

⁹ Between 1972 and 1978, at least 67 women undergoing second-trimester abortions in this country died as a result of the abortion procedure. See Department of Health and Human Services, Centers for Disease Control, *Abortion Surveillance: Annual Summary 1978*, at 48 (1980). See also Cadesky, Ravinsky & Lyons, *Dilation and Evacuation: A Preferred Method of Midtrimester Abortion*, 129 Am. J. Obstet. Gynecol. 329, 331 (1981) (6.9% complication rate for second-trimester D&E abortions; 55% complication rate for second-trimester prostaglandin instillation).

¹⁰ For example, the majority of second-trimester abortions after the sixteenth week of gestation are performed by means of intrauterine instillation of saline, see Grimes & Cates, *The Brief for Hypertonic Saline*, 15 Contemporary Ob/Gyn 29, 30 (1980), even though there is on the whole a greater death rate for instillation abortions than there is for D&E. See also Cates, et al., *The Risk of Dying from Legal Abortion in the United States, 1972-1975*, 15 Int'l J. Gynaecol. Obstet. 172, 175 (1977). For identification of less serious complications, see American College of Obstetricians and Gynecologists (ACOG), Technical Bulletin No. 37, *Hypertonic Saline Amnio-Infusion 1, 2-3* (1976) (now replaced by ACOG Technical Bulletin No. 56, *Methods of Midtrimester Abortion 75* (1979)).

¹¹ A leading cause of death and complications in D&E abortion patients is hemorrhage, see Cates & Grimes, *Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities*, 58 Obstetrics & Gynecology 401, 401-402 (1981), that can be prevented, detected, and treated during or soon after the procedure. Other potential complications of this procedure are uterine perforation and cervical tears, which are

The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in *free-standing qualified clinics that meet the state standards required for certification.*" APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). Those standards need not be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982) (hereinafter ACOG Standards). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

Although the State's interest in licensing medical facilities is compelling, the State's discretion to regulate on this basis does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12.

significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, *supra*, n. 10, at 78.

A major potential complication for all abortion techniques—infection—does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. See *Ashcroft*, 664 F. 2d 687, 690 n. 6 (CA8 1981), *rev'd in part & aff'd in part, ante*, p. —. Thus the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

normally

If In view of its interest, the State necessarily has considerable discretion in determining the appropriate standards for the licensing medical facilities, its discretion does not

"If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron, ante*, at 12. The issue here is whether Virginia's licensing requirements for outpatient surgical clinics performing second-trimester abortions are reasonable means of furthering the State's compelling interest in the woman's health.

C

The Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia. Those regulations may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing—~~matters not particularly relevant~~. These require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual, § 43.2¹², an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1.

¹²The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹³ and general building.¹⁴

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹⁵ laboratory,¹⁶ and pathology.¹⁷ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁸ and post-

¹³ These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹⁴ The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹⁵ See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁶ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical clinics providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁷ Section 43.6.3 requires that all tissue shall be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at —.

¹⁸ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical clinic providing

operative recovery.¹⁹ Finally, the regulations mandate some emergency services and evacuation planning.²⁰

III

Appellant does not attack expressly these regulations in his jurisdictional statement or in his principal brief. In those, he emphasizes that Virginia requires hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics that may perform second-trimester abor-

abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4.

Section 43.8.5 provides that the *facility* performing abortions "shall offer each patient *appropriate* counseling and instruction in the abortion procedure and in birth control methods." (emphasis added) Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, ~~it~~ is, unlike in *City of Akron*, for the woman, in conjunction with her physician, to decide what considerations are relevant to her decision. See *ante*, at 27-28. ✓ *it is*

¹⁹ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4. For a discussion of similar standards by various medical organizations, see n. 32, *infra*.

²⁰ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

tions. As appellant had not sought a license for his clinic, he appears to argue that the Virginia hospitalization requirements are comparable to those we have considered in *City of Akron* and *Ashcroft*.

Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that, even if he had applied for a license, it is uncertain whether it would have been granted; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations;" that Part II of the regulations does not cover an outpatient surgical facility where second trimester abortions are performed, but see n. 8, *supra*; and that medical evidence rebuts the view "that it is safer to perform second trimester abortions in hospitals."

Reply Brief for Appellant 1. None of these contentions finds support in this Court's prior opinions, and the Virginia requirements are strikingly different from those we invalidated in *City of Akron* and *Ashcroft*. [Indeed, it is evident that Virginia has adopted statutes and regulations compatible with our decisions.] We are convinced that the Virginia provisions are reasonably related to and further the State's compelling interest in protecting the health of the pregnant woman during the second trimester.²¹

The requirements of the first²² and second categories²³ of regulations discussed in Part II-C above have little relevance

²¹ No doubt there are costs incurred in complying with Virginia's requirements, but these are not burdens that necessarily invalidate the regulations. As an empirical matter, we have no reason to believe these costs will result in fewer *appropriate* facilities for performing second-trimester abortions. Ethical physicians are obligated to provide facilities consistent with the standards set by their profession. And appellant has not identified any significant differences between professional standards and the Virginia requirements.

²² ACOG's standards discuss many of Virginia's concerns about proper management and policies under the appropriate heading of "Quality Assurance." See ACOG Standards, *supra*, at 55 ("Each physician's office and

[Footnote 23 appears on p. 14]

Jim & Mark:
Let's talk
about wisdom
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to this case. They have not been challenged by appellant beyond his ~~general~~ condemnation of any requirement that second-trimester abortions—even those during the twenty-second week of pregnancy—be performed in hospitals, however defined and whether outpatient or not. In any event, as appears from the recommendations of ACOG and the American Public Health Association (APHA) set forth in the margin, see nn. 22, 23 and 24, Virginia's requirements, although more detailed with respect to specific facilities,²⁴ equipment, and

sweeping

outpatient clinic should assess whether effective and efficient management of health care has been accomplished.”). Like Virginia’s “narrative” requirement, Va. Regs. (Outpatient Hospitals) §§ 50.1.1, 50.2.1, ACOG’s standards suggest that the “outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnoses, appropriateness of use of laboratory and other services, and outcome of care.” ACOG Standards, *supra*, at 55–56. See National Abortion Federation (NAF), National Abortion Federation Standards 11 (1981) (hereinafter NAF Standards) (requiring written descriptions of procedures and policies in each area of care). Cf. Brief of the APHA as *Amicus Curiae* 29 n. 6. (supporting the NAF Standards for non-hospital abortion facilities as constituting “minimum standards”).

ACOG also advises that each ambulatory body should have a “governing body” that has the final authority and responsibility for the appointment of the medical staff, ACOG Standards, *supra*, at 60; cf. Va. Regs. (Outpatient Hospitals) § 40.3, and that “[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically,” ACOG Standards, *supra*, at 60. Cf. NAF Standards, *supra*, at 12 (responsibilities of chief administrative officer); Planned Parenthood of Metropolitan Washington, D.C., Inc., 1980 Guidelines for Operation, Maintenance and Evaluation of First Trimester Outpatient Abortion Facilities 1 (hereinafter “Planned Parenthood Guidelines”) (duties of administrator).

²⁴ This second category of Virginia regulations is consistent with those set forth by ACOG. ACOG recommends that even physicians’ offices provide at least a patient reception room, consultation room, two examining rooms, a utility room, and storage. ACOG Standards, *supra*, at 56–58. Cf. Planned Parenthood Guidelines, *supra*, n. 22, at 1–3 (detailing extensive physical requirements for first-trimester abortion clinics). ACOG’s

[Footnote 24 appears on p. 15]

personnel than the ACOG and APHA standards, are compatible with generally accepted medical standards and do not unreasonably burden the abortion decision.

standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evaluation, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See ACOG Standards, *supra*, at 61. Cf. S. Neubardt & H. Schulman, *Techniques of Abortion* 110-111 (2d ed. 1977) (similar list of facilities needed for model abortion care unit).

ACOG details the equipment to be found in the various rooms and areas. ACOG Standards, *supra*, at 57-58, 61. Cf. APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980) (hereinafter "APHA Guide") (any abortion facility should have "[a]n operating table, or conventional gynecologic examining table with accessories, located in a room which is adequately lighted and ventilated and meets all other environmental standards for surgical procedures"); Planned Parenthood Guidelines, *supra*, at 2. A doctor's examining room should contain instruments for vaginal examinations, supplies for obtaining cultures and smears, and equipment for diagnostic studies and operative procedures. ACOG Standards, *supra*, at 57. Cf. Planned Parenthood Guidelines, *supra*, at 2. When local anesthesia is used, the clinic or doctor's office should have emergency resuscitation equipment, including positive pressure oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. ACOG Standards, *supra*, at 57. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. *Id.*, at 61. Cf. APHA Guide, *supra*, at 655 (requiring oxygen, and equipment for artificial ventilation and resuscitation); NAF Standards, *supra*, n. 22, at 9 (requiring all facilities performing second-trimester abortions to have resuscitation bag, oxygen, and defibrillator if general anesthesia is administered); Planned Parenthood Guidelines, *supra*, at 2 (even first-trimester abortion clinics should have parenteral fluids, resuscitation equipment, and oxygen).

²⁴ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. ACOG Standards, *supra*, at 58, 61. Specific plans should be developed to evacuate patients in case of an emergency. *Id.*, at 59, 62. Cf. NAF Standards, *supra*, n.

Our concern centers on the patient services requirements of the Virginia regulations and whether they further the State's interest in the health and safety of the pregnant woman. We think they clearly do. Again, we have compared them to the standards used by ACOG and APHA, and we are impressed with the scrupulousness with which Virginia has drawn regulations reasonably related to its interest in protecting the pregnant woman's health. The sanitation²⁵ and record-keeping standards²⁶ are typical and not unreason-

22, at 8, 11; Planned Parenthood Guidelines, *supra*, n. 22, at 10.

²⁵ Infection can be a serious complication with any abortion procedure. See nn. 11 and 12, *supra*. Significant portions of the Virginia regulations are designed to assure that outpatient surgical clinics take appropriate steps to control infection, including sterile processing, appropriate waste disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Va. Regs. (Outpatient Hospitals) §§ 41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies. ACOG Standards, *supra*, at 58, 62. APHA Guide, *supra*, n. 23, at 655; NAF Standards, *supra*, n. 22, at 7 ("Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure. . . ."); Planned Parenthood Guidelines, *supra*, n. 22, at 2.

²⁶ The Virginia record-keeping requirements are similar to those detailed by ACOG for a physician's office, ACOG Standards, *supra*, at 54-55, 59-60, which require at the initial visit a comprehensive data base including information on reason for visit, menstrual history, obstetric history, gynecologic history, sexual history, past medical and surgical history, current medications, allergies, social history, and family history. For ambulatory surgical facilities, ACOG recommends that the patient's record contain sufficient information to justify the preoperative diagnosis and the operative procedure, and should at least contain patient identification data, history and physical examination, provisional diagnosis, diagnostic and therapeutic orders, surgeons' and nurses' notes, laboratory data, operative consent, operative report, anesthesia report, tissue report, medications record, and discharge summary and instructions. *Id.*, at 59. See also *id.*, at 60 ("On the day of surgery a preanesthetic evaluation, including an interval history, medical record review, and a heart and lung examination

able in detail. The laboratory services²⁷ support—and often are essential to—the direct medical services²⁸ performed by the physician²⁹ and nurse.³⁰ The post-operative recovery standards³¹ also comport with accepted medical practice.³²

should be performed by a physician and the findings should be noted in the record.”). We have found such requirements, “if not abused or overdone,” impose a legally insignificant burden on the *Roe* right. See *Planned Parenthood of Central Missouri v. Danforth*, 428 U. S. 52, 81 (1976). We do not think Virginia’s requirements are excessive. Cf. APHA Guide, *supra*, n. 23, at 655–656 (recommended reporting requirements); Planned Parenthood Guidelines, *supra*, n. 22, at 13 (record-keeping and reporting requirements).

²⁷ The risk of hemorrhage is reduced by requiring an outpatient surgical clinic to make hemoglobin or hematocrit determinations before initiating instillation. See ACOG Standards, *supra*, at 59 (“The laboratory data should include hemoglobin or hematocrit, urinalysis, and, in certain selected patients, other studies such as a chest x-ray, electrocardiogram, and electrolytes.”). See also APHA Guide, *supra*, n. 23, at 654 (“Appropriate laboratory procedures must include determination of hematocrit and Rh factor in every case. The value of other laboratory procedures will depend upon the population served; these may include sickle cell testing; endocervical and anal culture for gonorrhea; urinalysis; serologic testing for syphilis; and, when indicated cytologic screening for cancer.”); NAF Standards, *supra*, n. 22, at 7 (“Rh-immune globulin must be explained and administered to Rh-negative patients.”); Planned Parenthood Guidelines, *supra*, n. 22, at 8 (requiring lab facilities to be available on premises for pregnancy tests, urine protein and sugar, hematocrit or hemoglobin determination, and Rh typing).

²⁸ See ACOG Standards, *supra*, at 59 (“The appropriate records should be completed and laboratory data recorded *prior* to surgery.”) (emphasis added). ACOG also recommends that “[t]he physician should strive to identify pre-existing or concurrent illness, medications, and adverse drug reactions that may have a bearing on the operative procedure or anesthesia. *All records should be reviewed before any surgery is performed.*” *Id.*, at 60 (emphasis added). APHA Guide, *supra*, n. 23, at 654; Planned Parenthood Guidelines, *supra*, n. 22, at 8.

²⁹ For example, the ACOG requires careful laboratory work before anesthesia is administered, and even then, it must be given only by or under the supervision of a doctor: “Any ambulatory surgical unit that utilizes gen-

[Footnotes 30, 31, and 32 appear on p. 18]

The equipment requirements for emergency services are minimal³³ and are further prefaced with the word "adequate."³⁴

eral, epidural, or spinal anesthesia should do so under the direction of an anesthesiologist. These anesthetics should be administered by a qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation must be available." ACOG Standards, *supra*, at 53. Cf. APHA Guide, *supra*, n. 23, at 655; Planned Parenthood Guidelines, *supra*, n. 22, at 10.

³⁰ The ACOG Standards do not specifically require nurses for physicians' offices or for ambulatory surgical facilities, but note: "The efficient operation of an ambulatory surgical facility requires adequate staffing with administrative and professional personnel. The assignment of personnel should be based on the number of patients, patient profiles, type of procedures, and facility design." ACOG Standards, *supra*, at 60. Cf. *id.*, at 56 ("Administrative and professional personnel requirements will vary considerably in each physician's office and outpatient clinic depending on the patient load, pattern of practice, and type of facility."); Planned Parenthood Guidelines, *supra*, n. 22, at 7 (nurses); *id.*, at 7-8 (head laboratory technician); *id.*, at 9 ("It is strongly recommended that three staff persons be present in the procedure room: the operating physician, the physician's assistant and a counselor to assist the patient.").

³¹ See n. 19, *supra*.

³² Complications resulting from anesthesia are alleviated by requiring a physician to be present during the recovery period. See ACOG Standards, *supra*, at 53 ("The supervising anesthesiologist, or another physician qualified in cardiopulmonary resuscitation, should be present in the ambulatory surgical facility until all surgical patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the back-up hospital."); Planned Parenthood Guidelines, *supra*, n. 22, at 11; see also APHA Guide, *supra*, n. 23, at 655 ("[I]t will be necessary to periodically observe the temperature, pulse rate, blood pressure, and the amount of bleeding. In addition, the abdomen should be examined for evidence of intra-abdominal bleeding or injury."). Less serious complications can be monitored by the registered nurse on duty. See ACOG Standards, *supra*, at 53 ("During the recovery period, the patient

[Footnotes 33 and 34 appear on p. 19]

We do not suggest that all of the Virginia requirements are necessary for every second-trimester abortion. But a State simply cannot adopt regulations that serve every case with the same degree of relevance; "a State necessarily must have some latitude in adopting regulations of general applicability in this sensitive area." *City of Akron, ante*, at 16. Although a State's general licensing regulations must be drawn to further the State's interests in women's health for all reasonable periods of time within the second-trimester, a particular requirement "is not unconstitutional simply because it does not correspond perfectly to the asserted state interest" every day of the trimester. *Ante*, at 20.

should be under continuous observation by a qualified member of the health care team. This person should maintain a complete record of the patient's general condition including vital signs, blood loss, and occurrence of complications."); NAF Standards, *supra*, n. 22, at 6 ("The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area."); Planned Parenthood Guidelines, *supra*, at 11. The required one-hour recovery period is intended to permit detection of these complications. See APHA Guide, *supra*, at 655 (requiring post-operative observations "over a period of two or more hours, depending upon the type of anesthesia used"); Kerenyi, Mandelman & Sherman, *Five Thousand Consecutive Saline Inductions*, 116 Am. J. Obstet. & Gynecol. 593, 597 (1973); ACOG Standards, *supra*, at 53; App. 37 (defense expert witness concedes waiting period desirable).

³³ The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See APHA Guide, *supra*, n. 23, at 655; ACOG Standards, *supra*, at 52 ("There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication."); *id.*, at 58, 62; Cates & Grimes, *supra*, n. 11, at 407 (even for nonhospital facilities providing D&E, "arrangements for emergency care should be established with hospitals near the nonhospital facility"); NAF Standards, *supra*, n. 22, at 7; Planned Parenthood Guidelines, *supra*, n. 22, at 10 ("Each facility must have a functioning arrangement for emergency transport to a local accredited hospital.").

³⁴ Appellant's operating room contains practically all of the emergency services equipment required by the State. The record indicates that it has

We therefore conclude, at least on the record before us in this case, that Virginia's regulations concerning second-trimester abortions are reasonably related to and further the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.³⁵ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—between the physician and the patient.

IV

We hold that Virginia's requirement that second-trimester abortions be performed in properly equipped outpatient clin-

excellent lighting, wall outlets for oxygen, suction apparatus, resuscitation equipment, a defibrillator, an EKG machine, intravenous fluids, and complete anesthesia equipment. App. 21-22, 375-376. Although appellant sought a "certificate of need" from the Virginia Bureau of Resources Development, see n. 4, *supra*, he makes no contention that his office's facilities, personnel, or care conform fully to the requirements for an outpatient surgical clinic.

³⁵ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics requires the *same* services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the state's compelling interest.

ics is constitutional. The judgment of the Supreme Court of Virginia therefore is

Affirmed.

I have quickly marked the passages that reflect changes made after the reads of the 1st Chamber Draft for.

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

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From: Justice Powell

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COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT v. VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[March —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room, and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). The Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant broadly attacks Virginia's hospitalization requirements.³ He contends that they restrict the availability

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is necessary to save the woman's life, § 18.2-74.1; and (iv) is performed during the third trimester under certain circumstances, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defenses of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

³ Questions raised particularly with respect to Virginia's outpatient surgical clinics are considered in Part III, *infra*. Appellant raises two additional issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden

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of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions. He also argues that the Virginia requirements result in negative health consequences and, as applied to him and the abortions he performs in his well-equipped non-licensed clinic, do not further the State's interests.

~~part and concurring in the result).~~

We need not pause long here to consider the guiding principles, for we have set them out at length today in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p.

— For ~~our~~ purposes ~~here~~, the critical point is that we consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester," *Roe v. Wade*, 410 U. S. 113, 163 (1973), and is compelling throughout the remainder of the pregnancy.

~~This interest includes an interest in~~ the facilities and circumstances in which abortions are performed.

A

It is in furtherance of this compelling interest in maternal health that Virginia has enacted its hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under Virginia law.⁴ Virginia law does not, however, per-

of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

⁴A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant

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mit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1, which defines "hospital" to include "outpatient . . . hospitals." Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁵ defines outpatient hospital in pertinent part as "[i]nstitutions . . . which primarily provide facilities for the performance of surgical procedures on outpatients"⁶ and provides that sec-

contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here. Thus, without record evidence that appellant's facility qualifies as a surgical outpatient clinic *and* that he was denied a hospital license, the issue of whether the Falls Church facility would qualify under Virginia law is irrelevant to our determination in this case. See n. 7, *infra* (noting State's interpretation of the Virginia regulations).

⁵The regulations were promulgated pursuant to 1947 Va. Acts, c. 15, § 1514-a5, repealed by 1979 Acts, c. 711. Although not relevant to our determination here, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he has been prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982).

⁶Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

ond-trimester abortions may be performed in these clinics.⁷ Thus, under Virginia law, a second-trimester abortion may be performed in an outpatient surgical clinic⁸ provided that clinic has been licensed as a “hospital” by the State.

It is readily apparent that Virginia’s second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Association of Kansas City, Missouri, Inc. v. Ashcroft, ante*, at 5. In those cases, the regulations required that “all second-trimester abortions must be performed in general, acute-care facilities.” *Ashcroft, ante*, at 5. We found that such a requirement, by preventing the use of the dilatation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, “imposed a heavy, and unnecessary, burden on women’s access to a relatively inexpensive, otherwise accessible, and safe abortion procedure.” *City of Akron, ante*, at 20. The Court invalidated these laws ~~invalid~~ because they did not reasonably further the States’ interest in maternal health.

⁷ Part II of the regulations sets minimum standards for outpatient surgical clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services. Moreover, the State’s counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term “[O]utpatient abortion clinics” to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 (“Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).”).

⁸ We herein usually refer to the outpatient “hospitals” in Virginia that legally may perform second-trimester abortions as “outpatient surgical clinics.”

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for licensing as hospitals in which second trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

B

Second-trimester abortions may give rise to serious complications,⁹ and certain procedures significantly increase the risks. Although the increasingly common use and relative safety of the D&E method, see *City of Akron, ante*, at —, may make the need for particular equipment in and designs of a facility less imperative, the need for reasonable regulations has not been eliminated. D&E, despite its safety early in the second trimester, still may cause complications.¹⁰

⁹ See Cadesky, Ravinsky & Lyons, Dilation and Evacuation: A Preferred Method of Midtrimester Abortion, 129 Am. J. Obstet. Gynecol. 329, 331 (1981) Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: Annual Summary 1978, at 48 (1980).

¹⁰ Hemorrhaging is a leading cause of death and complications in D&E abortion patients. Other potential complications are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, Methods of Midtrimester Abortion 75 (1979).

A major potential complication for all abortion techniques—infection—normally does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. See *Ashcroft*, 664 F. 2d 687, 690, n. 6 (CA8 1981), rev'd in part and aff'd in part, *ante*, p. —. Thus the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

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The American Public Health Association (APHA), although recognizing “that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period,” still “[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification.” APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical professional has not thought the standards need be relaxed merely because the facility performs abortions: “Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician’s office and outpatient clinic or the free-standing and hospital-based ambulatory setting.” American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982) (hereinafter ACOG Standards). See also *id.*, at 52 (“Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation.”). Indeed, the medical profession’s standards for outpatient surgical facilities are stringent: “Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals.” *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not “permit it to adopt abortion regulations that depart from sound medical practice.” *City of Akron, ante*, at 12. “If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be ‘legitimately related to the objective the State seeks to accomplish.’ *Doe*, 410 U. S., at 195.” *City of Akron, ante*, at 12. The issue here is whether Virginia’s licensing requirements for outpatient surgical clinics perform-

ing second-trimester abortions are reasonable means of furthering the State's compelling interest in the woman's health.

C

The Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia.* These regulations may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,¹¹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹² and general building.¹³

¹¹ The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹² These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities.

[Footnote 13 is on p. 10]

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** In view of the wide range of surgery,
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each category.*

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹⁴ laboratory,¹⁵ and pathology.¹⁶ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁷ and post-operative recovery.¹⁸ Finally, the regulations mandate some

Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹⁴ The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹⁵ See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁶ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical clinics providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁷ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at —.

¹⁸ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical clinic providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient *appropriate* counseling and instruction in the abortion procedure and in birth control methods." Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, unlike in *City of*

[Footnote 19 is on p. 11]

emergency services and evacuation planning.¹⁹

III

Appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief. Instead, he challenges Virginia's requirement of hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics that may perform second-trimester abortions. As appellant had not sought a license for his clinic at the time he was indicted, he appears to argue that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus invalid.

Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that even if he had applied for a license, it is uncertain whether it would have been

Akron, it is for the woman, in conjunction with her physician, to decide what considerations are relevant to her decision. See *ante*, at 27-28.

¹⁸ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4. For a discussion of similar standards by various medical organizations, see n. 32, *infra*.

¹⁹ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

Only the last of these arguments is relevant to the validity of these statutes & regulations and appellant points to no evidence that supports her sweeping claim of "safety".

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SIMOPOULOS v. VIRGINIA

granted; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations;" that Part II of the regulations does not cover an outpatient surgical facility where second trimester abortions are performed, but see n. 8, *supra*; and that medical evidence rebuts the view "that it is safer to perform second trimester abortions in hospitals." Reply Brief for Appellant 1. ~~None of these contentions, however, makes the Virginia a hospital regulations invalid.~~ Moreover, the Virginia requirements are strikingly different from those we invalidated in *City of Akron* and *Ashcroft*. There certainly are costs incurred in complying with Virginia's requirements, but these burdens do not necessarily invalidate the regulations. Ethical physicians are obligated to provide facilities consistent with the standards set by their profession, and appellant has not identified any significant differences between professional standards and the Virginia requirements. We are convinced, at least on the record before us, that the Virginia provisions are reasonably related to and further the State's compelling interest in protecting the health of the pregnant woman during the second trimester.

The requirements of the first²⁰ and second categories²¹ of regulations discussed in Part II-C above have little relevance

²⁰ ACOG's standards discuss many of Virginia's concerns about proper management and policies under the appropriate heading of "Quality Assurance." See ACOG Standards *supra*, at 55 ("Each physician's office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished."). Like Virginia's "narrative" requirement, Va. Regs. (Outpatient Hospitals) §§ 50.1.1, 50.2.1, ACOG's standards suggest that the "outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnoses, appropriateness of use of laboratory and other services, and outcome of care." ACOG Standards 55-56. See National Abortion Federation (NAF), National Abortion Federation Standards 11 (1981) (hereinafter NAF Standards) (requiring written descriptions of procedures and policies in each area of care). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6. (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

[Footnote 21 is on p. 13]

Reader A

As we have noted above

Jim - This is a conclusion that does not advance the argument

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to this case. They have not been challenged by appellant beyond his sweeping condemnation of any requirement that second-trimester abortions—even those during the twenty-second week of pregnancy—be performed in hospitals, however defined and whether outpatient or not. In any event, as appears from the recommendations of ACOG and the American Public Health Association (APHA) set forth in the margin, see nn. 22, 23, and 24, Virginia's requirements, although more detailed with respect to specific facilities,²² equipment,

ACOG also advises that each ambulatory body should have a "governing body" that has the final authority and responsibility for the appointment of the medical staff, ACOG Standards 60; cf. Va. Regs. (Outpatient Hospitals) § 40.3, and that "[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically," ACOG Standards 60. Cf. NAF Standards 12 (responsibilities of chief administrative officer); Planned Parenthood of Metropolitan Washington, D.C., Inc., 1980 Guidelines for Operation, Maintenance and Evaluation of First Trimester Outpatient Abortion Facilities 1 (hereinafter "Planned Parenthood Guidelines") (duties of administrator).

²¹ This second category of Virginia regulations is consistent with those set forth by ACOG. ACOG recommends that even physicians' offices provide at least a patient reception room, consultation room, two examining rooms, a utility room, and storage. ACOG Standards 56-58. Cf. Planned Parenthood Guidelines, 1-3 (detailing extensive physical requirements for first-trimester abortion clinics). ACOG's standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evaluation, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See ACOG Standards 61.

ACOG details the equipment to be found in the various rooms and areas. ACOG Standards 57-58, 61. Cf. APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980) (hereinafter "APHA Guide") (any abortion facility should have "[a]n operating table, or conventional gynecologic examining table with accessories, located in a room which is adequately lighted and ventilated and meets all other environmental standards for surgical procedures"); Planned Parenthood Guide-

[Footnote 22 is on p. 14]

and personnel than the ACOG and APHA standards, are compatible with generally accepted medical standard.

Our concern centers on whether the patient services requirements of the Virginia regulations further the State's interest in the health and safety of the pregnant woman. We think they clearly do. Again, we have compared them to the standards used by ACOG and APHA, and we are impressed with the scrupulousness with which Virginia has drawn regulations reasonably related to its interest in protecting the pregnant woman's health. The sanitation²⁸ and record-keep-

lines 2. A doctor's examining room should contain instruments for vaginal examinations, supplies for obtaining cultures and smears, and equipment for diagnostic studies and operative procedures. ACOG Standards 57. Cf. Planned Parenthood Guidelines 2. When local anesthesia is used, the clinic or doctor's office should have emergency resuscitation equipment, including positive pressure oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. ACOG Standards 57. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. *Id.*, at 61. Cf. APHA Guide 655 (requiring oxygen, and equipment for artificial ventilation and resuscitation); NAF Standards 9 (requiring all facilities performing second-trimester abortions to have resuscitation bag, oxygen, and defibrillator if general anesthesia is administered); Planned Parenthood Guidelines 2 (even first-trimester abortion clinics should have parenteral fluids, resuscitation equipment, and oxygen).

²⁸ ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. ACOG Standards 58, 61. Specific plans should be developed to evacuate patients in case of an emergency. *Id.*, at 59, 62. Cf. NAF Standards 8, 11; Planned Parenthood Guidelines 10.

²⁹ Infection can be a serious complication with any abortion procedure. See nn. 11 and 12, *supra*. Significant portions of the Virginia regulations are designed to assure that outpatient surgical clinics take appropriate steps to control infection, including sterile processing, appropriate waste-disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Va. Regs. (Outpatient Hospitals) §§ 41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife

ing standards²⁴ are typical and not unreasonable in detail. The laboratory services²⁵ support—and often are essential to—the direct medical services²⁶ performed by the physician²⁷ and nurse.²⁸ The post-operative recovery standards²⁹ also comport with accepted medical practice,³⁰ and the

blades, and contaminated waste supplies. ACOG Standards 58, 62. APHA Guide 655; NAF Standards 7 (“Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure. . .”).

²⁴ The Virginia record-keeping requirements are similar to those detailed by ACOG for a physician’s office, ACOG Standards 54–55, 59–60, which require at the initial visit a comprehensive data base including information on reason for visit, menstrual history, obstetric history, gynecologic history, sexual history, past medical and surgical history, current medications, allergies, social history, and family history. For ambulatory surgical facilities, ACOG recommends that the patient’s record contain sufficient information to justify the preoperative diagnosis and the operative procedure, and should at least contain patient identification data, history and physical examination, provisional diagnosis, diagnostic and therapeutic orders, surgeons’ and nurses’ notes, laboratory data, operative consent, operative report, anesthesia report, tissue report, medications record, and discharge summary and instructions. *Id.*, at 59. See also *id.*, at 60 (“On the day of surgery a preanesthetic evaluation, including an interval history, medical record review, and a heart and lung examination should be performed by a physician and the findings should be noted in the record.”). We have found that such requirements, “if not abused or overdone,” impose a legally insignificant burden on the *Roe* right. See *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S. 52, 81 (1976). We do not think Virginia’s requirements are excessive. Cf. APHA Guide 655–656 (recommended reporting requirements); Planned Parenthood Guidelines 13 (record-keeping and reporting requirements).

²⁵ The risk of hemorrhage is reduced by requiring an outpatient surgical clinic to make hemoglobin or hematocrit determinations before initiating instillation. See ACOG Standards 59 (“The laboratory data should include hemoglobin or hematocrit, urinalysis, and, in certain selected patients, other studies such as a chest x-ray, electrocardiogram, and electrolytes.”). See also APHA Guide 654 (“Appropriate laboratory procedures must include determination of hematocrit and Rh factor in every case. The value of other laboratory procedures will depend upon the population served; these may include sickle cell testing; endocervical and anal culture for gon-

[Footnotes 26 through 30 are on pp. 16 and 17]

equipment requirements for emergency services are minimal.³¹

omission

We do not suggest that all of the Virginia requirements are necessary for every second-trimester abortion. But a State simply cannot adopt regulations that serve every case with

orrhea; urinalysis; serologic testing for syphilis; and, when indicated cytologic screening for cancer.”); NAF Standards 7 (“Rh-immune globulin must be explained and administered to Rh-negative patients.”); Planned Parenthood Guidelines 8 (requiring lab facilities to be available on premises for pregnancy tests, urine protein and sugar, hematocrit or hemoglobin determination, and Rh typing).

²⁶ See ACOG Standards 59 (“The appropriate records should be completed and laboratory data recorded *prior* to surgery.”) (emphasis added). ACOG also recommends that “[t]he physician should strive to identify pre-existing or concurrent illness, medications, and adverse drug reactions that may have a bearing on the operative procedure or anesthesia. *All records should be reviewed before any surgery is performed.*” *Id.*, at 60 (emphasis added). APHA Guide 654; Planned Parenthood Guidelines 8.

²⁷ For example, the ACOG requires careful laboratory work before anesthesia is administered, and even then, it must be given only by or under the supervision of a doctor: “Any ambulatory surgical unit that utilizes general, epidural, or spinal anesthesia should do so under the direction of an anesthesiologist. These anesthetics should be administered by a qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation must be available.” ACOG Standards 53. Cf. APHA Guide 655; Planned Parenthood Guidelines, *supra*, n. 22, at 10.

²⁸ The ACOG Standards do not specifically require nurses for physicians’ offices or for ambulatory surgical facilities, but note: “The efficient operation of an ambulatory surgical facility requires adequate staffing with administrative and professional personnel. The assignment of personnel should be based on the number of patients, patient profiles, type of procedures, and facility design.” ACOG Standards 60. Cf. *id.*, at 56 (“Administrative and professional personnel requirements will vary considerably in each physician’s office and outpatient clinic depending on the patient load, pattern of practice, and type of facility.”); Planned Parenthood Guidelines 7–8 (head laboratory technician); *id.*, at 9 (“It is strongly recommended that three staff persons be present in the procedure room: the operating physician, the physician’s assistant and a counselor to assist the patient.”).

²⁹ See n. 19, *supra*.

[Footnotes 30 and 31 are on pp. 17]

the same degree of relevance; “[a] State necessarily must have some latitude in adopting regulations of general applicability in this sensitive area.” *City of Akron, ante*, at 16. Although a State’s general licensing regulations must be drawn to further the State’s interests in women’s health for all reasonable periods of time within the second-trimester, a particular requirement “is not unconstitutional simply because it does not correspond perfectly in all cases to the asserted state interest.” *City of Akron, ante*, at 20.

³⁰ Complications resulting from anesthesia are alleviated by requiring a physician to be present during the recovery period. See ACOG Standards 53 (“The supervising anesthesiologist, or another physician qualified in cardiopulmonary resuscitation, should be present in the ambulatory surgical facility until all surgical patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the back-up hospital.”); Planned Parenthood Guidelines 11; see also APHA Guide 655 (“[I]t will be necessary to periodically observe the temperature, pulse rate, blood pressure, and the amount of bleeding. In addition, the abdomen should be examined for evidence of intra-abdominal bleeding or injury.”). Less serious complications can be monitored by the registered nurse on duty. See ACOG Standards 53 (“During the recovery period, the patient should be under continuous observation by a qualified member of the health care team. This person should maintain a complete record of the patient’s general condition including vital signs, blood loss, and occurrence of complications.”); NAF Standards 6 (“The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area.”); Planned Parenthood Guidelines 11. The required one-hour recovery period is intended to permit detection of these complications. See APHA Guide 655 (requiring post-operative observations “over a period of two or more hours, depending upon the type of anesthesia used”); Kerenyi, Mandelman & Sherman, *Five Thousand Consecutive Saline Inductions*, 116 Am. J. Obstet. & Gynecol. 593, 597 (1973); ACOG Standards 53; App. 37 (defense expert witness concedes waiting period desirable).

³¹ The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See APHA Guide 655; ACOG Standards 52 (“There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unan-

We therefore conclude, at least on the record before us in this case, that Virginia's regulations concerning second-trimester abortions are reasonably related to and further the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.³² As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—between the physician and the patient.

IV

We hold that Virginia's requirement that second-trimester abortions be performed in, properly equipped outpatient clinic is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

ticipated complication."); *id.*, at 58, 62; NAF Standards, *supra*, n. 22, at 7; Planned Parenthood Guidelines, *supra*, n. 22, at 10 ("Each facility must have a functioning arrangement for emergency transport to a local accredited hospital.").

³² Appellant argues that Part III of the regulations, covering first-trimester abortion clinics requires the *same* services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the state's compelling interest.

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SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[April —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

²The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony."

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, re-

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is necessary to save the woman's life, § 18.2-74.1; and (iv) is performed during the third trimester under certain circumstances, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

quired the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

Appellant argues that Virginia's statutory hospital requirement prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy and has negative health consequences. Appellant contends that this prohibition sharply restricts the availability of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit the post 12-week abortions. Appellant contends that the hospital monopoly is an unreasonable restraint on a woman's right to an abortion and that the State has not shown that the requirement furthers any compelling interest.

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). This interest, of course, embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. The State here argues that its hospitalization requirement is significantly different from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests. It thus becomes necessary to determine whether Vir-

ginia's hospitalization requirement is different from those considered earlier, or whether we should consider our decision in *City of Akron* controlling.

A

It is in furtherance of its compelling interest in maternal health that Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them. See n. 8, *infra* (noting State's interpretation of the Virginia regulations).

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Vir-

“outpatient . . . hospitals.”⁵ Section 20.2.11 of the Department of Health’s Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) (“regulations”)⁶ defines outpatient hospital in pertinent part as “[i]nstitutions

ginia Code, the title of the Code that contains many of Virginia’s health laws:

“The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State’s compelling interest in preserving and protecting maternal health.” 221 Va., at 1075, 277 S. E. 2d, at 204.

There is no basis for assuming that the court interpreted “hospital” in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

“‘Hospital’ means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals.”

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time “out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery).”

⁶ The regulations were promulgated pursuant to the State Board of Health’s general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

“classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profes-

... which primarily provide facilities for the performance of surgical procedures on outpatients"⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

sion and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations was considerably different from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpatient clinics in which abortions could be performed, regardless of the trimester. Thus, no distinction was made between first- and second-trimester abortions with respect to the appropriateness of and need for state regulation.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. At this hearing, Dr. William R. Hill, a member of the Board, presided, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that "[i]n general, they are a good set of standards and have our support." *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester "the State may regulate the [abortion] procedure in the interest of maternal health." *Id.*, at 7. But the clinics specifi-

[Footnotes 7 and 8 are on page 8]

be performed in an outpatient surgical clinic⁹ provided that clinic has been licensed as a "hospital" by the State.

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft*,

cally "propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia." *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical clinics in the State, agreed that the Board should not "compromise" the strict standards needed for outpatient surgical clinics in order to include outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. It therefore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval to the regulations before us on May 11, 1977.

The regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months after the effective date of the regulations. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said—and indeed appellant does not argue—that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

Although of no direct relevance to this case, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷ Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸ Part II of the regulations sets minimum standards for outpatient surgical clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and

[Footnote 9 is on page 9]

ante, at 4–5. In those cases, the regulations required that “all second-trimester abortions must be performed in general, acute-care facilities.” *Ashcroft, ante*, at 5. We found that such a requirement, by preventing the use of the dilatation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, “imposed a heavy, and unnecessary, burden on women’s access to a relatively inexpensive, otherwise accessible, and safe abortion procedure.” *City of Akron, ante*, at 20. The Court invalidated these laws because they did not reasonably further the state interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, “at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital.” *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia’s regulations, outpatient surgical clinics may qualify for licensing as hospitals in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

by the history of Part III, see n. 6, *infra*. Moreover, the State’s counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term “outpatient abortion clinics” to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 (“Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).”).

⁹We herein usually refer to the outpatient “hospitals” in Virginia that legally may perform second-trimester abortions as “outpatient surgical clinics.”

← Jim - I think there is language in *Acron* to effect that State may regulate these clinics that might be helpful to add - especially for the West Wing of the Court

B

Second-trimester abortions may give rise to serious complications,¹⁰ and certain procedures significantly increase the risks. Although the increasingly common use and relative safety of the D&E method, see *City of Akron, ante*, at 17-19, may make the need for particular equipment in and designs of a facility less imperative, the need for reasonable regulations has not been eliminated. D&E, despite its safety early in the second trimester, still may cause complications.¹¹

The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the

¹⁰ See Cadesky, Ravinsky & Lyons, *Dilation and Evacuation: A Preferred Method of Midtrimester Abortion*, 129 Am. J. Obstet. Gynecol. 329, 331 (1981); Department of Health and Human Services, Centers for Disease Control, *Abortion Surveillance: Annual Summary 1978*, at 48 (1980).

¹¹ Hemorrhaging is a leading cause of death and complications in D&E abortion patients. Other potential complications are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, *Methods of Midtrimester Abortion* 75 (1979).

A major potential complication for all abortion techniques—infection—normally does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. See *Ashcroft*, 664 F. 2d 687, 690, n. 6 (CA8 1981), rev'd in part and aff'd in part, *ante*, p. —. Thus the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982) (hereinafter ACOG Standards). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron, ante*, at 12. The issue here is the validity of Virginia's requirement that second-trimester abortions be performed in a licensed "hospital" given that the term "hospital" is defined to include "outpatient hospitals."

C

It is necessary to describe briefly the Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions in order to understand appellant's constitutional challenge and determine the validity of Virginia's hospitalization requirement. Those Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia,

and may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,¹² § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹³ and general building.¹⁴

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹⁵ laboratory,¹⁶ and pathology.¹⁷ Some of

¹² The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹³ These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹⁴ The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹⁵ See, e. g., Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be

the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁸ and post-operative recovery.¹⁹ Finally, the regulations mandate some emergency services and evacuation planning.²⁰

directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁸ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical clinics providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁷ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁸ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical clinic providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods." Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, unlike in *City of Akron*, it is for the woman, in conjunction with her physician, to decide what considerations are relevant to her decision. See *ante*, at 27.

¹⁹ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

²⁰ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation

IV

Appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief. Instead, he challenges Virginia's requirement of hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics ~~that may perform~~ second-trimester abortions. As appellant had not sought a license for his clinic at the time he was indicted, he appears to argue that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid.

Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical clinics exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient clinic license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgi-

plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

in which

Begin

may be performed.

Add arguments

- (1) Absent ^{specific} challenge Regs ~~proposed~~ ^{proposed} valid. (2) Also Appellant's attack on regs comes too late. (3) But on him to prove app. defense

meritless.

End

cal clinic where second-trimester abortions are performed. Some of these arguments are simply ~~wrong~~, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet some facility and equipment standards merely because they impose some costs and burdens. Compliance with the State's requirements will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people.

What is perhaps most important about appellant's constitutional challenges is what they do not challenge: Appellant has not argued that individual regulations are unreasonable. Despite full knowledge of the regulations at the time of his trial,²¹ appellant has elected to treat the Virginia hospitalization requirement as no different from those we reviewed in *City of Akron* and *Ashcroft*. Any silence of the record on the reasonableness of the regulations must be attributed to his failure to show their invalidity, for he has not produced any medical evidence, as the plaintiffs in *City of Akron* and *Ashcroft* ~~have done~~, to show that certain equipment or services required by the State are unreasonable requirements to impose on women seeking second-trimester abortions. In a word, he has not shown why the Virginia regulations do not further the State's compelling interest in the health and safety of the pregnant woman.

It is therefore unnecessary for this Court to review those regulations individually to determine whether alone or as a group they impose unreasonable conditions on outpatient hospital licensing in Virginia. Our task is much simpler, and that is to assure ourselves that the Virginia hospitalization requirement is not of the same nature as those invalidated in

²¹ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient clinic regulations; stating that he was seeking a license; but denying that he knew of the regulations when the abortion was performed).

did at great length,

City of Akron and *Ashcroft*. As we noted earlier, they are not. Nor do they appear to impose different, but also unreasonable requirements for second-trimester abortions. We have looked to the recommendations of ACOG and the American Public Health Association (APHA),²² and although Virginia's requirements may be more detailed with respect to specific facilities, equipment, and personnel, we believe that they are generally compatible with the medical standards set forth there for outpatient facilities performing second-trimester abortions. Certainly appellant has given us no reason to assume that they are unreasonable health and safety requirements.

We therefore conclude, at least on the record before us in this case, that appellant has not shown the Virginia regulations concerning second-trimester abortions to be an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²³ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not

²² See APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980). See also National Abortion Federation, National Abortion Federation Standards (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

²³ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—seem to accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—between the physician and the patient.

V

We hold that, on the record before us, Virginia's requirement for second-trimester abortions is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

From: **Justice Powell**

Circulated: _____

Recirculated: _____

2nd CHAMBERS DRAFT II

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[April —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony."

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, re-

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

quired the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia's statutory hospitalization requirement prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we today have found this argument persuasive when made in constitutional challenges to the acute-care, general hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement is significantly different from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them. See n. 8, *infra* (noting State's interpretation of the Virginia regulations).

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075,

“outpatient . . . hospitals.”⁵ Section 20.2.11 of the Department of Health’s Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) (“regulations”)⁶ defines outpatient hospital in pertinent part as “[i]nstitutions

277 S. E. 2d, at 204.

There is no basis for assuming that the court interpreted “hospital” in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

“‘Hospital’ means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals.”

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time “out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery).”

⁶ The regulations were promulgated pursuant to the State Board of Health’s general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

“classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients.” Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

. . . which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester. Thus, no distinction was made between first- and second-trimester abortions with respect to the appropriateness of and need for state regulation.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 9, 28, *infra*. It therefore is clear

[Footnotes 7 and 8 are on page 8]

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to

that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval to the regulations before us on May 11, 1977.

The regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said—and indeed appellant does not argue—that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,⁹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer,

⁹The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁰These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹¹The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

¹² See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*; § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods."

¹⁶ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation

B

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft, ante*, at 4-5. In those cases, the regulations required that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft, ante*, at 5. We found that such a requirement, by preventing the use of the dilation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron, ante*, at 20. The Court invalidated these laws because they did not reasonably further the state interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for

plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

licensing as hospitals in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

C

The remaining question is the constitutionality of Virginia's regulations. Second-trimester abortions may give rise to serious complications,¹⁸ and certain procedures significantly increase the risks. Although the increasingly common use and relative safety of the D&E method, see *City of Akron*, *ante*, at 17-19, may make the need for particular equipment in and designs of a facility less imperative, the need for reasonable regulations has not been eliminated. D&E, despite its safety in most cases early in the second trimester, still may cause complications.¹⁹

The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges en-

¹⁸ See Cadesky, Ravinsky & Lyons, Dilation and Evacuation: A Preferred Method of Midtrimester Abortion, 129 Am. J. Obstet. Gynecol. 329, 331 (1981); Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: Annual Summary 1978, at 48 (1980).

¹⁹ Medical evidence indicates that hemorrhaging is a leading cause of death and complications in D&E abortion patients. Other potential complications are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, Methods of Midtrimester Abortion (1979).

The Court of Appeals in *Ashcroft*, 664 F. 2d 687, 690, n. 6 (CA8 1981), *rev'd in part and aff'd in part*, *ante*, p. — that major potential complication for all abortion techniques—infection—normally does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. Thus, the medical evidence makes clear that the relative safety of the D&E procedure does not alleviate the need for standards designed to *prevent* infection.

dorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron, ante*, at 12. On their face, these Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.²⁰

²⁰ See American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 52-54 (5th ed. 1982); APHA *Recommended Program Guide for Abortion Services*, 70 Am. J. Pub. Health 652, 655 (1980). See also National Abortion Federation, *National Abortion*

We need not decide whether certain individual regulations are unreasonable on their face or invalid as applied to him. Despite full knowledge of the regulations at the time of his trial,²¹ appellant has elected to treat the Virginia hospitalization requirement as no different from those we reviewed in *City of Akron* and *Ashcroft*. To the extent the record is silent, the lack of evidence on the reasonableness of the regulations must be attributed to his failure to produce any medical evidence, as the plaintiffs in *City of Akron* and *Ashcroft* did at great length, to show that certain equipment or services required by the State are unreasonable requirements to impose on women seeking second-trimester abortions.²² In a

Federation Standards (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

²¹ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital regulations; stating that he was seeking a license; but denying that he knew of the regulations when the abortion was performed).

²² Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on this hospitalization requirement in § 18.2-73. Indeed, appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief, instead arguing that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid. Appellant's reply brief does criticize the Virginia regulations instead making only facial challenges in the broadest language and in conclusory terms: but not individually or on specific grounds the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical clinics exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient clinic license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical clinic where

word, he has not shown why the Virginia regulations do not further the State's compelling interest in the health and safety of the pregnant woman.

We therefore conclude, on the record before us in this case, that appellant has not shown the Virginia regulations concerning second-trimester abortions to be an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²³ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—seem to accommodate accepted medical prac-

second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet reasonable facility and equipment standards merely because they impose some costs and burdens. As *City of Akron* makes clear, see *ante*, at 12, in view of the State's compelling interest in the pregnant woman's health, it may adapt reasonable regulations. Compliance with the State's requirements certainly will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people.

²³ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

tice, and leave the method and timing of the abortion precisely where they belong—with the physician and the patient.

V

We hold that, on the record before us, Virginia's hospitalization requirement for second-trimester abortions is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

Jim Browning
23072
3d Chambers Draft II
6 copies

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Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
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Justice O'Connor

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3d

2nd CHAMBERS DRAFT II

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[April —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony."

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, re-

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

quired the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia's statutory hospitalization requirement prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we today have found this argument persuasive when made in constitutional challenges to the acute-care, general hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement is significantly different from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them. See n. 8, *infra* (noting State's interpretation of the Virginia regulations).

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075,

"outpatient . . . hospitals."⁵ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

277 S. E. 2d, at 204.

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

"*Hospital*" means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶ The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

. . . which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester. Thus, no distinction was made between first- and second-trimester abortions with respect to the appropriateness of and need for state regulation.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 8, 23, *infra*. It therefore is clear

[Footnotes 7 and 8 are on page 8]

8 23
^ ^

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to

that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval to the regulations before us on May 11, 1977.

The regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said—and indeed appellant does not argue—that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,⁹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer,

⁹The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁰These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹¹The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

¹² See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4. ⁹ and

~~Section 43.8.5 provides that the facility performing abortions~~ "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods." *id.*, § 43.8.5

¹⁶ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation

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B

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft, ante*, at 4-5. In those cases, the regulations required that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft, ante*, at 5. We found that such a requirement, by preventing the use of the dilation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron, ante*, at 20. The Court invalidated these laws because they did not reasonably further the state interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for

plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

licensing as hospitals in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

C

The remaining question is the constitutionality of Virginia's regulations.¹⁸ Second-trimester abortions may give rise to serious complications,¹⁹ and certain procedures significantly increase the risks. Although the increasingly common use and relative safety of the D&E method, see *City of Akron*, *ante*, at 17-19, may make the need for particular equipment in and designs of a facility less imperative, the need for reasonable regulations has not been eliminated. D&E, despite its safety in most cases early in the second trimester, still may cause complications.¹⁹

The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges en-

¹⁸ See Cadesky, Ravinsky & Lyons, Dilation and Evacuation: A Preferred Method of Midtrimester Abortion, 129 Am. J. Obstet. Gynecol. 329, 331 (1981); Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: Annual Summary 1978, at 48 (1980).

¹⁹ Medical evidence indicates that hemorrhaging is a leading cause of death and complications in D&E abortion patients. Other potential complications are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, Methods of Midtrimester Abortion (1979).

The Court of Appeals in *Ashcroft*, 664 F. 2d 687, 690, n. 6 (CA8 1981), rev'd in part and aff'd in part, *ante*, p. — that major potential complication for all abortion techniques—infection—normally does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. Thus, the medical evidence makes clear that the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

dorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron, ante*, at 12. On their face, these Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.

¹⁸ See American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 52-54 (5th ed. 1982); APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980). See also National Abortion Federation, *National Abortion*

We need not decide, ^{however,} whether certain individual regulations are unreasonable on their face or invalid as applied to ~~him~~ ^(appellant.) Despite full knowledge of the regulations at the time of his trial, ¹⁹ appellant has elected to treat the Virginia hospitalization requirement as no different from those we reviewed in *City of Akron* and *Ashcroft*. To the extent the record is silent, the lack of evidence on the reasonableness of the regulations must be attributed to his failure to produce any medical evidence, as ~~the~~ ²⁰ plaintiffs in *City of Akron* and *Ashcroft* did at great length, to show that certain equipment or services required by the State are unreasonable requirements to impose on women seeking second-trimester abortions. ²¹ In a

Federation Standards (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

¹⁹ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital regulations; stating that he was seeking a license; but denying that he knew of the regulations when the abortion was performed).

²⁰ Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on this hospitalization requirement in § 18.2-73. Indeed, appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief, instead arguing that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid. Appellant's reply brief does criticize the Virginia regulations, instead making only facial challenges in the broadest language and in conclusory terms: ~~but not individually or on specific grounds~~ the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical ²¹clinics exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient ²²clinic license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical ²³clinic where

(but not individually or on specific grounds)

(hospitals)

(hospital)

(hospital)

word, he has not shown why the Virginia regulations do not further the State's compelling interest in the health and safety of the pregnant woman.

We therefore conclude, on the record before us in this case, that appellant has not shown the Virginia regulations concerning second-trimester abortions to be an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²⁰ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—seem to accommodate accepted medical prac-

second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet reasonable facility and equipment standards merely because they impose some costs and burdens. As *City of Akron* makes clear, see *ante*, at 12, in view of the State's compelling interest in the pregnant woman's health, it may adapt reasonable regulations. Compliance with the State's requirements certainly will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people.

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

tice, and leave the method and timing of the abortion precisely where they belong—with the physician and the patient.

V

We hold that, on the record before us, Virginia's hospitalization requirement for second-trimester abortions is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

L.F.P.
4/10

From: **Justice Powell**

Circulated: _____

Recirculated: _____

3rd CHAMBERS DRAFT II

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT v. VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[April —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony."

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, re-

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

Jim - we refer to Va's
hospitalization "requirement"
or "requirements" almost
interchangeable. Certainly
when the Regs are
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the plural
is more
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SIMOPOULOS v. VIRGINIA

quired the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia's statutory hospitalization requirement prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we today have found this argument persuasive when made in constitutional challenges to the acute-care, general hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement is significantly different from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them. See n. 8, *infra* (noting State's interpretation of the Virginia regulations).

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075,

“outpatient . . . hospitals.”⁵ Section 20.2.11 of the Department of Health’s Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) (“regulations”)⁶ defines outpatient hospital in pertinent part as “[i]nstitutions

277 S. E. 2d, at 204.

There is no basis for assuming that the court interpreted “hospital” in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

“‘Hospital’ means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals.”

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time “out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery).”

⁶The regulations were promulgated pursuant to the State Board of Health’s general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

“classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients.” Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

... which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester. Thus, no distinction was made between first- and second-trimester abortions with respect to the appropriateness of and need for state regulation.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics do-

[Footnotes 7 and 8 are on p. 8]

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to

ing first-trimester abortions. See nn. 8, 23, *infra*. It therefore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval to the regulations before us on May 11, 1977.

The regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said—and indeed appellant does not argue—that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) §40.3; see also §40.1. They also require a policy and procedures manual,⁹ §43.2, an administrative officer, §40.6, a licensed physician who must supervise clinical services and perform surgical procedures, §42.1, and a registered nurse to be on duty at all times while the facility is in use, §42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," §50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer,

⁹The manual must describe emergency and elective procedures that may be performed at the facility, §41.2.1; the anesthesia that may be used, §41.2.2; the criteria and procedures for admissions and discharge, §41.2.4; written informed consent, §41.2.4; and procedures for housekeeping and infection control, §41.2.5.

¹⁰These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) §52.3.1.

¹¹The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§50.6.1, 50.7.1, 50.8.1, 50.8.4.

such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

¹² See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician, *id.*, § 43.8.4, and

the facility "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods, *id.*, § 43.85."

¹⁶ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemor-

B

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron*, ante, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft*, ante, at 4-5. In those cases, the regulations required that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, ante, at 5. We found that such a requirement, by preventing the use of the dilatation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron*, ante, at 20. The Court invalidated these laws because they did not reasonably further the state interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." Ante, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for licensing as hospitals in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

rhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

C

The remaining question is the constitutionality of Virginia's regulations. The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the

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State seeks to accomplish.' *Doe*, 410 U. S., at 195." [*City of Akron*, ante, at 12.] On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.¹⁸

We need not decide, however, whether certain individual regulations are unreasonable on their face or invalid as applied to appellant. Despite full knowledge of the regulations at the time of his trial,¹⁹ appellant has elected to treat the Virginia hospitalization requirement as no different from those we reviewed in *City of Akron* and *Ashcroft*. To the extent the record is silent, the lack of evidence on the reasonableness of the regulations must be attributed to his failure to produce any medical evidence, as plaintiffs in *City of Akron* and *Ashcroft* did at great length, to show that certain equipment or services required by the State are unreasonable requirements to impose on women seeking second-trimester abortions.²⁰ In a word, he has not shown why the Virginia

¹⁸ See American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services 52-54 (5th ed. 1982); APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980). See also National Abortion Federation, National Abortion Federation Standards (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

¹⁹ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital regulations; stating that he was seeking a license; but denying that he knew of the regulations when the abortion was performed).

²⁰ Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on the hospitalization requirement in § 18.2-73. Indeed, appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief, instead arguing that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid. Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: but the record is silent on the applicability of those regulations to his facility; that the record does not

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regulations do not further the State's compelling interest in the health and safety of the pregnant woman.

We therefore conclude, on the record before us in this case, that appellant has not shown the Virginia regulations concerning second-trimester abortions to be an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²¹ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing ~~to it~~ that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron

show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet reasonable facility and equipment standards merely because they impose some costs and burdens. As *City of Akron* makes clear, see *ante*, at 12, in view of the State's compelling interest in the pregnant woman's health, it may adopt reasonable regulations. Compliance with the State's requirements certainly will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people.

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—seem to accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—with the physician and the patient.

V

We hold that, on the record before us, Virginia's hospitalization requirement for second-trimester abortions is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

MAR 3 1983

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

From: Justice Powell

Circulated: ^{Mar} ~~Feb~~ 3 1983

Recirculated: _____

1st DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[March —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant broadly attacks Virginia's hospitalization requirements.³ He contends that they restrict the availability

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is necessary to save the woman's life, § 18.2-74.1; and (iv) is performed during the third trimester under certain circumstances, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

³Questions raised particularly with respect to Virginia's outpatient surgical clinics are considered in Part III, *infra*. Appellant raises two additional issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden

of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions. He also argues that the Virginia requirements result in negative health consequences and, as applied to him and the abortions he performs in his well-equipped non-licensed clinic, do not further the State's interests.

We need not pause long here to consider the guiding principles, for we have set them out at length today in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, at 9-12, 14-16. For present purposes here, the critical point is that we consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester," *Roe v. Wade*, 410 U. S. 113, 163 (1973), and is compelling throughout the remainder of the pregnancy. This interest, of course, embraces the facilities and circumstances in which abortions are performed. *Id.*, at 150.

A

It is in furtherance of this compelling interest in maternal health that Virginia has enacted its hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under Virginia law.⁴ Virginia law does not, however, per-

of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

⁴A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a ques-

mit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1, which defines "hospital" to include "outpatient . . . hospitals." Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁵ defines outpatient hospital in pertinent part as "[i]nstitutions . . . which primarily provide facilities for the performance of surgical procedures on outpatients"⁶ and provides that second-trimester abortions may be performed in these clinics.⁷

tion of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here. Thus, without record evidence that appellant's facility qualifies as a surgical outpatient clinic *and* that he was denied a hospital license, the issue of whether the Falls Church facility would qualify under Virginia law is irrelevant to our determination in this case. See n. 7, *infra* (noting State's interpretation of the Virginia regulations).

⁵The regulations were promulgated pursuant to 1947 Va. Acts, c. 15, § 1514-a5, repealed by 1979 Acts, c. 711. Although not relevant to our determination here, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he has been prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982).

⁶Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁷Part II of the regulations sets minimum standards for outpatient surgi-

Thus, under Virginia law, a second-trimester abortion may be performed in an outpatient surgical clinic⁸ provided that clinic has been licensed as a "hospital" by the State.

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron*, ante, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft*, ante, at 45. In those cases, the regulations required that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, ante, at 5. We found that such a requirement, by preventing the use of the dilatation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron*, ante, at 20. The Court invalidated these laws invalid because they did not reasonably further the state interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be per-

cal clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, i. e., §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

⁸ We herein usually refer to the outpatient "hospitals" in Virginia that legally may perform second-trimester abortions as "outpatient surgical clinics."

formed as safely in an outpatient clinic as in a full-service hospital." *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for licensing as hospitals in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

B

Second-trimester abortions may give rise to serious complications,⁹ and certain procedures significantly increase the risks. Although the increasingly common use and relative safety of the D&E method, see *City of Akron*, *ante*, at 17-19 may make the need for particular equipment in and designs of a facility less imperative, the need for reasonable regulations has not been eliminated. D&E, despite its safety early in the second trimester, still may cause complications.¹⁰

The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast

⁹See Cadesky, Ravinsky & Lyons, Dilation and Evacuation: A Preferred Method of Midtrimester Abortion, 129 Am. J. Obstet. Gynecol. 329, 331 (1981), Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: Annual Summary 1978, at 48 (1980).

¹⁰Hemorrhaging is a leading cause of death and complications in D&E abortion patients. Other potential complications are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, Methods of Midtrimester Abortion 75 (1979).

A major potential complication for all abortion techniques—infection—normally does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. See *Ashcroft*, 664 F. 2d 687, 690, n. 6 (CA8 1981), *rev'd in part and aff'd in part*, *ante*, p. —. Thus the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982) (hereinafter ACOG Standards). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron, ante*, at 12. The issue here is whether Virginia's licensing requirements for outpatient surgical clinics performing second-trimester abortions are reasonable means of furthering the State's compelling interest in the woman's health.

C

The Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia. These regulations may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) §40.3; see also §40.1. They also require a policy and procedures manual,¹¹ §43.2, an administrative officer, §40.6, a licensed physician who must supervise clinical services and perform surgical procedures, §42.1, and a registered nurse to be on duty at all times while the facility is in use, §42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," §50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹² and general building.¹³

¹¹ The manual must describe emergency and elective procedures that may be performed at the facility, §41.2.1; the anesthesia that may be used, §41.2.2; the criteria and procedures for admissions and discharge, §41.2.4; written informed consent, §41.2.4; and procedures for housekeeping and infection control, §41.2.5.

¹² These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) §52.3.1.

¹³ The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpa-

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹⁴ laboratory,¹⁵ and pathology.¹⁶ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁷ and post-operative recovery.¹⁸ Finally, the regulations mandate some emergency services and evacuation planning.¹⁹

tient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹⁴ See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁵ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical clinics providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁶ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at —.

¹⁷ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical clinic providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient *appropriate* counseling and instruction in the abortion procedure and in birth control methods." Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, unlike in *City of Akron*, it is for the woman, in conjunction with her physician, to decide what considerations are relevant to her decision. See *ante*, at 27-28.

¹⁸ Each patient shall be observed for post-operative complications for one

[Footnote 19 is on p. 11]

III

Appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief. Instead, he challenges Virginia's requirement of hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics that may perform second-trimester abortions. As appellant had not sought a license for his clinic at the time he was indicted, he appears to argue that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus invalid.

Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that even if he had applied for a license, it is uncertain whether it would have been granted; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations;" that Part II of the regulations does not cover an outpatient surgical facility where second trimester abortions are performed, but see n. 8, *supra*; and that medical evidence rebuts the view "that it is

hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4. For a discussion of similar standards by various medical organizations, see n. 32, *infra*.

¹⁹See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

safer to perform second trimester abortions in hospitals.” Reply Brief for Appellant 1. Only the last of these arguments is relevant to the validity of these statutes and regulations, and appellant points to no evidence that supports his generalized claim of “safety.” We have noted above that the Virginia requirements are strikingly different from those we invalidated in *City of Akron* and *Ashcroft*. Compliance with the state’s requirements will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people. Moreover, ethical physicians are obligated to provide facilities consistent with the standards set by their profession, and appellant has not identified any significant differences between professional standards and the Virginia requirements. We are convinced, at least on the record before us, that the Virginia provisions are reasonably related to and further the State’s compelling interest in protecting the health of the pregnant woman during the second trimester.

The requirements of the first²⁰ and second categories²¹ of regulations discussed in Part II-C above have little relevance to this case. They have not been challenged by appellant be-

²⁰ ACOG’s standards discuss many of Virginia’s concerns about proper management and policies under the appropriate heading of “Quality Assurance.” See ACOG Standards 55 (“Each physician’s office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished.”). Like Virginia’s “narrative” requirement, Va. Regs. (Outpatient Hospitals) §§ 50.1.1, 50.2.1, ACOG’s standards suggest that the “outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnoses, appropriateness of use of laboratory and other services, and outcome of care.” ACOG Standards 55–56. See National Abortion Federation (NAF), National Abortion Federation Standards 11 (1981) (hereinafter NAF Standards) (requiring written descriptions of procedures and policies in each area of care). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6. (supporting the NAF Standards for non-hospital abortion facilities as constituting “minimum standards”).

ACOG also advises that each ambulatory body should have a “governing body” that has the final authority and responsibility for the appointment of

yond his sweeping condemnation of any requirement that second-trimester abortions—even those during the twenty-second week of pregnancy—be performed in hospitals, however defined and whether outpatient or not. In any event, as appears from the recommendations of ACOG and the American Public Health Association (APHA) set forth in the margin, see nn. 22, 23, and 24, Virginia's requirements, although more detailed with respect to specific facilities,²² equipment,

the medical staff, ACOG Standards 60; cf. Va. Regs. (Outpatient Hospitals) § 40.3, and that "[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically," ACOG Standards 60. Cf. NAF Standards 12 (responsibilities of chief administrative officer); Planned Parenthood of Metropolitan Washington, D.C., Inc., 1980 Guidelines for Operation, Maintenance and Evaluation of First Trimester Outpatient Abortion Facilities 1 (hereinafter "Planned Parenthood Guidelines") (duties of administrator).

²² This second category of Virginia regulations is consistent with those set forth by ACOG. ACOG recommends that even physicians' offices provide at least a patient reception room, consultation room, two examining rooms, a utility room, and storage. ACOG Standards 56-58. Cf. Planned Parenthood Guidelines, 1-3 (detailing extensive physical requirements for first-trimester abortion clinics). ACOG's standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evaluation, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See ACOG Standards 61.

ACOG details the equipment to be found in the various rooms and areas. ACOG Standards 57-58, 61. Cf. APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980) (hereinafter "APHA Guide") (any abortion facility should have "[a]n operating table, or conventional gynecologic examining table with accessories, located in a room which is adequately lighted and ventilated and meets all other environmental standards for surgical procedures"); Planned Parenthood Guidelines 2. A doctor's examining room should contain instruments for vaginal examinations, supplies for obtaining cultures and smears, and equipment for diagnostic studies and operative procedures. ACOG Standards 57. Cf. Planned Parenthood Guidelines 2. When local anesthesia is used, the

and personnel than the ACOG and APHA standards, are compatible with generally accepted medical standard.

Our concern centers on whether the patient services requirements of the Virginia regulations further the State's interest in the health and safety of the pregnant woman. We think they clearly do. Again, we have compared them to the standards used by ACOG and APHA, and we are impressed with the scrupulousness with which Virginia has drawn regulations reasonably related to its interest in protecting the pregnant woman's health. The sanitation²³ and record-keeping standards²⁴ are typical and not unreasonable in detail.

clinic or doctor's office should have emergency resuscitation equipment, including positive pressure oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. ACOG Standards 57. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. *Id.*, at 61. Cf. APHA Guide 655 (requiring oxygen, and equipment for artificial ventilation and resuscitation); NAF Standards 9 (requiring all facilities performing second-trimester abortions to have resuscitation bag, oxygen, and defibrillator if general anesthesia is administered); Planned Parenthood Guidelines 2 (even first-trimester abortion clinics should have parenteral fluids, resuscitation equipment, and oxygen).

²³ ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. ACOG Standards 58, 61. Specific plans should be developed to evacuate patients in case of an emergency. *Id.*, at 59, 62. Cf. NAF Standards 8, 11; Planned Parenthood Guidelines 10.

²⁴ Infection can be a serious complication with any abortion procedure. See nn. 11 and 12, *supra*. Significant portions of the Virginia regulations are designed to assure that outpatient surgical clinics take appropriate steps to control infection, including sterile processing, appropriate waste-disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Va. Regs. (Outpatient Hospitals) §§ 41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies. ACOG Standards 58, 62. APHA Guide 655; NAF Standards 7 ("Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure. . . .").

²⁴ The Virginia record-keeping requirements are similar to those detailed

The laboratory services²⁵ support—and often are essential to—the direct medical services²⁶ performed by the physician²⁷ and nurse.²⁸ The post-operative recovery standards²⁹ also comport with accepted medical practice,³⁰ and the

by ACOG for a physician's office, ACOG Standards 54-55, 59-60, which require at the initial visit a comprehensive data base including information on reason for visit, menstrual history, obstetric history, gynecologic history, sexual history, past medical and surgical history, current medications, allergies, social history, and family history. For ambulatory surgical facilities, ACOG recommends that the patient's record contain sufficient information to justify the preoperative diagnosis and the operative procedure, and should at least contain patient identification data, history and physical examination, provisional diagnosis, diagnostic and therapeutic orders, surgeons' and nurses' notes, laboratory data, operative consent, operative report, anesthesia report, tissue report, medications record, and discharge summary and instructions. *Id.*, at 59. See also *id.*, at 60 ("On the day of surgery a preanesthetic evaluation, including an interval history, medical record review, and a heart and lung examination should be performed by a physician and the findings should be noted in the record."). We have found that such requirements, "if not abused or overdone," impose a legally insignificant burden on the *Roe* right. See *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S. 52, 81 (1976). We do not think Virginia's requirements are excessive. Cf. APHA Guide 655-656 (recommended reporting requirements); Planned Parenthood Guidelines 13 (record-keeping and reporting requirements).

²⁵ The risk of hemorrhage is reduced by requiring an outpatient surgical clinic to make hemoglobin or hematocrit determinations before initiating instillation. See ACOG Standards 59 ("The laboratory data should include hemoglobin or hematocrit, urinalysis, and, in certain selected patients, other studies such as a chest x-ray, electrocardiogram, and electrolytes."). See also APHA Guide 654 ("Appropriate laboratory procedures must include determination of hematocrit and Rh factor in every case. The value of other laboratory procedures will depend upon the population served; may include sickle cell testing; endocervical and anal culture for gonorrhea; urinalysis; serologic testing for syphilis; and, when indicated cytologic screening for cancer."); NAF Standards 7 ("Rh-immune globulin must be explained and administered to Rh-negative patients."); Planned Parenthood Guidelines 8 (requiring lab facilities to be available on premises for pregnancy tests, urine protein and sugar, hematocrit or hemoglobin determination, and Rh typing).

²⁶ See ACOG Standards 59 ("The appropriate records should be completed and laboratory data recorded *prior* to surgery.") (emphasis added).

[Footnotes 27 through 31 are on pp. 16 and 17]

equipment requirements for emergency services are minimal.⁸¹

We do not suggest that all of the Virginia requirements are necessary for every second-trimester abortion. But a State simply cannot adopt regulations that serve every case with

ACOG also recommends that "[t]he physician should strive to identify pre-existing or concurrent illness, medications, and adverse drug reactions that may have a bearing on the operative procedure or anesthesia. *All records should be reviewed before any surgery is performed.*" *Id.*, at 60 (emphasis added). APHA Guide 654; Planned Parenthood Guidelines 8.

⁸¹ For example, the ACOG requires careful laboratory work before anesthesia is administered, and even then, it must be given only by or under the supervision of a doctor: "Any ambulatory surgical unit that utilizes general, epidural, or spinal anesthesia should do so under the direction of an anesthesiologist. These anesthetics should be administered by a qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation must be available." ACOG Standards 53. Cf. APHA Guide 655; Planned Parenthood Guidelines, *supra*, n. 22, at 10.

⁸² The ACOG Standards do not specifically require nurses for physicians' offices or for ambulatory surgical facilities, but note: "The efficient operation of an ambulatory surgical facility requires adequate staffing with administrative and professional personnel. The assignment of personnel should be based on the number of patients, patient profiles, type of procedures, and facility design." ACOG Standards 60. Cf. *id.*, at 56 ("Administrative and professional personnel requirements will vary considerably in each physician's office and outpatient clinic depending on the patient load, pattern of practice, and type of facility."); Planned Parenthood Guidelines 7-8 (head laboratory technician); *id.*, at 9 ("It is strongly recommended that three staff persons be present in the procedure room: the operating physician, the physician's assistant and a counselor to assist the patient.").

⁸³ See n. 19, *supra*.

⁸⁴ Complications resulting from anesthesia are alleviated by requiring a physician to be present during the recovery period. See ACOG Standards 53 ("The supervising anesthesiologist, or another physician qualified in cardiopulmonary resuscitation, should be present in the ambulatory surgical facility until all surgical patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the

the same degree of relevance; “[a] State necessarily must have some latitude in adopting regulations of general applicability in this sensitive area.” *City of Akron, ante*, at 16. Although a State’s general licensing regulations must be drawn to further the State’s interests in women’s health for all reasonable periods of time within the second-trimester, a particular requirement “is not unconstitutional simply because it does not correspond perfectly in all cases to the asserted state interest.” *City of Akron, ante*, at 20.

We therefore conclude, at least on the record before us in this case, that Virginia’s regulations concerning second-trimester abortions are reasonably related to and further the

back-up hospital.”); Planned Parenthood Guidelines 11; see also APHA Guide 655 (“[I]t will be necessary to periodically observe the temperature, pulse rate, blood pressure, and the amount of bleeding. In addition, the abdomen should be examined for evidence of intra-abdominal bleeding or injury.”). Less serious complications can be monitored by the registered nurse on duty. See ACOG Standards 53 (“During the recovery period, the patient should be under continuous observation by a qualified member of the health care team. This person should maintain a complete record of the patient’s general condition including vital signs, blood loss, and occurrence of complications.”); NAF Standards 6 (“The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area.”); Planned Parenthood Guidelines 11. The required one-hour recovery period is intended to permit detection of these complications. See APHA Guide 655 (requiring post-operative observations “over a period of two or more hours, depending upon the type of anesthesia used”); Kerenyi, Mandelman & Sherman, *Five Thousand Consecutive Saline Inductions*, 116 Am. J. Obstet. & Gynecol. 593, 597 (1973); ACOG Standards 53; App. 37 (defense expert witness concedes waiting period desirable).

³¹ The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See APHA Guide 655; ACOG Standards 52 (“There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication.”); *id.*, at 58, 62; NAF Standards, *supra*, n. 22, at 7; Planned Parenthood Guidelines, *supra*, n. 22, at 10 (“Each facility must have a functioning arrangement for emergency transport to a local accredited hospital.”).

State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.³² As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—between the physician and the patient.

IV

We hold that Virginia's requirement that second-trimester abortions be performed in, properly equipped outpatient clinic is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

³² Appellant argues that Part III of the regulations, covering first-trimester abortion clinics requires the *same* services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the state's compelling interest.

MAR 4 1983

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

L. F. P.

From: Justice Powell

Circulated: MAR 4 1983

Recirculated: _____

7

1st DRAFT

SUPREME COURT OF THE UNITED STATES

Nos. 81-1255 AND 81-1623

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
ET AL., PETITIONERS

81-1255

v.

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL.

JOHN ASHCROFT, ATTORNEY GENERAL OF
MISSOURI, ET AL., PETITIONERS

81-1623

v.

PLANNED PARENTHOOD ASSOCIATION OF
KANSAS CITY, MISSOURI, INC.,
ET AL., PETITIONERS

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF
APPEALS FOR THE EIGHTH CIRCUIT

[Decided March —, 1983]

JUSTICE POWELL delivered the opinion of the Court:

These cases, like *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Simopoulos v. Virginia*, post, p. —, present questions as to the validity of state statutes regulating the performance of abortions.

I

Planned Parenthood of Kansas City, Missouri, Inc., two physicians who perform abortions, and an abortion clinic ("plaintiffs") filed a complaint in the District Court for the Western District of Missouri challenging, as unconstitutional,

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

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

² Mo. Rev. Stat. § 188.047 provides:

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

³ Mo. Rev. Stat. § 188.030.3 provides:

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

⁴ Mo. Rev. Stat. § 188.028 provides:

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

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

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

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

After hearing testimony from a number of expert witnesses, the District Court invalidated all of these sections except the pathology requirement. 483 F. Supp. 679, 699-701 (1980).⁵ The Court of Appeals for the Eighth Circuit re-

physician has received the informed written consent of the minor; or

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

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

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

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

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

"(a) Grant the petition for majority rights for the purpose of consenting

[Footnote 5 is on p. 4]

versed the District Court's judgment with respect to § 188.028, thereby upholding the requirement that a minor secure parental or judicial consent to an abortion. It also held that the District Court erred in sustaining § 188.047, the pathology requirement. The District Court's judgment with respect to the second-physician requirement was affirmed, and the case was remanded for further proceedings and findings relating to the second-trimester hospitalization requirement. 655 F. 2d 848, 872-873 (1981). On remand, the District Court affirmed its holding that the second-trimester hospitalization requirement was unconstitutional. The Court of Appeals affirmed this judgment. 664 F. 2d 687, 691 (1981). We granted certiorari. — U. S. — (1982).

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

II

to the abortion; or

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

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

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

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

In *City of Akron*, we invalidated a city ordinance requiring physicians to perform all second-trimester abortions at general or special hospitals accredited by the Joint Commission on Accreditation of Hospitals (JCAH) or by the American Osteopathic Association. *Ante*, at 13. Missouri's hospitalization requirements are similar to those enacted by Akron, as all second-trimester abortions must be performed in general, acute-care facilities.⁶ For the reasons stated in *City of Akron*, we held that such a requirement "unreasonably infringes upon a woman's constitutional right to obtain an abortion." *Ante*, at 20-21. For the same reasons, we affirm the Court of Appeals' judgment that §188.025 is unconstitutional.

III

We turn now to the State's second-physician requirement.

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

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

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

In *Roe v. Wade*, 410 U. S. 113 (1973), the Court recognized that the State has a compelling interest in the life of a viable fetus: “[T]he State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.” *Id.*, at 164–165. See *Colautti v. Franklin*, 439 U. S. 379, 386–387 (1979); *Beal v. Doe*, 432 U. S. 438, 445–446 (1977). Several of the Missouri statutes undertake such regulation. Post-viability abortions are proscribed except when necessary to preserve the life or the health of the woman. Mo. Rev. Stat. § 188.030.1 (Supp. 1982). The State also forbids the use of abortion procedures fatal to the viable fetus unless alternative procedures pose a greater risk to the health of the woman. § 188.030.2.

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

The lower courts invalidated § 188.030.3.⁷ The plaintiffs, respondents here on this issue, urge affirmance on the

⁷The courts below found that there is no possible justification for a second-physician requirement whenever D&E is used since no viable fetus can survive a D&E procedure. 483 F. Supp., at 694; 655 F. 2d, at 865. Accordingly, they found the provision overbroad. As the Court of Appeals noted, however, the choice of D&E after viability is subject to the requirements of § 188.030.2. See *id.*, at 865, and n. 28. Thus, D&E is not to be used when the fetus is viable; when other methods are more likely to preserve its life; and when alternative procedures do not pose a greater risk to the woman’s life or health. Cf. *id.*, at 865 (some physicians testified they

grounds that the second-physician requirement distorts the traditional doctor-patient relationship, and is both impractical and costly. They note that Missouri does not require two physicians in attendance for any other medical or surgical procedure, including childbirth or delivery of a premature infant. These are not insubstantial arguments, and we view the issue as a close one.

The first physician's primary concern will be the life and health of the woman. Many third-trimester abortions in Missouri will be emergency operations,⁸ as the State only permits these late abortions when they are necessary to preserve the life or the health of the woman. It is not unreasonable for the State to assume that during the operation the first physician's attention and skills will be directed to preserving the woman's ~~condition~~, and not to protecting the actual life of those fetuses who survive the abortion procedure.

health

would not use D&E in third-trimester); American College of Obstetricians and Gynecologists (ACOG) Technical Bulletin No. 56, Methods of Midtrimester Abortion 4 (1979) (mortality rate for D&E less than or similar to that of instillation abortions up to 20 weeks). There is nothing in the record to indicate that D&E will be the method that poses the least risk to the woman in every situation in which there are compelling medical reasons for performing an abortion after viability. Cf. 655 F. 2d, at 865 (experts disagree whether D&E should ever be used after viability). We therefore cannot assume that all third-trimester abortions will be D&E abortions, or that there will be no live births. Thus, the State's compelling interest in preserving the life of the fetus when there is a live birth justifies the State in requiring a second physician at every third-trimester abortion.

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

Viable fetuses will be in immediate and grave danger because of their premature birth. A second physician, in situations where Missouri permits third-trimester abortions, may be of assistance to the woman's physician in preserving the health and life of the child.

By giving immediate medical attention to a fetus that is delivered alive, the second physician will assure that the State's interests are protected more fully than the first physician alone would be able to do. And given the compelling interest that the State has in preserving life, we cannot say that the Missouri requirement of a second physician in those unusual circumstances where Missouri permits a third-trimester abortion is unconstitutional. Preserving the life of a viable fetus that is aborted may not often be possible,⁹ but the State legitimately may choose to provide safeguards for the comparatively few instances of live birth that occur. We believe the second-physician requirement furthers the State's compelling interest in protecting the lives of viable fetuses, and we reverse the judgment of the Court of Appeals holding that § 188.030.3 is unconstitutional.

IV

Section 188.047 requires a pathology report for every abortion performed. Even in the early weeks of pregnancy, however, "[c]ertain regulations that have no significant impact on the woman's exercise of her right to decide to have an abortion may be permissible where justified by important state health objectives." *City of Akron*, at 11. See

⁹See ACOG Technical Bulletin No. 56, *supra* n. 7, at 4 (as high as 7% live-birth rate for intrauterine instillation of uterotonic agents); Stroh & Hinman, Reported Live Births Following Induced Abortion: Two and One-Half Years' Experience in Upstate New York, 126 Am. J. Obstet. Gynecol. 83, 83-84 (1976) (26 live births following saline induced-abortions; 9 following hysterotomy; 1 following oxytocin-induced abortion) (one survival out of 38 live births.)

Planned Parenthood of Central Mo. v. Danforth, 428 U. S. 52, 80-81 (1976). The question is whether § 188.047 unconstitutionally burdens a woman's abortion decision. We hold that it does not.

In regulating hospital services within the State, Missouri requires that "[a]ll tissue surgically removed, with the exception of such tissue as tonsils, adenoids, hernial sacs and prepuces, shall be examined by a pathologist, either on the premises or by arrangement outside of the hospital." 13 Mo. Admin. Code 50-20.030(3)(A)7 (1977). Although Missouri apparently does not require pathology reports in all procedures, this does not mean that such a requirement is invalid simply because it touches on the woman's abortion right during the first weeks of pregnancy. Rather, the specific issue here is whether § 188.047, which on its face and in effect is reasonably related to generally accepted medical standards and maternal health,¹⁰ "further[s] important health-related

¹⁰ A pathological examination is designed to assist in the detection of fatal ectopic pregnancies, hydatridiforme moles or other precancerous growths, and a variety of other problems that can only be discovered through a pathological examination. The District Court noted that several medical experts testified that pathology should be done in every case of abortion. 483 F. Supp., at 700, n. 49. Moreover, the ACOG standards for abortion services state that for all surgical services performed on an ambulatory outpatient basis: "Tissue removed *should* be submitted to a pathologist for an examination. . . . In the situation of elective termination of pregnancy, the attending physician should record a description of the gross products. Unless definite embryonic or fetal parts can be identified, the products of elective interruptions of pregnancy *must* be submitted to a pathologist for gross and microscopic examination." ACOG, Standards for Obstetric-Gynecologic Services 52 (5th ed. 1982) (emphasis added). The standards of the National Abortion Federation (NAF), whose members include the institutional plaintiffs in this case, itself provides: "*All tissue must be examined grossly at the time of the abortion procedure by a physician or trained assistant and the results recorded in the chart.* In the absence of visible fetal parts or placenta upon gross examination, obtained tissue may be examined under a low power microscope If this

State concerns," *City of Akron, ante*, at 12, without interfering with the woman's decision to have an abortion.

As the Court of Appeals recognized, pathology examinations are clearly "useful and even necessary in some cases," because "abnormalities in the tissue may warn of serious, possibly fatal disorders." 655 F. 2d, at 870. Examining tissue removed during an abortion provides a State with an opportunity to further its interest in promoting the health of its citizens. Additionally, questions about the long-range complications of abortions and their effect on subsequent pregnancies remain. See App. 72-73 (testimony of Dr. Willard Cates, Jr.); Levin, et al., Association of Induced Abortion with Subsequent Pregnancy Loss, 243 J. A. M. A. 2495, 2499 (1980). Recorded pathology reports, in concert with abortion complication reports, provide a statistical basis for studying those complications.¹¹ Cf. *Danforth*, 428 U. S., at 81.

In light of these factors, we think the small additional cost¹²

examination is inconclusive, the tissue should be sent to the nearest suitable pathology laboratory for microscopic examination." NAF, National Abortion Federation Standards 6 (1981) (emphasis in original) (compliance with standards obligatory for NAF member facilities to remain in good standing). See Brief of the American Public Health Association as *Amicus Curiae* in Nos. 81-185, 81-746, 81-1172, at 29, n. 6 (supporting the NAF standards for non-hospital abortion facilities as constituting "minimum standards"). Cf. Planned Parenthood of Metropolitan Washington, D. C., Inc., 1980 Guidelines for Operation, Maintenance and Evaluation of First Trimester Outpatient Abortion Facilities 10 ("Gross examination must be performed on all specimens. Microscopic tissue analysis must be done for all cases when immediate gross evaluation is inadequate or does not confirm a normal gestation.").

¹¹Section 188.047 requires that a copy of the report be sent to the State's division of health.

¹²The estimated cost of compliance for plaintiff Reproductive Health Services was \$19.40 per abortion performed. 483 F. Supp., at 700, n. 48. There was testimony in the District Court that the additional cost of pathology would range from \$10.00 to \$40.00. See *ibid.*

of a tissue examination¹³ does not significantly burden a pregnant woman's abortion decision. In *Danforth*, this Court unanimously upheld Missouri's recordkeeping requirement as "useful to the State's interest in protecting the health of its female citizens, and [as] a resource that is relevant to decisions involving medical experience and judgment," 428 U. S., at 81.¹⁴ We view the requirement for a pathology report as comparable and as a relatively insignificant burden. Accordingly, we reverse the judgment of the Court of Appeals on this point.

V

As we noted in *City of Akron*, the relevant legal standards with respect to parental consent requirements are not in dispute. See *ante*, at 21; *Bellotti v. Baird*, 443 U. S. 622, 640-642, 643-644 (1979) (plurality opinion) (*Bellotti II*); *id.*, at 656-657 (WHITE, J., dissenting). A State's interest in protecting immature minors will sustain a requirement of a consent substitute, either parental or judicial. It is clear, however, that "the State must provide an alternative procedure whereby a pregnant minor may demonstrate that she is sufficiently mature to make the abortion decision herself or that, despite her immaturity, an abortion would be in her

¹³ Plaintiffs also note that § 188.047 does not specify whether the pathologist must make a microscopic examination. State regulations, however, state: "All reports shall contain the findings of a gross examination. If fetal parts or placenta are not identified, then an accompanying microscopic tissue report must also be filed with the Division of Health." 13 Mo. Admin. Code 50-151.030(1) (1981).

¹⁴ The *Danforth* Court also noted that "[t]he added requirements for confidentiality, with the sole exception for public health officers, and for retention for seven years, a period not unreasonable in length, assist and persuade us in our determination of the constitutional limits." 428 U. S., at 81. Missouri extends the identical safeguards found reassuring in *Danforth* to the pathology reports at issue here. See Mo. Rev. Stat. §§ 188.055.2, 188.060 (Supp. 1982).

best interests.”¹⁵ *City of Akron, ante*, at 21–22.¹⁶ The issue here is one purely of statutory construction: whether Missouri provides a judicial alternative that is consistent with these established legal standards.¹⁷

The Missouri statute, § 188.028.2,¹⁸ in relevant part, provides:

¹⁵ The plurality in *Bellotti II* also required that the alternative to parental consent must “assure” that the resolution of this issue “will be completed with anonymity and sufficient expedition to provide an effective opportunity for an abortion to be obtained.” *Id.*, at 644. Confidentiality here is assured by the statutory requirement that allows the minor to use her initials on the petition. Mo. Rev. Stat. § 188.028.2(1) (Supp. 1982). As to expedition of appeals, § 188.028.2(6) provides in relevant part:

“The notice of intent to appeal shall be given within twenty-four hours from the date of issuance of the order. The record on appeal shall be completed and the appeal shall be perfected within five days from the filing of notice to appeal. Because time may be of the essence regarding the performance of the abortion, the supreme court of this state shall, by court rule, provide for expedited appellate review of cases appealed under this section.”

We believe this section provides the framework for a constitutionally sufficient means of expediting judicial proceedings. Immediately after the effective date of this statutory enactment, the District Court enjoined enforcement. No unemancipated pregnant minor has been required to comply with this section. Thus, to this point in time, there has been no need for the state supreme court to promulgate rules concerning appellate review. There is no reason to believe that Missouri will not expedite any appeal consistent with the mandate in our prior opinions.

¹⁶ Cf. *H.L. v. Matheson*, 450 U. S., at 406–407, and n. 14, 411 (upholding a parental notification requirement but not extending the holding to mature or emancipated minors or to immature minors showing such notification detrimental to their best interests). The lower courts found that § 188.028’s notice requirement was unconstitutional. 655 F. 2d, at 873; 483 F. Supp., at 701. The State has not sought review of that judgment here. Thus, in the posture in which it appears before this Court for review, § 188.028 contains no requirement for parental notification.

¹⁷ The Missouri statute also exempts “emancipated” women under the age of 18 both from the requirement of parental consent and from the alternative requirement of a judicial proceeding. Plaintiffs argue that the word “emancipated” in this context is void for vagueness, but we disagree. Cf. *H.L. v. Matheson*, *supra*, at 407 (using word to describe a minor). Al-

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

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

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

“(c) Deny the petition, setting forth the grounds on which the petition is denied[.]”

On its face, § 188.028.2(4) authorizes juvenile courts¹⁹ to choose among any of the alternatives outlined in the section. The Court of Appeals concluded that a denial of the petition permitted in subsection (c) “would initially require the court to find that the minor was not emancipated and was not mature enough to make her own decision and that an abortion was not in her best interests.” 655 F. 2d, at 858. Plaintiffs contend that this interpretation is unreasonable. We do not agree.

though the question whether a minor is emancipated turns upon the facts and circumstances of each individual case, the Missouri courts have adopted general rules to guide that determination, and the term is one of general usage and understanding in the Missouri common law. See *Black v. Cole*, 626 S. W. 2d 397, 398 (Mo. App. 1981) (quoting 67 C. J. S. Parent and Child § 86, at 811 (1950)); *In re the Marriage of Heddy*, 535 S. W. 2d 276, 279 (Mo. App. 1976) (same); *Wurth v. Wurth*, 313 S. W. 2d 161, 164 (Mo. App. 1958) (same), rev'd on other grounds, 322 S. W. 2d 745 (Mo. 1959).

¹⁸ See n. 4, *supra*. This Court in *Danforth* held unconstitutional Missouri's parental consent requirement for all unmarried minors under the age of 18. 428 U. S., at 75. In response to our decision, Missouri enacted the section challenged here. This new statute became effective shortly before our decision in *Bellotti II*.

¹⁹ We have indicated in prior opinions that a minor should have access to an “independent decisionmaker.” *H.L. v. Matheson*, *supra*, at 420 (PowELL, J., concurring). Missouri has provided for a judicial decisionmaker. We therefore need not consider whether a qualified and independent non-judicial decisionmaker would be appropriate. Cf. *Bellotti II*, 443 U.S., at 643, n. 22.

Where fairly possible, courts should construe a statute to avoid a danger of unconstitutionality. The Court of Appeals was aware, if the statute provides discretion to deny permission to a minor for *any* "good cause," that arguably it would violate the principles that this Court has set forth. *Ibid.* It recognized, however, that before exercising any option, the juvenile court must receive evidence on "the emotional development, maturity, intellect and understanding of the minor." Mo. Rev. Stat. § 188.028.2(3) (Supp. 1982). The court then reached the logical conclusion that "findings and the ultimate denial of the petition must be supported by a showing of 'good cause.'" 655 F. 2d, at 858. The Court of Appeals reasonably found that a court could not deny a petition "for good cause" unless it first found—after having received the required evidence—that the minor was not mature enough to make her own decision. See *Bellotti II*, 443 U. S., at 643-644, 647-648 (plurality opinion). We conclude that the Court of Appeals correctly interpreted the statute and that § 188.028, as interpreted, avoids any constitutional infirmities.²⁰

VI

The judgment of the Court of Appeals, insofar as it invali-

²⁰ Plaintiffs also argue that, in light of the ambiguity of § 188.028.2(4), as evidenced by the differing interpretations placed upon it, the appropriate course of judicial restraint is abstention. This Court has found such an approach appropriate. See *Bellotti v. Baird*, 428 U. S. 132, 146-147 (1976) (*Bellotti I*). Plaintiffs did not, however, argue in the Court of Appeals that the court should abstain, and Missouri has no certification procedure whereby this Court can refer questions of state statutory construction to the state supreme court. See 655 F. 2d, at 861, n. 20; 17 C. Wright, A. Miller & E. Cooper, *Federal Practice and Procedure* § 4248, at 525, n. 29 (1978 and Supp. 1982). Such a procedure "greatly simplifie[d]" our analysis in *Bellotti I*, *supra*, at 151. Moreover, where, as here, a statute is susceptible to a fair construction that obviates the need to have the state courts render the saving construction, there is no reason for federal courts to abstain.

dated Missouri's second-trimester hospitalization requirement and upheld the State's parental consent provision, is affirmed. The judgment invalidating the requirement of a pathology report for all abortions and the requirement that a second physician attend the abortion of any viable fetus is reversed. We vacate the judgment upholding an award of attorney's fees for all hours expended by plaintiffs' attorneys and remand for proceedings consistent with *Hensley v. Eckhart*, — U. S. — (1983).

It is so ordered.

Changes: 1, 5-9, 11-20

MAR 13 1983

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

L.F.P.

From: Justice Powell

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2nd DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[March —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant broadly attacks Virginia's hospitalization requirements.³ He contends that they restrict the availability

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is necessary to save the woman's life, § 18.2-74.1; and (iv) is performed during the third trimester under certain circumstances, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

³ Questions raised particularly with respect to Virginia's outpatient surgical clinics are considered in Part III, *infra*. Appellant raises two additional issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden

of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions. He also argues that the Virginia requirements result in negative health consequences and, as applied to him and the abortions he performs in his well-equipped non-licensed clinic, do not further the State's interests.

We need not pause long here to consider the guiding principles, for we have set them out at length today in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, at 9-12, 14-16. For present purposes, the critical point is that we consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester," *Roe v. Wade*, 410 U. S. 113, 163 (1973), and is compelling throughout the remainder of the pregnancy. This interest, of course, embraces the facilities and circumstances in which abortions are performed. *Id.*, at 150.

A

It is in furtherance of this compelling interest in maternal health that Virginia has enacted its hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under Virginia law.⁴ Virginia law does not, however, per-

of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

⁴A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his

mit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁵ that defines "hospital" to include "outpatient . . . hospitals."⁶ Section 20.2.11 of the Depart-

clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them. See n. 9, *infra* (noting State's interpretation of the Virginia regulations).

⁵The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently than it is interpreted in title 32.1, and specifically in § 32.1-123.1. See n. 6, *infra*.

⁶ Section 32.1-123.1 provides:

from its interpretation

ment of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁷ defines outpatient hospital in pertinent part as "[i]nstitutions . . . which primarily provide facilities for the performance of

"*Hospital*" means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁷The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

✓ (1) classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients. "

✓ ? Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979))⁸ The State Board of Health gave preliminary approval on December 1, 1976, and a public hearing was held January 26, 1977. At this hearing, Dr. William R. Hill, a member of the Board, presided, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School repre-

to the regulations

surgical procedures on outpatients”⁸ and provides that second-trimester abortions may be performed in these clinics.⁹ Thus, under Virginia law, a second-trimester abortion may be performed in an outpatient surgical clinic¹⁰ provided that clinic has been licensed as a “hospital” by the State.

✓
 sending Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The primary topic discussed at the hearing was the effect the new regulations would have on abortion clinics in the State. The Board apparently made changes in the regulations before giving its final approval on May 11, 1977.⁷ The regulations became effective on June 30, 1977. The abortion for which ~~petitioner~~ *appellant* was prosecuted was performed on November 10, 1979, some two years and five months after the effective date of the regulations. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said—and indeed appellant does not argue—that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

Although of no direct relevance to this case, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁸ Section 32.1-125 of the Code provides: “No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article.” See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁹ Part II of the regulations sets minimum standards for outpatient surgical clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services. Moreover, the State’s counsel at oral argument represented that facilities

[Footnote 10 is on p. 8]

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron*, ante, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft*, ante, at 4-5. In those cases, the regulations required that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, ante, at 5. We found that such a requirement, by preventing the use of the dilation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron*, ante, at 20. The Court invalidated these laws because they did not reasonably further the state interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." Ante, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for

licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

¹⁰ We herein usually refer to the outpatient "hospitals" in Virginia that legally may perform second-trimester abortions as "outpatient surgical clinics."

licensing as hospitals in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

B

Second-trimester abortions may give rise to serious complications,¹¹ and certain procedures significantly increase the risks. Although the increasingly common use and relative safety of the D&E method, see *City of Akron*, *ante*, at 17-19, may make the need for particular equipment in and designs of a facility less imperative, the need for reasonable regulations has not been eliminated. D&E, despite its safety early in the second trimester, still may cause complications.¹²

The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Tri-*

¹¹ See Cadesky, Ravinsky & Lyons, *Dilation and Evacuation: A Preferred Method of Midtrimester Abortion*, 129 Am. J. Obstet. Gynecol. 329, 331 (1981); Department of Health and Human Services, Centers for Disease Control, *Abortion Surveillance: Annual Summary 1978*, at 48 (1980).

¹² Hemorrhaging is a leading cause of death and complications in D&E abortion patients. Other potential complications are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, *Methods of Midtrimester Abortion* 75 (1979).

A major potential complication for all abortion techniques—infection—normally does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. See *Ashcroft*, 664 F. 2d 687, 690, n. 6 (CA8 1981), *rev'd in part and aff'd in part*, *ante*, p. —. Thus the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

mester Abortion 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), Standards for Obstetric-Gynecologic Services 54 (5th ed. 1982) (hereinafter ACOG Standards). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron, ante*, at 12. The issue here is whether Virginia's licensing requirements for outpatient surgical clinics performing second-trimester abortions are reasonable means of furthering the State's compelling interest in the woman's health.

C

The Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia. These regulations may be

grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,¹³ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁴ and general building.¹⁵

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer,

¹³ The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁴ These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹⁵ The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

such as anesthesia,¹⁶ laboratory,¹⁷ and pathology.¹⁸ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁹ and post-operative recovery.²⁰ Finally, the regulations mandate some emergency services and evacuation planning.²¹

¹⁶ See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁷ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical clinics providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁸ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁹ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical clinic providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods." Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, unlike in *City of Akron*, it is for the woman, in conjunction with her physician, to decide what considerations are relevant to her decision. See *ante*, at 27.

²⁰ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation tech-

[Footnote 21 is on p. 13]

III

Appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief. Instead, he challenges Virginia's requirement of hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics that may perform second-trimester abortions. As appellant had not sought a license for his clinic at the time he was indicted, he appears to argue that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid.

Appellant's reply brief does criticize the Virginia regulations on various grounds. He argues that even if he had applied for a license, it is uncertain whether it would have been granted; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; that Part II of the regulations does not cover an outpatient surgical facility where second-trimester abortions are performed, but see n. 9, *supra*; and that medical evidence rebuts the view "that it is

niques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4. For a discussion of similar standards by various medical organizations, see n. 30, *infra*.

²¹ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

safer to perform second trimester abortions in hospitals.” Reply Brief for Appellant 1. Only the last of these arguments is relevant to the validity of these statutes and regulations, and appellant points to no evidence that supports his generalized claim of “safety.” We have noted above that the Virginia requirements are strikingly different from those we invalidated in *City of Akron* and *Ashcroft*. Compliance with the State’s requirements will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people. Moreover, ethical physicians are obligated to provide facilities consistent with the standards set by their profession, and appellant has not identified any significant differences between professional standards and the Virginia requirements. We are convinced, at least on the record before us, that the Virginia provisions are reasonably related to and further the State’s compelling interest in protecting the health of the pregnant woman during the second trimester.

The requirements of the first²² and second categories²³ of regulations discussed in Part II-C above have little relevance

²² ACOG’s standards discuss many of Virginia’s concerns about proper management and policies under the appropriate heading of “Quality Assurance.” See ACOG Standards 55 (“Each physician’s office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished.”). Like Virginia’s “narrative” requirement, Va. Regs. (Outpatient Hospitals) §§ 50.1.1, 50.2.1, ACOG’s standards suggest that the “outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnoses, appropriateness of use of laboratory and other services, and outcome of care.” ACOG Standards 55–56. See National Abortion Federation (NAF), National Abortion Federation Standards 11 (1981) (hereinafter NAF Standards) (requiring written descriptions of procedures and policies in each area of care). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6. (supporting the NAF Standards for non-hospital abortion facilities as constituting “minimum standards”).

ACOG also advises that each ambulatory body should have a “governing

[Footnote 23 is on p. 15]

to this case. They have not been challenged by appellant beyond his sweeping condemnation of any requirement that second-trimester abortions—even those during the twenty-second week of pregnancy—be performed in hospitals, however defined and whether outpatient or not. In any event, as appears from the recommendations of ACOG and the American Public Health Association (APHA) set forth in the margin, see nn. 22-24, Virginia's requirements, although more detailed with respect to specific facilities,²⁴ equipment, and per-

body" that has the final authority and responsibility for the appointment of the medical staff, ACOG Standards 60; cf. Va. Regs. (Outpatient Hospitals) § 40.3, and that "[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically," ACOG Standards 60. Cf. NAF Standards 12 (responsibilities of chief administrative officer); Planned Parenthood of Metropolitan Washington, D.C., Inc., 1980 Guidelines for Operation, Maintenance and Evaluation of First Trimester Outpatient Abortion Facilities 1 (hereinafter Planned Parenthood Guidelines) (duties of administrator).

²⁴This second category of Virginia regulations is consistent with those set forth by ACOG. ACOG recommends that even physicians' offices provide at least a patient reception room, consultation room, two examining rooms, a utility room, and storage. ACOG Standards 56-58. Cf. Planned Parenthood Guidelines 1-3 (detailing extensive physical requirements for first-trimester abortion clinics). ACOG's standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evaluation, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See ACOG Standards 61.

ACOG details the equipment to be found in the various rooms and areas. ACOG Standards 57-58, 61. Cf. APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980) (hereinafter APHA Guide) (any abortion facility should have "[a]n operating table, or conventional gynecologic examining table with accessories, located in a room which is adequately lighted and ventilated and meets all other environmental standards for surgical procedures"); Planned Parenthood Guide-

[Footnote 24 is on p. 16]

sonnel than the ACOG and APHA standards, are compatible with generally accepted medical standards.

Our concern centers on whether the patient services requirements of the Virginia regulations further the State's interest in the health and safety of the pregnant woman. We think they clearly do. Again, we have compared them to the standards used by ACOG and APHA, and we are impressed with the scrupulousness with which Virginia has drawn regulations reasonably related to its interest in protecting the pregnant woman's health. The sanitation²⁵ and recordkeep-

lines 2. A doctor's examining room should contain instruments for vaginal examinations, supplies for obtaining cultures and smears, and equipment for diagnostic studies and operative procedures. ACOG Standards 57. Cf. Planned Parenthood Guidelines 2. When local anesthesia is used, the clinic or doctor's office should have emergency resuscitation equipment, including positive pressure oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. ACOG Standards 57. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. *Id.*, at 61. Cf. APHA Guide 655 (requiring oxygen, and equipment for artificial ventilation and resuscitation); NAF Standards 9 (requiring all facilities performing second-trimester abortions to have resuscitation bag, oxygen, and defibrillator if general anesthesia is administered); Planned Parenthood Guidelines 2 (even first-trimester abortion clinics should have parental fluids, resuscitation equipment, and oxygen).

²⁴ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. ACOG Standards 58, 61. Specific plans should be developed to evacuate patients in case of an emergency. *Id.*, at 59, 62. Cf. NAF Standards 8, 11; Planned Parenthood Guidelines 10.

²⁵Infection can be a serious complication with any abortion procedure. See n. 12, *supra*. Significant portions of the Virginia regulations are designed to assure that outpatient surgical clinics take appropriate steps to control infection, including sterile processing, appropriate waste-disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Va. Regs. (Outpatient Hospitals) §§ 41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife blades, and

ing standards²⁶ are typical and not unreasonable in detail. The laboratory services²⁷ support—and often are essential to—the direct medical services²⁸ performed by the physician²⁹ and nurse.³⁰ The post-operative recovery standards³¹ also comport with accepted medical practice,³² and the

contaminated waste supplies. ACOG Standards 58, 62. APHA Guide 655; NAF Standards 7 (“Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure. . . .”).

²⁶ The Virginia recordkeeping requirements are similar to those detailed by ACOG for a physician’s office, ACOG Standards 54–55, 59–60, which require at the initial visit a comprehensive data base including information on reason for visit, menstrual history, obstetric history, gynecologic history, sexual history, past medical and surgical history, current medications, allergies, social history, and family history. For ambulatory surgical facilities, ACOG recommends that the patient’s record contain sufficient information to justify the preoperative diagnosis and the operative procedure, and should at least contain patient identification data, history and physical examination, provisional diagnosis, diagnostic and therapeutic orders, surgeons’ and nurses’ notes, laboratory data, operative consent, operative report, anesthesia report, tissue report, medications record, and discharge summary and instructions. *Id.*, at 59. See also *id.*, at 60 (“On the day of surgery a preanesthetic evaluation, including an interval history, medical record review, and a heart and lung examination should be performed by a physician and the findings should be noted in the record.”). We have found that such requirements, “if not abused or overdone,” impose a legally insignificant burden on the *Roe* right. See *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S. 52, 81 (1976). We do not think Virginia’s requirements are excessive. Cf. APHA Guide 655–656 (recommended reporting requirements); Planned Parenthood Guidelines 13 (recordkeeping and reporting requirements).

²⁷ The risk of hemorrhage is reduced by requiring an outpatient surgical clinic to make hemoglobin or hematocrit determinations before initiating instillation. See ACOG Standards 59 (“The laboratory data should include hemoglobin or hematocrit, urinalysis, and, in certain selected patients, other studies such as a chest x-ray, electrocardiogram, and electrolytes.”). See also APHA Guide 654 (“Appropriate laboratory procedures must include determination of hematocrit and Rh factor in every case. The value of other laboratory procedures will depend upon the population served;

[Footnotes 28, 29, and 30 are on p. 18]

equipment requirements for emergency services are minimal.³³

We do not suggest that all of the Virginia requirements are necessary for every second-trimester abortion. But a State simply cannot adopt regulations that serve every case with

may include sickle cell testing; endocervical and anal culture for gonorrhea; urinalysis; serologic testing for syphilis; and, when indicated cytologic screening for cancer.”); NAF Standards 7 (“Rh-immune globulin must be explained and administered to Rh-negative patients.”); Planned Parenthood Guidelines 8 (requiring lab facilities to be available on premises for pregnancy tests, urine protein and sugar, hematocrit or hemoglobin determination, and Rh typing).

³² See ACOG Standards 59 (“The appropriate records should be completed and laboratory data recorded *prior* to surgery.”) (emphasis added). ACOG also recommends that “[t]he physician should strive to identify pre-existing or concurrent illness, medications, and adverse drug reactions that may have a bearing on the operative procedure or anesthesia. *All records should be reviewed before any surgery is performed.*” *Id.*, at 60 (emphasis added). APHA Guide 654; Planned Parenthood Guidelines 8.

³³ For example, the ACOG requires careful laboratory work before anesthesia is administered, and even then, it must be given only by or under the supervision of a doctor: “Any ambulatory surgical unit that utilizes general, epidural, or spinal anesthesia should do so under the direction of an anesthesiologist. These anesthetics should be administered by a qualified anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation must be available.” ACOG Standards 53. Cf. APHA Guide 655; Planned Parenthood Guidelines 10.

³⁴ The ACOG Standards do not specifically require nurses for physicians’ offices or for ambulatory surgical facilities, but note: “The efficient operation of an ambulatory surgical facility requires adequate staffing with administrative and professional personnel. The assignment of personnel should be based on the number of patients, patient profiles, type of procedures, and facility design.” ACOG Standards 60. Cf. *id.*, at 56 (“Administrative and professional personnel requirements will vary considerably in each physician’s office and outpatient clinic depending on the patient load, pattern of practice, and type of facility.”); Planned Parenthood Guidelines 7–8 (head laboratory technician); *id.*, at 9 (“It is strongly recommended

[Footnotes 31, 32 and 33 are on p. 19]

the same degree of relevance; “[a] State necessarily must have some latitude in adopting regulations of general applicability in this sensitive area.” *City of Akron, ante*, at 15–16. Although a State’s general licensing regulations must be drawn to further the State’s interests in women’s health for all reasonable periods of time within the second-trimester, a particular requirement “is not unconstitutional simply because it does not correspond perfectly in all cases to the asserted state interest.” *City of Akron, ante*, at 20.

that three staff persons be present in the procedure room: the operating physician, the physician’s assistant and a counselor to assist the patient.”).

²¹ See n. 20, *supra*.

²² Complications resulting from anesthesia are alleviated by requiring a physician to be present during the recovery period. See ACOG Standards 53 (“The supervising anesthesiologist, or another physician qualified in cardiopulmonary resuscitation, should be present in the ambulatory surgical facility until all surgical patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the back-up hospital.”); Planned Parenthood Guidelines 11; see also APHA Guide 655 (“[I]t will be necessary to periodically observe the temperature, pulse rate, blood pressure, and the amount of bleeding. In addition, the abdomen should be examined for evidence of intra-abdominal bleeding or injury.”). Less serious complications can be monitored by the registered nurse on duty. See ACOG Standards 53 (“During the recovery period, the patient should be under continuous observation by a qualified member of the health care team. This person should maintain a complete record of the patient’s general condition including vital signs, blood loss, and occurrence of complications.”); NAF Standards 6 (“The recovery area must be supervised by a licensed nurse or physician who is immediately available to the recovery area.”); Planned Parenthood Guidelines 11. The required one-hour recovery period is intended to permit detection of these complications. See APHA Guide 655 (requiring post-operative observations “over a period of two or more hours, depending upon the type of anesthesia used”); Kerenyi, Mandelman & Sherman, Five Thousand Consecutive Saline Inductions, 116 Am. J. Obstet. & Gynecol. 593, 597 (1973); ACOG Standards 53; App. 37 (defense expert witness concedes waiting period desirable).

²³ The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See APHA Guide 655; ACOG Standards

We therefore conclude, at least on the record before us in this case, that Virginia's regulations concerning second-trimester abortions are reasonably related to and further the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.³⁴ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—between the physician and the patient.

IV

We hold that Virginia's requirement that second-trimester abortions be performed in properly equipped outpatient clinics is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

52 ("There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication."); *id.*, at 58, 62; NAF Standards 7; Planned Parenthood Guidelines 10 ("Each facility must have a functioning arrangement for emergency transport to a local accredited hospital.").

³⁴ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

L. J. P.

Changes: 1, 5-21

MAR 13 1983

MAR 15 1983

From: Justice Powell

Circulated: _____

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2nd DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT v. VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[March —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979 he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant broadly attacks Virginia's hospitalization requirements.³ He contends that they restrict the availability

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is necessary to save the woman's life, § 18.2-74.1; and (iv) is performed during the third trimester under certain circumstances, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

³ Questions raised particularly with respect to Virginia's outpatient surgical clinics are considered in Part III, *infra*. Appellant raises two additional issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden

of abortions after the first trimester by granting a monopoly to the few licensed hospitals that will permit mid-trimester abortions. He also argues that the Virginia requirements result in negative health consequences and, as applied to him and the abortions he performs in his well-equipped non-licensed clinic, do not further the State's interests.

We need not pause long here to consider the guiding principles, for we have set them out at length today in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, at 9-12, 14-16. For present purposes, the critical point is that we consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester," *Roe v. Wade*, 410 U. S. 113, 163 (1973), and is compelling throughout the remainder of the pregnancy. This interest, of course, embraces the facilities and circumstances in which abortions are performed. *Id.*, at 150.

A

It is in furtherance of this compelling interest in maternal health that Virginia has enacted its hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under Virginia law.⁴ Virginia law does not, however, per-

of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

⁴A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). Surgery is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his

mit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁵ that defines "hospital" to include "outpatient . . . hospitals."⁶ Section 20.2.11 of the Depart-

clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them. See n. 9, *infra* (noting State's interpretation of the Virginia regulations).

⁵The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 6, *infra*.

⁶Section 32.1-123.1 provides:

ment of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁷ defines outpatient hospital in pertinent part as "[i]nstitutions . . . which primarily provide facilities for the performance of

"Hospital" means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁷The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations ~~was~~ considerably ~~different~~ from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpatient ~~clinics~~ in which abortions could be performed, regardless of the trimester. Thus, no distinction was made between first- and second-trimester abortions with respect to the appropriateness of and need for state regulation.

(different)

facilities

surgical procedures on outpatients”⁸ and provides that second-trimester abortions may be performed in these clinics.⁹ Thus, under Virginia law, a second-trimester abortion may be performed in an outpatient surgical clinic¹⁰ provided that clinic has been licensed as a “hospital” by the State.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. At this hearing, Dr. William R. Hill, a member of the Board, presided, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic, abortion clinics; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical clinics in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical clinics in order to include outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. It therefore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board

See n. 9,
infra.

[Footnotes 8 and 9 are on p. 8]

It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft, ante*, at 4-5. In those cases, the regulations required that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft, ante*, at 5. We found that such a requirement, by preventing the use of the dilation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron, ante*, at 20. The Court invalidated these laws because they did not reasonably further the state interest in maternal health.

gave its final approval to the regulations before us on May 11, 1977.

The regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months after the effective date of the regulations. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said—and indeed appellant does not argue—that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

Although of no direct relevance to this case, we note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁸Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁹Part II of the regulations sets minimum standards for outpatient surgical clinics that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3,

[Footnote 10 is on p. 9]

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for licensing as hospitals in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

B

Second-trimester abortions may give rise to serious complications,¹¹ and certain procedures significantly increase the risks. Although the increasingly common use and relative safety of the D&E method, see *City of Akron, ante*, at 17-19, may make the need for particular equipment in and designs of

43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 7, *infra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

¹⁰ We herein usually refer to the outpatient "hospitals" in Virginia that legally may perform second-trimester abortions as "outpatient surgical clinics."

¹¹ See Cadesky, Ravinsky & Lyons, Dilation and Evacuation: A Preferred Method of Midtrimester Abortion, 129 Am. J. Obstet. Gynecol. 329, 331 (1981); Department of Health and Human Services, Centers for Disease Control, Abortion Surveillance: Annual Summary 1978, at 48 (1980).

in most cases

a facility less imperative, the need for reasonable regulations has not been eliminated. D&E, despite its safety early in the second trimester, still may cause complications.¹²

The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982) (hereinafter ACOG Standards). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the

¹² Hemorrhaging is a leading cause of death and complications in D&E abortion patients. Other potential complications are uterine perforation and cervical tears, which are significantly increased in comparison to other second-trimester procedures. See ACOG Technical Bulletin No. 56, *Methods of Midtrimester Abortion* 75 (1979).

A major potential complication for all abortion techniques—infection—normally does not arise until 24 to 72 hours after the procedure has taken place, by which time the woman usually will have been discharged from any facility. See *Ashcroft*, 664 F. 2d 687, 690, n. 6 (CA8 1981), rev'd in part and aff'd in part, *ante*, p. —. Thus the relative safety of the D&E procedure does not alleviate the need for standards designed to prevent infection.

medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, but its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." *City of Akron, ante*, at 12. "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be 'legitimately related to the objective the State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron, ante*, at 12. The issue here is whether Virginia's licensing requirements for outpatient surgical clinics performing second-trimester abortions are reasonable means of furthering the State's compelling interest in the woman's health.

C

The Virginia regulations applicable to outpatient surgical clinics performing second-trimester abortions are, with few exceptions, the same regulations applicable to all outpatient surgical clinics in Virginia. These regulations may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,¹³ § 43.2, an administrative officer, § 40.6, a licensed

¹³ The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and

physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁴ and general building.¹⁵

The most important group of regulations for our purposes relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹⁶ laboratory,¹⁷ and pathology.¹⁸ Some of

infection control, § 41.2.5.

¹⁴These services may be provided within the outpatient surgical clinic if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹⁵The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹⁶See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹⁷Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical clinics providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁸Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological

the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁹ and post-operative recovery.²⁰ Finally, the regulations mandate some emergency services and evacuation planning.²¹

examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁹ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical clinic providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician. *Id.*, § 43.8.4.

Section 43.8.5 provides that the facility performing abortions "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods." Virginia does not require that the doctor personally provide this counseling or specify the means by which this counseling is performed. Under this requirement, unlike in *City of Akron*, it is for the woman, in conjunction with her physician, to decide what considerations are relevant to her decision. See *ante*, at 27.

²⁰ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4. For a discussion of similar standards by various medical organizations, see n. 30, *infra*.

²¹ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all

III

Appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief. Instead, he challenges Virginia's requirement of hospitalization for second-trimester abortions without alluding to the fact that the statutory term "hospital" is defined to include outpatient surgical clinics that may perform second-trimester abortions. As appellant had not sought a license for his clinic at the time he was indicted, he appears to argue that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid.

Appellant's reply brief does criticize the Virginia regulations ~~on various grounds~~. He argues that even if he had applied for a license, it is uncertain whether it would have been granted; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; that Part II of the regulations does not cover an outpatient surgical facility where second-trimester abortions are performed, but see n. 9, *supra*; and that medical evidence rebuts the view "that it is safer to perform second trimester abortions in hospitals." Reply Brief for Appellant 1. Only the last of these arguments is relevant to the validity of these statutes and regulations, and appellant points to no evidence that supports his generalized claim of "safety." We have noted above that the Virginia requirements are strikingly different from those we invalidated in *City of Akron* and *Ashcroft*. Compliance with the State's requirements will entail costs, but this can be said of most regulations adopted by governments to protect the health and safety of people. Moreover, ethical physicians are obligated to provide facilities consistent with the standards set by their profession, and appellant has not identified any significant differences between professional standards

times."

individually
or on
specific

and the Virginia requirements. We are convinced, at least on the record before us, that the Virginia provisions are reasonably related to and further the State's compelling interest in protecting the health of the pregnant woman during the second trimester.

The requirements of the first²² and second categories²³ of regulations discussed in Part II-C above have little relevance

²² ACOG's standards discuss many of Virginia's concerns about proper management and policies under the appropriate heading of "Quality Assurance." See ACOG Standards 55 ("Each physician's office and outpatient clinic should assess whether effective and efficient management of health care has been accomplished."). Like Virginia's "narrative" requirement, Va. Regs. (Outpatient Hospitals) §§ 50.1.1, 50.2.1, ACOG's standards suggest that the "outpatient clinic evaluation of patient care should assess the completeness of medical records, the accuracy of diagnoses, appropriateness of use of laboratory and other services, and outcome of care." ACOG Standards 55-56. See National Abortion Federation (NAF), National Abortion Federation Standards 11 (1981) (hereinafter NAF Standards) (requiring written descriptions of procedures and policies in each area of care). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6. (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

ACOG also advises that each ambulatory body should have a "governing body" that has the final authority and responsibility for the appointment of the medical staff, ACOG Standards 60; cf. Va. Regs. (Outpatient Hospitals) § 40.3, and that "[w]ritten policies describing specific responsibilities of each member of the team are desirable, and should be reviewed and revised periodically," ACOG Standards 60. Cf. NAF Standards 12 (responsibilities of chief administrative officer); Planned Parenthood of Metropolitan Washington, D.C., Inc., 1980 Guidelines for Operation, Maintenance and Evaluation of First Trimester Outpatient Abortion Facilities 1 (hereinafter Planned Parenthood Guidelines) (duties of administrator).

²³ This second category of Virginia regulations is consistent with those set forth by ACOG. ACOG recommends that even physicians' offices provide at least a patient reception room, consultation room, two examining rooms, a utility room, and storage. ACOG Standards 56-58. Cf. Planned Parenthood Guidelines 1-3 (detailing extensive physical requirements for first-trimester abortion clinics). ACOG's standards for an ambulatory surgical facility are more detailed, providing space for reception, waiting, administrative activities, patient dressing, lockers, preoperative evalua-

to this case. They have not been challenged by appellant beyond his sweeping condemnation of any requirement that second-trimester abortions—even those during the twenty-second week of pregnancy—be performed in hospitals, however defined and whether outpatient or not. In any event, as appears from the recommendations of ACOG and the American Public Health Association (APHA) set forth in the margin, see nn. 22-24, Virginia's requirements, although more detailed with respect to specific facilities,²⁴ equipment, and per-

tion, physical examination, laboratory testing, preparation of anesthesia, performance of surgical procedures, preparation and sterilization of instruments, storage of equipment, storage of drugs and fluids, postanesthetic recovery, staff activities, and janitorial and utility support. See ACOG Standards 61.

ACOG details the equipment to be found in the various rooms and areas. ACOG Standards 57-58, 61. Cf. APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980) (hereinafter APHA Guide) (any abortion facility should have "[a]n operating table, or conventional gynecologic examining table with accessories, located in a room which is adequately lighted and ventilated and meets all other environmental standards for surgical procedures"); Planned Parenthood Guidelines 2. A doctor's examining room should contain instruments for vaginal examinations, supplies for obtaining cultures and smears, and equipment for diagnostic studies and operative procedures. ACOG Standards 57. Cf. Planned Parenthood Guidelines 2. When local anesthesia is used, the clinic or doctor's office should have emergency resuscitation equipment, including positive pressure oxygen, intravenous equipment and fluids, suction, and a cardiac monitor. ACOG Standards 57. Ambulatory surgical centers should, in addition to oxygen, suction, and resuscitation equipment, provide for emergency lighting and intercommunications. *Id.*, at 61. Cf. APHA Guide 655 (requiring oxygen, and equipment for artificial ventilation and resuscitation); NAF Standards 9 (requiring all facilities performing second-trimester abortions to have resuscitation bag, oxygen, and defibrillator if general anesthesia is administered); Planned Parenthood Guidelines 2 (even first-trimester abortion clinics should have parenteral fluids, resuscitation equipment, and oxygen).

²⁴ ACOG provides that both clinics and ambulatory facilities should meet all state and local building, safety, and fire codes. ACOG Standards 58, 61. Specific plans should be developed to evacuate patients in case of an

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sonnel than the ACOG and APHA standards, ¹⁷ *appear to be* are compatible with generally accepted medical standards. |

Our concern centers on whether the patient services requirements of the Virginia regulations further the State's interest in the health and safety of the pregnant woman. We think they clearly do. Again, we have compared them to the standards used by ACOG and APHA, and we are impressed with the scrupulousness with which Virginia has drawn regulations reasonably related to its interest in protecting the pregnant woman's health. The sanitation²⁵ and recordkeeping standards²⁶ are typical and not unreasonable in detail. |

emergency. *Id.*, at 59, 62. Cf. NAF Standards 8, 11; Planned Parenthood Guidelines 10.

²⁵ Infection can be a serious complication with any abortion procedure. See n. 12, *supra*. Significant portions of the Virginia regulations are designed to assure that outpatient surgical clinics take appropriate steps to control infection, including sterile processing, appropriate waste-disposal and laundry practices, isolation of nonpotable water, and protection of the integrity of the operating suite. See Va. Regs. (Outpatient Hospitals) §§ 41.2.5, 43.2.1, 43.2.2, 43.10.1, 43.11, 43.12.3, 43.12.5, 52.2.5, 52.2.6, 52.2.7 & 52.2.13. ACOG recommends that all facilities develop procedures for controlling and disposing of needles, syringes, glass, knife blades, and contaminated waste supplies. ACOG Standards 58, 62. APHA Guide 655; NAF Standards 7 ("Surgical instruments must be sufficient in number to permit individual sterilization of the instruments used for each procedure. . . ."). |

²⁶ The Virginia recordkeeping requirements are similar to those detailed by ACOG for a physician's office, ACOG Standards 54-55, 59-60, which require at the initial visit a comprehensive data base including information on reason for visit, menstrual history, obstetric history, gynecologic history, sexual history, past medical and surgical history, current medications, allergies, social history, and family history. For ambulatory surgical facilities, ACOG recommends that the patient's record contain sufficient information to justify the preoperative diagnosis and the operative procedure, and should at least contain patient identification data, history and physical examination, provisional diagnosis, diagnostic and therapeutic orders, surgeons' and nurses' notes, laboratory data, operative consent, operative report, anesthesia report, tissue report, medications record, and discharge summary and instructions. *Id.*, at 59. See also *id.*, at 60 ("On |

The laboratory services²⁷ support—and often are essential to—the direct medical services²⁸ performed by the physician²⁹ and nurse.³⁰ The post-operative recovery standards³¹ also comport with accepted medical practice,³² and the

the day of surgery a preanesthetic evaluation, including an interval history, medical record review, and a heart and lung examination should be performed by a physician and the findings should be noted in the record.”). We have found that such requirements, “if not abused or overdone,” impose a legally insignificant burden on the *Roe* right. See *Planned Parenthood of Central Mo. v. Danforth*, 428 U. S. 52, 81 (1976). We do not think Virginia’s requirements are excessive. Cf. APHA Guide 655–656 (recommended reporting requirements); Planned Parenthood Guidelines 13 (recordkeeping and reporting requirements).

²⁷ The risk of hemorrhage is reduced by requiring an outpatient surgical clinic to make hemoglobin or hematocrit determinations before initiating instillation. See ACOG Standards 59 (“The laboratory data should include hemoglobin or hematocrit, urinalysis, and, in certain selected patients, other studies such as a chest x-ray, electrocardiogram, and electrolytes.”). See also APHA Guide 654 (“Appropriate laboratory procedures must include determination of hematocrit and Rh factor in every case. The value of other laboratory procedures will depend upon the population served; may include sickle cell testing; endocervical and anal culture for gonorrhea; urinalysis; serologic testing for syphilis; and, when indicated cytologic screening for cancer.”); NAF Standards 7 (“Rh-immune globulin must be explained and administered to Rh-negative patients.”); Planned Parenthood Guidelines 8 (requiring lab facilities to be available on premises for pregnancy tests, urine protein and sugar, hematocrit or hemoglobin determination, and Rh typing).

²⁸ See ACOG Standards 59 (“The appropriate records should be completed and laboratory data recorded *prior* to surgery.”) (emphasis added). ACOG also recommends that “[t]he physician should strive to identify pre-existing or concurrent illness, medications, and adverse drug reactions that may have a bearing on the operative procedure or anesthesia. *All records should be reviewed before any surgery is performed.*” *Id.*, at 60 (emphasis added). APHA Guide 654; Planned Parenthood Guidelines 8.

²⁹ For example, the ACOG requires careful laboratory work before anesthesia is administered, and even then, it must be given only by or under the supervision of a doctor: “Any ambulatory surgical unit that utilizes general, epidural, or spinal anesthesia should do so under the direction of an anesthesiologist. These anesthetics should be administered by a qualified

[Footnotes 30, 31, and 32 are on p. 19]

equipment requirements for emergency services are minimal.³³

We do not suggest that all of the Virginia requirements are necessary for every second-trimester abortion. But a State simply cannot adopt regulations that serve every case with

anesthesiologist, another qualified physician, or a certified nurse-anesthetist under the supervision of an anesthesiologist. When any form of anesthesia is used, trained personnel and proper equipment for cardiopulmonary resuscitation must be available." ACOG Standards 53. Cf. APHA Guide 655; Planned Parenthood Guidelines 10.

³⁰The ACOG Standards do not specifically require nurses for physicians' offices or for ambulatory surgical facilities, but note: "The efficient operation of an ambulatory surgical facility requires adequate staffing with administrative and professional personnel. The assignment of personnel should be based on the number of patients, patient profiles, type of procedures, and facility design." ACOG Standards 60. Cf. *id.*, at 56 ("Administrative and professional personnel requirements will vary considerably in each physician's office and outpatient clinic depending on the patient load, pattern of practice, and type of facility."); Planned Parenthood Guidelines 7-8 (head laboratory technician); *id.*, at 9 ("It is strongly recommended that three staff persons be present in the procedure room: the operating physician, the physician's assistant and a counselor to assist the patient.").

³¹See n. 20, *supra*.

³²Complications resulting from anesthesia are alleviated by requiring a physician to be present during the recovery period. See ACOG Standards 53 ("The supervising anesthesiologist, or another physician qualified in cardiopulmonary resuscitation, should be present in the ambulatory surgical facility until all surgical patients have been discharged. This physician should oversee the postanesthetic recovery area and should share with the surgeon responsibility for discharging patients or transferring them to the back-up hospital."); Planned Parenthood Guidelines 11; see also APHA Guide 655 ("[I]t will be necessary to periodically observe the temperature, pulse rate, blood pressure, and the amount of bleeding. In addition, the abdomen should be examined for evidence of intra-abdominal bleeding or injury."). Less serious complications can be monitored by the registered nurse on duty. See ACOG Standards 53 ("During the recovery period, the patient should be under continuous observation by a qualified member of the health care team. This person should maintain a complete record of the patient's general condition including vital signs, blood loss, and occurrence of complications."); NAF Standards 6 ("The recovery area must be

[Footnote 33 is on p. 20]

the same degree of relevance; “[a] State necessarily must have some latitude in adopting regulations of general applicability in this sensitive area.” *City of Akron, ante*, at 15-16. Although a State’s general licensing regulations must be drawn to further the State’s interests in women’s health for all reasonable periods of time within the second-trimester, a particular requirement “is not unconstitutional simply because it does not correspond perfectly in all cases to the asserted state interest.” *City of Akron, ante*, at 20.

We therefore conclude, at least on the record before us in this case, that Virginia’s regulations concerning second-trimester abortions are reasonably related to and further the State’s compelling interest in “protecting the woman’s own health and safety.” *Roe*, 410 U. S., at 150.³⁴ As we empha-

supervised by a licensed nurse or physician who is immediately available to the recovery area.”); Planned Parenthood Guidelines 11. The required one-hour recovery period is intended to permit detection of these complications. See APHA Guide 655 (requiring post-operative observations “over a period of two or more hours, depending upon the type of anesthesia used”); Kerenyi, Mandelman & Sherman, Five Thousand Consecutive Saline Inductions, 116 Am. J. Obstet. & Gynecol. 593, 597 (1973); ACOG Standards 53; App. 37 (defense expert witness concedes waiting period desirable).

³³The arrangements for emergency transfer to an acute-care, general hospital are clearly reasonable. See APHA Guide 655; ACOG Standards 52 (“There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication.”); *id.*, at 58, 62; NAF Standards 7; Planned Parenthood Guidelines 10 (“Each facility must have a functioning arrangement for emergency transport to a local accredited hospital.”).

³⁴Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, part Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State’s compelling interest.

sized in *Roe*, “[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient.” *Ibid.* Unlike Akron in *City of Akron* or Missouri in *Ashcroft*, Virginia does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State’s requirements—the statutes and the regulations—accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—between the physician and the patient.

IV

We hold that Virginia’s requirement that second-trimester abortions be performed in properly equipped outpatient clinics is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

Jim Brennan
23072

3d Draft
24 copies

3d Draft

3d CHAMBERS DRAFT H

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

Jim's Master

From: Justice Powell

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SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[April —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Ass'n. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

²The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or miscarriage, he shall be guilty of a Class 4 felony."

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders the indictment unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Columbia statute in *Vuitch*, as construed by this Court, re-

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

his conviction

quired the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120–121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701–703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069–1070, 277 S. E. 2d, at 200–201.

III

We consistently have recognized and reaffirm today that a State has an “important and legitimate interest in the health of the mother” that becomes “‘compelling’ . . . at approximately the end of the first trimester.” *Roe v. Wade*, 410 U. S. 113, 163 (1973). [✓] This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia’s ~~statutory hospitalization requirement~~ prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we ~~today have found this argument persuasive when made in~~ constitutional challenges to the acute-care general hospital requirements at issue there. [✓] The State of Virginia argues here that its hospitalization requirement is significantly different from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State’s interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians’ offices are not regulated under

See City of Akron,
ante, at 10 [✓]

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Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ ~~that~~ defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them. See ~~n. 8, *infra* (noting State's interpretation of the Virginia regulations).~~

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075,

"outpatient . . . hospitals."⁵ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

277 S. E. 2d, at 204.

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

"*Hospital*' means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶ The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

... which primarily provide facilities for the performance of surgical procedures on outpatients"⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester. ~~Thus, no distinction was made between first- and second-trimester abortions with respect to the appropriateness of and need for state regulation.~~

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that "[i]n general, they are a good set of standards and have our support." *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester "the State may regulate the [abortion] procedure in the interest of maternal health." *Id.*, at 7. But the clinics specifically "propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia." *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not "compromise" the strict standards needed for outpatient surgical hospitals in order to include these outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics do-

[Footnotes 7 and 8 are on p. 8]

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to

ing first-trimester abortions. See nn. 8, 23, *infra*. It therefore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval to the regulations before us on May 11, 1977.

The regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later. In view of the public hearing on January 26, 1977, attended as noted above by representatives of various organizations specifically concerned with abortions, it cannot be said — and indeed appellant does not argue — that he was not fully aware of the regulations and the statutory requirement that his clinic be licensed.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸ Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term “outpatient abortion clinics” to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 (“Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).”).

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all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,⁹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹ *the final*

no new TP ~~The most important group of regulations for our purposes~~ relates to patient care services. Most of these set the requirements for various services that the facility may offer,

⁹The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁰These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹¹The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

¹² See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician, *id.*, § 43.8.4, and

the facility "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods," *id.*, § 43.85.

¹⁶ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemor-

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It is readily apparent that Virginia's second-trimester hospitalization requirement is significantly different from those at issue in *City of Akron*, ante, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft*, ante, at 4-5. In those cases, the regulations required that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, ante, at 5. We found that such a requirement, by preventing the use of the dilation and evacuation method (D&E) of performing abortions in appropriate non-hospital settings, "imposed a heavy, and unnecessary, burden on women's access to a relatively inexpensive, otherwise accessible, and safe abortion procedure." *City of Akron*, ante, at 20. The Court invalidated these laws because they did not reasonably further the state interest in maternal health.

One of the most important factors in our analysis in *City of Akron* was the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *Ante*, at 19. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's regulations, outpatient surgical clinics may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

rhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

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The remaining question is the constitutionality of Virginia's regulations. ^v The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979) (emphasis added). The medical profession has not thought the standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

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In view of its interest, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities, ^{but} its discretion does not "permit it to adopt abortion regulations that depart from sound medical practice." ^{City of Akron, ante, at 12.} "If a State requires licensing or undertakes to regulate the performance of abortions during [the second trimester], the health standards adopted must be legitimately related to the objective the

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it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

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State seeks to accomplish.' *Doe*, 410 U. S., at 195." *City of Akron*, ante, at 12.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.¹⁸

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We need not decide, however, whether certain individual regulations are unreasonable on their face or invalid as applied to appellant. Despite full knowledge of the regulations at the time of his trial,¹⁹ appellant has elected to treat the Virginia hospitalization requirement as no different from those we reviewed in *City of Akron* and *Ashcroft*. To the extent the record is silent, the lack of evidence on the reasonableness of the regulations must be attributed to his failure to produce any medical evidence, as plaintiffs in *City of Akron* and *Ashcroft* did at great length, to show that certain equipment or services required by the State are unreasonable requirements to impose on women seeking second-trimester abortions.²⁰ In a word, he has not shown why the Virginia

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¹⁸ See American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services 52-54 (5th ed. 1982); APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980). See also National Abortion Federation, National Abortion Federation Standards (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

¹⁹ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital regulations; stating that he was seeking a license; but denying that he knew of the regulations when the abortion was performed).

²⁰ Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on the hospitalization requirement in § 18.2-73. Indeed, appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief, instead arguing that the Virginia hospitalization requirements are comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid. Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: but the record is silent on the applicability of those regulations to his facility; that the record does not

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~~regulations do not further the State's compelling interest in the health and safety of the pregnant woman.~~

We therefore conclude, on the record before us in this case, that appellant has not shown the Virginia regulations⁹ concerning second-trimester abortions to be an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²¹ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike *Akron*

hospitalization
requirement

the provisions at issue in

show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet reasonable facility and equipment standards merely because they impose some costs and burdens. As *City of Akron* makes clear, see *ante*, at 12, in view of the State's compelling interest in the pregnant woman's health, it may adopt reasonable regulations. Compliance with the State's requirements certainly will entail costs, but this can be said of ~~most~~ regulations adopted by governments to protect the health and safety of people.

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

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^

appears

(hospitalization requirement) *(and)* *in City of Akron or Missouri in Ashcroft, Virginia* does not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirements—the statutes and the regulations—*seem* to accommodate accepted medical practice, and leave the method and timing of the abortion precisely where they belong—with the physician and the patient. *'s statute and regulations)*

V

We hold that, on the record before us, Virginia's hospitalization requirement for second-trimester abortions is constitutional. The judgment of the Supreme Court of Virginia is

comports with

Affirmed.

APR 12 1983

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

From: Justice Powell

Circulated: _____

Recirculated: _____

3rd DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT v. VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[April —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S.E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders his conviction unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, ante, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them.

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

"outpatient . . . hospitals."⁵ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

"*Hospital*' means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

... which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of two abortion clinics, the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these first-trimester outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 8, 23, *infra*. It there-

[Footnotes 7 and 8 are on p. 8]

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations re-

fore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval, and the regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

quire personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) §40.3; see also §40.1. They also require a policy and procedures manual,⁹ §43.2, an administrative officer, §40.6, a licensed physician who must supervise clinical services and perform surgical procedures, §42.1, and a registered nurse to be on duty at all times while the facility is in use, §42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," §50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹ The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of

⁹The manual must describe emergency and elective procedures that may be performed at the facility, §41.2.1; the anesthesia that may be used, §41.2.2; the criteria and procedures for admissions and discharge, §41.2.4; written informed consent, §41.2.4; and procedures for housekeeping and infection control, §41.2.5.

¹⁰These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) §52.3.1.

¹¹The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹²See, *e. g.*, Va. Regs. (Outpatient Hospitals) §43.1.1 (service must be directed by licensed physician); *id.*, §43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) §43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and al-

the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

bumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴ Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵ Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician, *id.*, § 43.8.4, and the facility "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods," *id.*, § 43.8.5.

¹⁶ Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷ See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

B

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron*, ante, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft*, ante, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron*, ante, at 19. The requirements at issue, however, mandated that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, ante, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

The remaining question is the constitutionality of Virginia's regulations. In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.¹⁸ The American Pub-

¹⁸ See American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services 52-54 (5th ed. 1982); APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980). See also National Abortion Federation, National Abortion

lic Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider each of the regulations separately. Despite personal knowledge of the regulations at least by the time of his trial,¹⁹ appellant introduced no medical evidence questioning the reasonableness of any of them. This is to be contrasted with the evidence in *City of Akron* and *Ashcroft*,

Federation Standards (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

¹⁹ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

where the plaintiffs sought at great length to show that particular requirements as to equipment and services were unreasonable restraints on women seeking second-trimester abortions. Appellant persisted in arguing broadly that Virginia's hospitalization requirements are no different in substance from those we reviewed in the *City of Akron* and *Ashcroft* cases.²⁰ Indeed, not until his reply brief in this Court did appellant criticize the regulations apart from Virginia's statutory hospitalization requirement.

We therefore conclude, on the record before us in this case, that appellant has not shown the Virginia hospitalization re-

²⁰ Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on the hospitalization requirement in § 18.2-73. Indeed, appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief, instead arguing that the Virginia hospitalization requirement is comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid. Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet reasonable facility and equipment standards merely because they impose some costs and burdens. As *City of Akron* makes clear, see *ante*, at 12, in view of the State's compelling interest in the pregnant woman's health, it may adopt reasonable regulations. Compliance with the State's requirements certainly will entail costs, but this can be said of all regulations adopted by governments to protect the health and safety of people.

quirement concerning second-trimester abortions to be an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²¹ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike the provisions at issue in *City of Akron* and *Ashcroft*, Virginia's statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's hospitalization requirement appears to comport with accepted medical practice and leave the method and timing of the abortion precisely where they belong—with the physician and the patient. to

V

We hold that, on the record before us, Virginia's hospitalization requirement for second-trimester abortions is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

APR 12 1983

*Draft accompanying
HAB's letter of 5/4. This
draft reflects his proposed
changes. My clerks have
- by marginal notes -
indicated their views*

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

HAB

(Sent to
LFP)

From: Justice Powell

Circulated: _____

Recirculated: _____

3rd DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT v. VIRGINIA

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[April —, 1983]

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We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

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P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

²The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S.E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders his conviction unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, ante, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is ~~the validity of these requirements, not whether appellant's clinic and his procedures would have complied with them.~~

⁴The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

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"outpatient . . . hospitals."⁵ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

"*Hospital* means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

... which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of two abortion clinics, the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these first-trimester outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 8, 23, *infra*. It there-

[Footnotes 7 and 8 are on p. 8]

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories.

The first grouping relates to organization, management, policies, procedures, and staffing. These regulations re-

fore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval, and the regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷ Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸ Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week, amenorrhea).").

quire personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,⁹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹ The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of

⁹ The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁰ These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹¹ The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹² See, e. g., Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing, Coomb's testing where woman is Rh-negative, urinalysis for sugar and al-

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the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

bumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician, *id.*, § 43.8.4, and the facility "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods," *id.*, § 43.8.5.

¹⁶Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all times."

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B

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Association of Kansas City, Mo., Inc. v. Ashcroft, ante*, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron, ante*, at 19. The requirements at issue, however, mandated that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft, ante*, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

~~The remaining question is the constitutionality of Virginia's regulations.~~ In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

~~On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.~~¹⁸ The American Pub-

¹⁸ See American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services 52-54 (5th ed. 1982); APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652, 655 (1980). See also National Abortion Federation, National Abortion

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lic Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider each of the regulations separately. Despite personal knowledge of the regulations at least by the time of his trial,¹⁰ appellant introduced no medical evidence questioning the reasonableness of any of them. This is to be contrasted with the evidence in *City of Akron* and *Ashcroft*,

Federation Standards (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

¹⁰See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

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"appellant has not attacked them as being insufficiently related to the State's interest in protecting maternal health.¹⁹ His challenge throughout this litigation has been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. *Send* Indeed, appellant has taken the position, both before the lower courts and before this Court, that a state licensing requirement for outpatient abortion facilities would be constitutional. See 9 Record 196a, 214a; Brief for Appellant in No. 801107 (Va.S.Ct.), p.35; Juris. Statement 16; Brief for Appellant 32, 43, n. 75, 46. In essence, appellant has argued" *ok see my change*

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"Given the plain language of the Virginia regulations and the history of their adoption, see notes _____, supra, we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions. Appellant has thus challenged a statutory scheme that does not exist in Virginia: a requirement that second-trimester abortions be performed in full-service hospitals. Since appellant has declined to challenge the constitutionality of the Virginia regulations, we have no occasion to pass on them." *ok* *no*

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where the plaintiffs sought at great length to show that particular requirements as to equipment and services were unreasonable restraints on women seeking second-trimester abortions. Appellant persisted in arguing broadly that Virginia's hospitalization requirements are no different in substance from those we reviewed in the *City of Akron* and *Ashcroft* cases.²⁰ Indeed, not until his reply brief in this Court did appellant criticize the regulations apart from Virginia's statutory hospitalization requirement.

We therefore conclude, on the record before us in this case, that appellant has not shown the Virginia hospitalization re-

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²⁰ Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on the hospitalization requirement in § 18.2-73. Indeed, appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief, instead arguing that the Virginia hospitalization requirement is comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid. Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet reasonable facility and equipment standards merely because they impose some costs and burdens. As *City of Akron* makes clear, see *ante*, at 12, in view of the State's compelling interest in the pregnant woman's health, it may adopt reasonable regulations. Compliance with the State's requirements certainly will entail costs, but this can be said of all regulations adopted by governments to protect the health and safety of people.

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quirement ^(that) concerning second-trimester abortions to be an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²¹ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike the provisions at issue in *City of Akron* and *Ashcroft*, Virginia's statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's hospitalization requirement appears to comport with accepted medical practice and leaves the method and timing of the abortion precisely where they belong—with the physician and the patient.

V

~~We hold that, on the record before us, Virginia's hospitalization requirement for second-trimester abortions is constitutional.~~ The judgment of the Supreme Court of Virginia is

Affirmed.

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the same services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require more technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

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To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

From: Justice Powell

Circulated: _____

Recirculated: APR 28 1983

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SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[May —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

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P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

²The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders his conviction unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, ante, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, the issue before us is the validity of those requirements, not whether appellant's clinic and his procedures would have complied with them.

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

"outpatient . . . hospitals."⁶ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁶ Section 32.1-123.1 provides:

"*Hospital*' means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

. . . which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of two abortion clinics, the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these first-trimester outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 8, 23, *infra*. It there-

[Footnotes 7 and 8 are on p. 8]

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories. The first grouping relates to organization, management, policies, procedures, and staffing. These regulations

fore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval, and the regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,⁹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹ The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of

⁹The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁰These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹¹The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹²See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing,

the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician, *id.*, § 43.8.4, and the facility "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods," *id.*, § 43.8.5.

¹⁶Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all

B

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron*, ante, at 13, and *Planned Parenthood Assoc. of Kansas City, Mo., Inc. v. Ashcroft*, ante, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron*, ante, at 19. The requirements at issue, however, mandated that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, ante, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

The remaining question is the constitutionality of Virginia's regulations. In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions.¹⁸ The American Pub-

times."

¹⁸ See American College of Obstetricians and Gynecologists, Standards for Obstetric-Gynecologic Services 51-62 (5th ed. 1982); APHA Recommended Program Guide for Abortion Services, 70 Am. J. Pub. Health 652,

lic Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider each of the regulations separately. Despite personal knowledge of the regulations at least by the time of his trial,¹⁹ appellant introduced no medical evidence questioning the reasonableness of any of them. This is to be contrasted with the evidence in *City of Akron* and *Ashcroft*,

655 (1980). See also National Abortion Federation, *National Abortion Federation Standards* (1981). Cf. Brief of the APHA as *Amicus Curiae* 29, n. 6 (supporting the NAF Standards for non-hospital abortion facilities as constituting "minimum standards").

¹⁹ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

where the plaintiffs sought at great length to show that particular requirements as to equipment and services were unreasonable restraints on women seeking second-trimester abortions. Appellant persisted in arguing broadly that Virginia's hospitalization requirements are no different in substance from those we reviewed in the *City of Akron* and *Ashcroft* cases.²⁰ Indeed, not until his reply brief in this Court did appellant criticize the regulations apart from Virginia's statutory hospitalization requirement.

We therefore conclude, on the record before us in this case, that appellant has not shown the Virginia hospitalization requirement concerning second-trimester abortions to be an

²⁰ Appellant has presented no evidence challenging the validity of the regulations as distinguished from his attack on the hospitalization requirement in § 18.2-73. Indeed, appellant does not attack these regulations expressly in his jurisdictional statement or in his principal brief, instead arguing that the Virginia hospitalization requirement is comparable to those we have invalidated in *City of Akron* and *Ashcroft*, and thus also invalid. Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*. And certainly appellant cannot argue that the State has no right to require appellant to meet reasonable facility and equipment standards merely because they impose some costs and burdens. As *City of Akron* makes clear, see *ante*, at 12, in view of the State's compelling interest in the pregnant woman's health, it may adopt reasonable regulations. Compliance with the State's requirements certainly will entail costs, but this can be said of all regulations adopted by governments to protect the health and safety of people.

unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²¹ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike the provisions at issue in *City of Akron* and *Ashcroft*, Virginia's statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's hospitalization requirement appears to comport with accepted medical practice and leave the method and timing of the abortion precisely where they belong—with the physician and the patient.

V

We hold that, on the record before us, Virginia's hospitalization requirement for second-trimester abortions is constitutional. The judgment of the Supreme Court of Virginia is

Affirmed.

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only regulations before us, however, relate to second-trimester abortions, and we find those requirements reasonably related to the State's compelling interest.

Reflects changes tentatively
made in response to H.A.B.'s
numerous suggestions.

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

L.F.P.

MAY 7 1983

From: Justice Powell

Circulated: _____

Recirculated: _____

4th DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[May —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

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² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

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The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, ante, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, it is irrelevant to the issue before us whether appellant's clinic and his procedures would have complied with the Virginia regulations.

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

"outpatient . . . hospitals."⁵ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

"*Hospital*' means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

. . . which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of two abortion clinics, the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these first-trimester outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 8, 23, *infra*. It there-

[Footnotes 7 and 8 are on p. 8]

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories. The first grouping relates to organization, management, policies, procedures, and staffing. These regulations

fore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval, and the regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

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- with
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sentence.
See p 11, third
paragraph.

require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,⁹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹ The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of

⁹ The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁰ These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹¹ The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹² See, e. g., Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³ Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing,

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the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician, *id.*, § 43.8.4, and the facility "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods," *id.*, § 43.8.5.

¹⁶Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all

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It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron*, ante, at 13, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron*, ante, at 19. The requirements at issue, however, mandated that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft*, ante, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions. The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second tri-

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mester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider whether Virginia's regulations are constitutional in every particular. Despite personal knowledge of the regulations at least by the time of trial, appellant has not attacked them as being insufficiently related to the State's interest in protecting health.¹⁸ His challenge throughout this litigation appears to have been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. In essence, appellant has argued that Virginia's hospitalization requirements are no different in substance from those

¹⁸ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

reviewed in the *City of Akron* and *Ashcroft* cases.¹⁹ At the same time, however, appellant took the position—both before the Virginia courts and this Court—that a state licensing requirement for outpatient abortion facilities would be constitutional.²⁰ We can only assume that by continuing to challenge the Virginia hospitalization requirement petitioner either views the Virginia regulations in some unspecified way as unconstitutional or challenges a hospitalization requirement that does not exist in Virginia. Yet, not until his reply brief in this Court did he elect to criticize the regulations apart from his broadside attack on the entire Virginia hospitalization requirement.

Given the plain language of the Virginia regulations and the history of their adoption, see n. 6, *supra*, we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions. We conclude that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's compelling interest in

¹⁹ Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*, and none has been raised below.

²⁰ See 8 Record 196a, 214a; Brief for Appellant in No. 801107 (Va. S. Ct.), p. 35; Juris. Statement 16; Brief for Appellant 32, 43 n. 75, 46.

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“protecting the woman’s own health and safety.” *Roe*, 410 U. S., at 150.²¹ As we emphasized in *Roe*, “[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient.” *Ibid.* Unlike the provisions at issue in *City of Akron* and *Ashcroft*, Virginia’s statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State’s requirement that second-trimester abortions be performed in licensed clinics appears to comport with accepted medical practice, and leaves the method and timing of the abortion precisely where they belong—with the physician and the patient.

IV

The judgment of the Supreme Court of Virginia is

Affirmed.

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only issue before us, however, relates to second-trimester abortions.

Not circulated

L.F.P.

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

MAY 7 1983

From: Justice Powell

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Recirculated: _____

4th DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[May —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders his conviction unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, ante, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see also *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, it is irrelevant to the issue before us whether appellant's clinic and his procedures would have complied with the Virginia regulations.

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

"outpatient . . . hospitals."⁵ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

"*Hospital*' means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶ The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

... which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of two abortion clinics, the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these first-trimester outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 8, 23, *infra*. It there-

[Footnotes 7 and 8 are on p. 8]

be performed in an outpatient surgical clinic provided that clinic has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories. The first grouping relates to organization, management, policies, procedures, and staffing. These regulations

fore is clear that Virginia has recognized the need for discrete and different sets of regulations for the two periods. The Board gave its final approval, and the regulations became effective on June 30, 1977. The abortion for which appellant was prosecuted was performed on November 10, 1979, some two years and five months later.

We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical clinics).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual,⁹ § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services,¹⁰ and general building.¹¹ The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia,¹² laboratory,¹³ and pathology.¹⁴ Some of

⁹The manual must describe emergency and elective procedures that may be performed at the facility, § 41.2.1; the anesthesia that may be used, § 41.2.2; the criteria and procedures for admissions and discharge, § 41.2.4; written informed consent, § 41.2.4; and procedures for housekeeping and infection control, § 41.2.5.

¹⁰These services may be provided within the outpatient surgical hospital if the services comply with applicable requirements of the Department of Health's Rules and Regulations for the Licensure of General and Special Hospitals or through a contractual arrangement with nearby facilities. Va. Regs. (Outpatient Hospitals) § 52.3.1.

¹¹The regulations contain customary provisions with respect to meeting building codes, zoning ordinances, and the like. See Va. Regs. (Outpatient Hospitals) §§ 50.6.1, 50.7.1, 50.8.1, 50.8.4.

¹²See, *e. g.*, Va. Regs. (Outpatient Hospitals) § 43.1.1 (service must be directed by licensed physician); *id.*, § 43.1.2 (physician responsible for anesthesia must be present for administration and recovery).

¹³Each patient admitted must receive "appropriate routine laboratory testing." See Va. Regs. (Outpatient Hospitals) § 43.6.1. Outpatient surgical hospitals providing abortion services also must conduct pregnancy testing, hemoglobin or hematocrit determinations, blood and Rh typing,

the requirements relate to sanitation, laundry, and the physical plant. See, *e. g.*, Va. Regs. (Outpatient Hospitals) §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission,¹⁵ and post-operative recovery.¹⁶ Finally, the regulations mandate some emergency services and evacuation planning.¹⁷

Coomb's testing where woman is Rh-negative, urinalysis for sugar and albumin, culture for gonorrheal infection, § 64.1.3, and, where medically indicated, serologic testing for syphilis and a Papanicolaou smear, § 64.1.4.

¹⁴Section 43.6.3 requires that all tissue be submitted for a pathology examination, with pathology services for abortion patients meeting the minimum requirements of § 64.2.4 (must be "submitted for histological examination by a pathologist in all cases where gross examination by the attending physician does not confirm presence of fetal parts"). See *Ashcroft, ante*, at 8-11.

¹⁵Section 43.8.1 provides for a medical history and physical examination before initiating any procedure. Sufficient time to permit review of laboratory tests must be allowed between initial examination and initiation of any procedure. *Id.*, § 43.8.3. In an outpatient surgical hospital providing abortion services, the diagnosis of pregnancy is the responsibility of the performing physician, *id.*, § 43.8.4, and the facility "shall offer each patient appropriate counseling and instruction in the abortion procedure and in birth control methods," *id.*, § 43.8.5.

¹⁶Each patient shall be observed for post-operative complications for one hour under the direct supervision of a nurse trained in resuscitation techniques and other emergency procedures. Va. Regs. (Outpatient Hospitals) §§ 43.9.1, 43.9.2. A licensed physician must be present on the premises until the patient is discharged on his written orders. *Id.*, §§ 43.9.3, 43.9.4.

¹⁷See Va. Regs. (Outpatient Hospitals) § 43.4.1 (written evacuation plan); *id.*, § 43.5.1 ("adequate monitoring equipment, suction apparatus, oxygen, and related items necessary for resuscitation and control of hemorrhage and other complications"); *id.*, § 43.5.2 (ambulance service to a licensed general hospital). Section 43.5.3 provides:

"A written agreement shall be executed with a general hospital to ensure that any patient of the outpatient surgical hospital shall receive needed emergency treatment. The agreement shall be with a licensed general hospital capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice and which has a physician in the hospital and available for emergency service at all

B

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft, ante*, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron, ante*, at 19. The requirements at issue, however, mandated that "all second-trimester abortions must be performed in general, acute-care facilities." *Ashcroft, ante*, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions. The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second tri-

times."

mester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider whether Virginia's regulations are constitutional in every particular. Despite personal knowledge of the regulations at least by the time of trial, appellant has not attacked them as being insufficiently related to the State's interest in protecting health.¹⁸ His challenge throughout this litigation appears to have been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. In essence, appellant has argued that Virginia's hospitalization requirements are no different in substance from those

¹⁸ See nn. 3, 6, *supra*; Record Vol. 5, pp. 55-56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

reviewed in the *City of Akron* and *Ashcroft* cases.¹⁹ At the same time, however, appellant took the position—both before the Virginia courts and this Court—that a state licensing requirement for outpatient abortion facilities would be constitutional.²⁰ We can only assume that by continuing to challenge the Virginia hospitalization requirement petitioner either views the Virginia regulations in some unspecified way as unconstitutional or challenges a hospitalization requirement that does not exist in Virginia. Yet, not until his reply brief in this Court did he elect to criticize the regulations apart from his broadside attack on the entire Virginia hospitalization requirement.

Given the plain language of the Virginia regulations and the history of their adoption, see n. 6, *supra*, we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions. We conclude that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's compelling interest in

¹⁹ Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others are irrelevant, see n. 3, *supra*, and none has been raised below.

²⁰ See 8 Record 196a, 214a; Brief for Appellant in No. 801107 (Va. S. Ct.), p. 35; Juris. Statement 16; Brief for Appellant 32, 43 n. 75, 46.

omission

omission

new

"protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.²¹ As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike the provisions at issue in *City of Akron* and *Ashcroft*, Virginia's statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirement that second-trimester abortions be performed in licensed clinics appears to comport with accepted medical practice, and leaves the method and timing of the abortion precisely where they belong—with the physician and the patient.

IV

The judgment of the Supreme Court of Virginia is

Affirmed.

| omission

²¹ Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only issue before us, however, relates to second-trimester abortions.

Revised: 1, 5, 7-12

MAY 21 1983

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

From: Justice Powell

Circulated: MAY 23 1983

Recirculated: _____

4th DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[May —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church, Virginia. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹ Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

² The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, — U. S. —, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders his conviction unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, ante, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, it is irrelevant to the issue before us whether appellant's clinic and his procedures would have complied with the Virginia regulations.

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

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... which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester.

The State Board of Health gave preliminary approval to the proposed regulations on December 1, 1976, and a public hearing was held January 26, 1977. Dr. William R. Hill, a member of the Board, presided at this hearing, and staff present from the Department included two doctors and the Director of the Bureau of Medical and Nursing Facilities Services. Witnesses included the Associate Executive Director of the Virginia Hospital Association; a representative of five outpatient abortion clinics in the State; representatives of two abortion clinics, the Richmond Medical Center and the Hillcrest Clinic; a professor from Eastern Virginia Medical School representing Planned Parenthood of Southside Tidewater and the Tidewater OBGYN Society; the Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital; the Administrator of Leigh Memorial Hospital; a representative of the Virginia Society for Human Life; and a representative of the Northern Virginia Medical Center. See Commonwealth of Virginia Department of Health, Public Hearing In Re: Proposed Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (January 26, 1977). The Executive Director of the Virginia Hospital Association stated that “[i]n general, they are a good set of standards and have our support.” *Id.*, at 4. The abortion clinics were concerned, however, about the imposition of the regulations on outpatient abortion clinics then performing first-trimester abortions. The clinics acknowledged that during the second trimester “the State may regulate the [abortion] procedure in the interest of maternal health.” *Id.*, at 7. But the clinics specifically “propose[d] that clinics or other facilities that perform abortions during the first trimester be specifically excluded from the Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia.” *Id.*, at 26. See also *id.*, at 28. The Medical Director of the Ambulatory Surgical Center of Leigh Memorial Hospital, concerned about the need to set high standards for outpatient surgical hospitals in the State, agreed that the Board should not “compromise” the strict standards needed for outpatient surgical hospitals in order to include these first-trimester outpatient abortion clinics within the same set of regulations. See *id.*, at 30. Following the hearing, the Board added Part III, the regulations of which apply only to clinics doing first-trimester abortions. See nn. 8, 12, *infra*. It there-

[Footnotes 7 and 8 are on p. 8]

be performed in an outpatient surgical hospital provided that facility has been licensed as a "hospital" by the State.

The Virginia regulations applicable to the performance of second-trimester abortions in outpatient surgical hospitals are, with few exceptions, the same regulations applicable to all outpatient surgical hospitals in Virginia, and may be grouped for purposes of discussion into three main categories. The first grouping relates to organization, management, policies, procedures, and staffing. These regulations

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We note that new but similar regulations now supersede the regulations in effect when appellant performed the abortion for which he was prosecuted. See Department of Health, Rules and Regulations for the Licensure of Hospitals in Virginia, pt. IV (1982). These new regulations were promulgated pursuant to Va. Code §§ 32.1-12, 32.1-127, enacted in 1979.

⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical hospitals).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual, § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services, §§ 52.1, 52.2, 52.3, and general building, §§ 50.6.1, 50.7.1, 50.8.1, 52.4. The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia, § 43.1, laboratory, §§ 43.6.1, 64.1.3, 64.1.4, and pathology, §§ 43.6.3, 64.2.4. Some of the requirements relate to sanitation, laundry, and the physical plant. §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission, § 43.8, and post-operative recovery, § 43.9. Finally, the regulations mandate some emergency services and evacuation planning. §§ 43.4.1, 43.5.

B

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft, ante*, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron, ante*, at 19. The requirements at issue, however, mandated that "all second-trimester abor-

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tions must be performed in general, acute-care facilities." *Ashcroft, ante*, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

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In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions. The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), Stand-

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ards for Obstetric-Gynecologic Services 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider whether Virginia's regulations are constitutional in every particular. Despite personal knowledge of the regulations at least by the time of trial, appellant has not attacked them as being insufficiently related to the State's interest in protecting health.⁹ His challenge throughout this litigation appears to have been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. In essence, appellant has argued that Virginia's hospitalization requirements are no different in substance from those reviewed in the *City of Akron* and *Ashcroft* cases.¹⁰ At the

⁹ See nn. 3, 6, *supra*; 5 Record 55-56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

¹⁰ Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: that the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others

same time, however, appellant took the position—both before the Virginia courts and this Court—that a state licensing requirement for outpatient abortion facilities would be constitutional.¹¹ We can only assume that by continuing to challenge the Virginia hospitalization requirement petitioner either views the Virginia regulations in some unspecified way as unconstitutional or challenges a hospitalization requirement that does not exist in Virginia. Yet, not until his reply brief in this Court did he elect to criticize the regulations apart from his broadside attack on the entire Virginia hospitalization requirement.

Given the plain language of the Virginia regulations and the history of their adoption, see n. 6, *supra*, we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions. We conclude that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.¹² As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike the

are irrelevant, see n. 3, *supra*, and none has been raised below.

¹¹ See 8 Record 196a, 214a; Brief for Appellant in No. 801107 (Va. S. Ct.), p. 35; Juris. Statement 16; Brief for Appellant 32, 43 n. 75, 46.

¹² Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only issue before us, however, relates to second-trimester abortions.

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provisions at issue in *City of Akron* and *Ashcroft*, Virginia's statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirement that second-trimester abortions be performed in licensed clinics appears to comport with accepted medical practice, and leaves the method and timing of the abortion precisely where they belong—with the physician and the patient.

IV

The judgment of the Supreme Court of Virginia is

| omission

Affirmed.

Justice Powell

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Reporter of Decisions.

D STATES

SIMOPOULOS v. VIRGINIA

APPEAL FROM THE SUPREME COURT OF VIRGINIA

No. 81-185. Argued November 30, 1982—Decided June —, 1983

Appellant, an obstetrician-gynecologist, was convicted after a Virginia state-court trial for violating Virginia statutory provisions make it unlawful to perform an abortion during the second trimester of pregnancy outside of a licensed hospital. "Hospital" is defined to include outpatient hospitals, and State Department of Health regulations define "outpatient hospital" as including institutions that primarily furnish facilities for the performance of surgical procedures on outpatients. The regulations also provide that second-trimester abortions may be performed in an outpatient surgical clinic licensed as a "hospital" by the State. The evidence at appellant's trial established, *inter alia*, that he performed a second-trimester abortion on an unmarried minor by an injection of saline solution at his unlicensed clinic; that the minor understood appellant to agree to her plan to deliver the fetus in a motel and did not recall being advised to go to a hospital when labor began, although such advice was included in an instruction sheet provided her by appellant; and that the minor, alone in a motel, aborted her fetus 48 hours after the saline injection. The Virginia Supreme Court affirmed appellant's conviction.

Held:

(of Virginia)

1. The Virginia abortion statute was not unconstitutionally applied to appellant on the asserted ground that the State failed to allege in the indictment and to prove lack of medical necessity for the abortion. Under the authoritative construction of the statute by the Virginia Supreme Court, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt (until) appellant invoked medical necessity as a defense. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. And appellant's contention that the prosecution failed to prove that his acts in fact caused the fetus' death is meritless, in view of the undisputed facts proved at trial. Pp. 3-4.

(of Virginia)

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JOB

Syllabus

2. Virginia's requirement that second-trimester abortions be performed in licensed outpatient clinics is not an unreasonable means of furthering the State's important and legitimate interest in protecting the woman's health, which interest becomes "compelling" at approximately the end of the first trimester. In *Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City v. Ashcroft*, ante, p. —, constitutional challenges were upheld with regard to requirements mandating that all second-trimester abortions be performed in "general, acute-care facilities." In contrast, the Virginia statutes and regulations do not require that such abortions be performed exclusively in full-service hospitals, but permit their performance at licensed outpatient clinics. Thus, the decisions in *Akron* and *Ashcroft*, are not controlling here. Although a State's discretion in determining standards for the licensing of medical facilities does not permit it to adopt abortion regulations that depart from accepted medical practice, the Virginia regulations on their face are compatible with accepted medical standards governing outpatient second-trimester abortions. Pp. 4-13.

221 Va. 1059, 227 S. E. 2d 194, affirmed.

JUN 9 1983

Change: 3

To: The Chief Justice
Justice Brennan
Justice White
Justice Marshall
Justice Blackmun
Justice Rehnquist
Justice Stevens
Justice O'Connor

From: Justice Powell

Circulated: _____

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5th DRAFT

SUPREME COURT OF THE UNITED STATES

No. 81-185

CHRIS SIMOPOULOS, APPELLANT *v.* VIRGINIA

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA

[June —, 1983]

JUSTICE POWELL delivered the opinion of the Court.

We have considered today mandatory hospitalization requirements for second-trimester abortions in *City of Akron v. Akron Center for Reproductive Health, Inc.*, ante, p. —, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft*, ante, p. —. The principal issue here is whether Virginia's mandatory hospitalization requirement is constitutional.

I

Appellant is a practicing obstetrician-gynecologist certified by the American Board of Obstetrics and Gynecology. In November, 1979, he practiced at his office in Woodbridge, Virginia, at four local hospitals, and at his clinic in Falls Church, Virginia. The Falls Church clinic has an operating room and facilities for resuscitation and emergency treatment of cardiac/respiratory arrest. Replacement and stabilization fluids are on hand. Appellant customarily performs first-trimester abortions at his clinic. During the time relevant to this case, the clinic was not licensed, nor had appellant sought any license for it.

P.M. was a 17-year old high-school student when she went to appellant's clinic on November 8, 1979. She was unmarried, and told appellant that she was approximately 22 weeks pregnant. She requested an abortion but did not want her parents to know. Examination by appellant confirmed that

P.M. was five months pregnant, well into the second trimester. Appellant testified that he encouraged her to confer with her parents and discussed with her the alternative of continuing the pregnancy to term. She did return home, but never advised her parents of her decision.

Two days later, P.M. returned to the clinic with her boy friend. The abortion was performed by an injection of saline solution. P.M. told appellant that she planned to deliver the fetus in a motel, and understood him to agree to this course. Appellant gave P.M. a prescription for an analgesic and a "Post-Injection Information" sheet that stated that she had undergone "a surgical procedure" and warned of a "wide range of normal reactions." App. 199. The sheet also advised that she call the physician if "heavy" bleeding began. Although P.M. did not recall being advised to go to a hospital when labor began, this was included on the instruction sheet. *Id.*, at 200.

P.M. went to a motel. Alone, she aborted her fetus in the motel bathroom 48 hours after the saline injection. She left the fetus, follow-up instructions, and pain medication in the wastebasket at the motel. Her boy friend took her home. Police found the fetus later that day and began an investigation.¹

Appellant was indicted² for unlawfully performing an abortion during the second trimester of pregnancy outside of

¹Except as permitted by statute, persons performing an abortion are guilty of a Class 4 felony under Virginia law and subject to mandatory license revocation. Va. Code §§ 18.2-71, 54-316(3), 54-317(1), 54.321.2 (1982). A Class 4 felony is punishable by a sentence of two to ten years in prison. Va. Code § 18.2-10(d).

²The indictment alleges a violation of Va. Code § 18.2-71, which provides:

"Except as provided in other sections of this article, if any person administer to, or cause to be taken by a woman, any drug or other thing, or use means, with intent to destroy her unborn child, or to produce abortion or miscarriage, and thereby destroy such child, or produce such abortion or

a licensed hospital and was convicted by the Circuit Court of Fairfax County sitting without a jury. The Supreme Court of Virginia unanimously affirmed the conviction. *Simopoulos v. Commonwealth*, 221 Va. 1059, 277 S. E. 2d 194 (1981). This appeal followed. We noted probable jurisdiction, 456 U. S. 988, and now affirm.

II

Appellant raises two issues that do not require extended treatment. He first contends that Va. Code § 18.2-71 was applied unconstitutionally to him, because lack of medical necessity for the abortion was not alleged in the indictment, addressed in the prosecution's case, or mentioned by the trier of fact. Appellant contends that this failure renders his conviction unconstitutional for two reasons: (i) the State failed to meet its burden of alleging necessity in the indictment, as required by *United States v. Vuitch*, 402 U. S. 62 (1971); and (ii) the prosecution failed to meet its burden of persuasion, as required by *Patterson v. New York*, 432 U. S. 197 (1977).

The authoritative construction of § 18.2-71 by the Supreme Court of Virginia makes it clear that, at least with respect to the defense of medical necessity, the prosecution was not obligated to prove lack of medical necessity beyond a reasonable doubt *until* appellant invoked medical necessity as a defense. See 221 Va., at 1069, 277 S. E. 2d, at 200. Appellant's reliance on *Vuitch* thus is misplaced: the District of Co-

miscarriage, he shall be guilty of a Class 4 felony."

The Virginia Code sets forth four exceptions to this statute: there is no criminal liability if the abortion (i) is performed within the first trimester, § 18.2-72; (ii) is performed in a licensed hospital in the second trimester, § 18.2-73; (iii) is performed during the third trimester under certain circumstances, § 18.2-74; and (iv) is necessary to save the woman's life, § 18.2-74.1. The indictment here alleged a violation of § 18.2-71 and expressly negated any defense of hospitalization under § 18.2-73 and any first-trimester defense under § 18.2-72. The indictment did not, however, rebut the other defenses.

lumbia statute in *Vuitch*, as construed by this Court, required the prosecution to make this allegation. See 402 U. S., at 70. Placing upon the defendant the burden of going forward with evidence on an affirmative defense is normally permissible. See *Engle v. Isaac*, 456 U. S. 107, 120-121, and n. 20 (1982); *Mullaney v. Wilbur*, 421 U. S. 684, 701-703, nn. 28, 30, 31 (1975).

Appellant also contends that the prosecution failed to prove that his acts in fact caused the death of the fetus. In view of the undisputed facts proved at trial, summarized above, this contention is meritless. See 221 Va., at 1069-1070, 277 S. E. 2d, at 200-201.

III

We consistently have recognized and reaffirm today that a State has an "important and legitimate interest in the health of the mother" that becomes "'compelling' . . . at approximately the end of the first trimester." *Roe v. Wade*, 410 U. S. 113, 163 (1973). See *City of Akron*, ante, at 10. This interest embraces the facilities and circumstances in which abortions are performed. See *id.*, at 150. Appellant argues, however, that Virginia prohibits all non-hospital second-trimester abortions and that such a requirement imposes an unconstitutional burden on the right of privacy. In *City of Akron* and *Ashcroft*, we upheld such a constitutional challenge to the acute-care hospital requirements at issue there. The State of Virginia argues here that its hospitalization requirement differs significantly from the hospitalization requirements considered in *City of Akron* and *Ashcroft* and that it reasonably promotes the State's interests.

A

In furtherance of its compelling interest in maternal health, Virginia has enacted a hospitalization requirement for abortions performed during the second trimester. As a general proposition, physicians' offices are not regulated under

Virginia law.³ Virginia law does not, however, permit a physician licensed in the practice of medicine and surgery to perform an abortion during the second trimester of pregnancy unless "such procedure is performed in a hospital licensed by the State Department of Health." Va. Code § 18.2-73 (1982). The Virginia abortion statute itself does not define the term "hospital." This definition is found in Va. Code § 32.1-123.1,⁴ that defines "hospital" to include

³ A physician's office is explicitly excluded from the hospital licensing statutes and regulations unless the office is used principally for performing surgery. Va. Code § 32.1-124(5). "Surgery" is not defined. Appellant contends that whether his facility principally performs surgery is a question of fact that has not been resolved, and that it is uncertain whether his clinic may be licensed as a "hospital." He notes that *after* he performed the abortion on P.M. he requested a certificate of need, see *id.*, § 32.1-102.3, but was informed by the Office of the Attorney General that his "clinic-office cannot be licensed as a hospital" and that "if you wish to perform this type of procedure, you must, in essence, build a hospital to do it." App. to Reply Brief for Appellant 3a, 4a. Appellant did not seek a license before he performed the abortion at issue here, nor does he now argue that his clinic would meet the requirements of the Virginia statute and regulations. Rather, he broadly attacks the validity of the state hospitalization requirements as applied to second-trimester abortions. Thus, it is irrelevant to the issue before us whether appellant's clinic and his procedures would have complied with the Virginia regulations.

⁴ The Supreme Court of Virginia views the word "hospital" in § 18.2-73 as referring to the definition of that term in § 32.1-123.1. This is made clear by the court's general reference in its opinion to title 32.1 of the Virginia Code, the title of the Code that contains many of Virginia's health laws:

"The state is empowered to license and regulate hospitals, clinics, home health agencies, and other medical care facilities, *see generally*, Title 32.1 of the Code, and to fix and enforce different standards of medical care for different facilities. The General Assembly has decided that medical procedures employed in second-trimester abortions must be performed in hospitals. Based upon the evidence in this record, we are of the opinion that the hospital requirement is reasonably related to the State's compelling interest in preserving and protecting maternal health." 221 Va., at 1075, 277 S. E. 2d, at 204.

"outpatient . . . hospitals."⁵ Section 20.2.11 of the Department of Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) ("regulations")⁶ defines outpatient hospital in pertinent part as "[i]nstitutions

There is no basis for assuming that the court interpreted "hospital" in § 18.2-73 any differently from its interpretation in title 32.1, and specifically in § 32.1-123.1. See n. 5, *infra*.

⁵ Section 32.1-123.1 provides:

"*Hospital*' means any facility in which the primary function is the provision of diagnosis, of treatment, and of medical and nursing services, surgical or nonsurgical, for two or more nonrelated individuals, including hospitals known by varying nomenclature or designation such as sanatoriums, sanitariums and general, acute, short-term, long-term, outpatient and maternity hospitals."

The definition of hospital in effect in 1975 when § 18.2-73 was enacted is similar. See Va. Code § 32.298(2) (1973) (repealed by 1979 Acts, c. 711). It specifically included at that time "out-patient surgical hospitals (which term shall not include the office or offices of one or more physicians or surgeons unless such office or offices are used principally for performing surgery)."

⁶The regulations were promulgated pursuant to the State Board of Health's general authority to adopt rules and regulations prescribing minimum standards for hospitals. This authority permits it to

"classify hospitals in accordance with the character of treatment, care, or service rendered or offered, and prescribe the minimum standards and requirements for each class in conformity with provisions of this chapter, with the guiding principles expressed or implied herein, and with due regard to and in reasonable conformity to the standards of health, hygiene, sanitation, and safety as established and recognized by the medical profession and by specialists in matters of public health and safety, having due regard to the availability of physicians, surgeons, nurses and other assistants, and the cost and expense to the hospital and the resulting costs to the patients." Va. Code § 32-301 (1973) (repealed by 1979 Acts, c. 711) (similar rulemaking authority currently is granted in Va. Code §§ 32.1-12 and 32.1-127 (1979)).

The first draft of the regulations differed considerably from the regulations that the Board finally approved. See Department of Health, Draft I, Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (October 27, 1976). The most important difference was that the requirements now in Part II of the regulations were applicable to all outpa-

. . . which primarily provide facilities for the performance of surgical procedures on outpatients”⁷ and provides that second-trimester abortions may be performed in these clinics.⁸ Thus, under Virginia law, a second-trimester abortion may

tient facilities in which abortions could be performed, regardless of the trimester.

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be performed in an outpatient surgical hospital provided that facility has been licensed as a "hospital" by the State.

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⁷Section 32.1-125 of the Code provides: "No person shall establish, conduct, maintain, or operate in this Commonwealth any hospital . . . unless such hospital . . . is licensed as provided in this article." See also Va. Regs. (Outpatient Hospitals) § 30.1 (similar provision specifically governing outpatient surgical hospitals).

⁸Part II of the regulations sets minimum standards for outpatient surgical hospitals that may perform second-trimester abortions. This interpretation is confirmed by several sections in Part II, *i. e.*, §§ 43.6.2, 43.6.3, 43.7.3(c), 43.8.4, 43.8.5, 43.9.5, all of which refer to abortion services, and by the history of Part III, see n. 6, *supra*. Moreover, the State's counsel at oral argument represented that facilities licensed pursuant to Part II legally may perform second-trimester abortions. Tr. of Oral Arg. 33.

Virginia uses the term "outpatient abortion clinics" to refer specifically to those facilities meeting the minimum standards of Part III of the regulations. See Va. Regs. (Outpatient Hospitals), p. i. Facilities meeting these standards are limited to performing abortions only during the first trimester of pregnancy. *Ibid.* See *id.*, § 62.1.2 ("Any procedure performed to terminate a pregnancy [in an outpatient abortion clinic] shall be performed prior to the end of the first trimester (12th week amenorrhea).").

require personnel and facilities "necessary to meet patient and program needs." Va. Regs. (Outpatient Hospitals) § 40.3; see also § 40.1. They also require a policy and procedures manual, § 43.2, an administrative officer, § 40.6, a licensed physician who must supervise clinical services and perform surgical procedures, § 42.1, and a registered nurse to be on duty at all times while the facility is in use, § 42.2. The second category of requirements outlines construction standards for outpatient surgical clinics, but also provides that "deviations from the requirements prescribed herein may be approved if it is determined that the purposes of the minimum requirements have been fulfilled," § 50.2.1. There are also construction requirements that set forth standards for the public areas, clinical areas, laboratory and radiology services, §§ 52.1, 52.2, 52.3, and general building, §§ 50.6.1, 50.7.1, 50.8.1, 52.4. The final group of regulations relates to patient care services. Most of these set the requirements for various services that the facility may offer, such as anesthesia, § 43.1, laboratory, §§ 43.6.1, 64.1.3, 64.1.4, and pathology, §§ 43.6.3, 64.2.4. Some of the requirements relate to sanitation, laundry, and the physical plant. §§ 43.2, 43.10, 43.11, 43.12.6. There are also guidelines on medical records, § 43.7, pre-operative admission, § 43.8, and post-operative recovery, § 43.9. Finally, the regulations mandate some emergency services and evacuation planning. §§ 43.4.1, 43.5.

B

It is readily apparent that Virginia's second-trimester hospitalization requirement differs from those at issue in *City of Akron, ante*, at 13, and *Planned Parenthood Assn. of Kansas City, Mo., Inc. v. Ashcroft, ante*, at 4-5. In those cases, we recognized the medical fact that, "at least during the early weeks of the second trimester[,] D&E abortions may be performed as safely in an outpatient clinic as in a full-service hospital." *City of Akron, ante*, at 19. The requirements at issue, however, mandated that "all second-trimester abor-

tions must be performed in general, acute-care facilities." *Ashcroft, ante*, at 5. In contrast, the Virginia statutes and regulations do not require that second-trimester abortions be performed exclusively in full-service hospitals. Under Virginia's hospitalization requirement, outpatient surgical hospitals may qualify for licensing as "hospitals" in which second-trimester abortions lawfully may be performed. Thus, our decisions in *City of Akron* and *Ashcroft* are not controlling here.

In view of its interest in protecting the health of its citizens, the State necessarily has considerable discretion in determining standards for the licensing of medical facilities. Although its discretion does not permit it to adopt abortion regulations that depart from accepted medical practice, it does have a legitimate interest in regulating second-trimester abortions and setting forth the standards for facilities in which such abortions are performed.

On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions. The American Public Health Association (APHA), although recognizing "that greater use of the dilatation and evacuation procedure make[s] it possible to perform the vast majority of second trimester abortions during or prior to the 16th [w]eek after the last menstrual period," still "[u]rges endorsement of the provision of second trimester abortion in free-standing qualified clinics that meet the state standards required for certification." APHA, *The Right to Second Trimester Abortion* 1, 2 (1979). The medical profession has not thought that a State's standards need be relaxed merely because the facility performs abortions: "Ambulatory care facilities providing abortion services should meet the same standards of care as those recommended for other surgical procedures performed in the physician's office and outpatient clinic or the free-standing and hospital-based ambulatory setting." American College of Obstetricians and Gynecologists (ACOG), Stand-

ards for Obstetric-Gynecologic Services 54 (5th ed. 1982). See also *id.*, at 52 ("Free-standing or hospital-based ambulatory surgical facilities should be licensed to conform to requirements of state or federal legislation."). Indeed, the medical profession's standards for outpatient surgical facilities are stringent: "Such facilities should maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Ibid.*

We need not consider whether Virginia's regulations are constitutional in every particular. Despite personal knowledge of the regulations at least by the time of trial, appellant has not attacked them as being insufficiently related to the State's interest in protecting health.⁹ His challenge throughout this litigation appears to have been limited to an assertion that the State cannot require all second-trimester abortions to be performed in full-service general hospitals. In essence, appellant has argued that Virginia's hospitalization requirements are no different in substance from those reviewed in the *City of Akron* and *Ashcroft* cases.¹⁰ At the

⁹ See nn. 3, 6, *supra*; 5 Record 55-56 (appellant acknowledging existence of the outpatient hospital license; stating that he was seeking a license; but denying that he knew of the licensing program when the abortion was performed).

¹⁰ Appellant's reply brief does criticize the Virginia regulations, but not individually or on specific grounds, instead making only facial challenges in the broadest language and in conclusory terms: that the record is silent on the applicability of those regulations to his facility; that the record does not show whether any outpatient surgical hospitals exist in Virginia or whether, if they exist, they allow second-trimester abortions; that the record is silent on the reasonableness of the regulations; that he had no opportunity to defend against the regulations at trial; that it is uncertain whether, if he had applied for an outpatient hospital license, it would have been granted; that obtaining a license is an arduous process; that Virginia courts have had no opportunity to construe the "licensing statutes and regulations"; and that Part II of the regulations does not cover an outpatient surgical hospital where second-trimester abortions are performed. Some of these arguments are simply meritless, see n. 8, *supra*, and others

same time, however, appellant took the position—both before the Virginia courts and this Court—that a state licensing requirement for outpatient abortion facilities would be constitutional.¹¹ We can only assume that by continuing to challenge the Virginia hospitalization requirement petitioner either views the Virginia regulations in some unspecified way as unconstitutional or challenges a hospitalization requirement that does not exist in Virginia. Yet, not until his reply brief in this Court did he elect to criticize the regulations apart from his broadside attack on the entire Virginia hospitalization requirement.

Given the plain language of the Virginia regulations and the history of their adoption, see n. 6, *supra*, we see no reason to doubt that an adequately equipped clinic could, upon proper application, obtain an outpatient hospital license permitting the performance of second-trimester abortions. We conclude that Virginia's requirement that second-trimester abortions be performed in licensed clinics is not an unreasonable means of furthering the State's compelling interest in "protecting the woman's own health and safety." *Roe*, 410 U. S., at 150.¹² As we emphasized in *Roe*, "[t]he State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient." *Ibid.* Unlike the

are irrelevant, see n. 3, *supra*, and none has been raised below.

¹¹ See 8 Record 196a, 214a; Brief for Appellant in No. 801107 (Va. S. Ct.), p. 35; Juris. Statement 16; Brief for Appellant 32, 43 n. 75, 46.

¹² Appellant argues that Part III of the regulations, covering first-trimester abortion clinics, requires the *same* services and equipment as Part II. In fact, Part III has detailed regulations that do not appear in Part II. See, e. g., Va. Regs. (Outpatient Hospitals) §§ 63.1.1(b), § 63.3, 64.2.5(a)-(m). Appellant contends that, given these extensive regulations for first-trimester abortion clinics, the only way to require *more* technological support for second-trimester abortions would be to restrict them to acute-care, general hospitals. The only issue before us, however, relates to second-trimester abortions.

provisions at issue in *City of Akron* and *Ashcroft*, Virginia's statute and regulations do not require that the patient be hospitalized as an inpatient or that the abortion be performed in a full-service, acute-care hospital. Rather, the State's requirement that second-trimester abortions be performed in licensed clinics appears to comport with accepted medical practice, and leaves the method and timing of the abortion precisely where they belong—with the physician and the patient.

IV

The judgment of the Supreme Court of Virginia is

Affirmed.