No. 81-185

In the Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Appellant,

v.

COMMONWEALTH OF VIRGINIA,
Appellee.

Appeal From The Supreme Court Of Virginia

BRIEF AMICUS CURIAE OF AMERICANS UNITED FOR LIFE IN SUPPORT OF APPELLEE, COMMONWEALTH OF VIRGINIA

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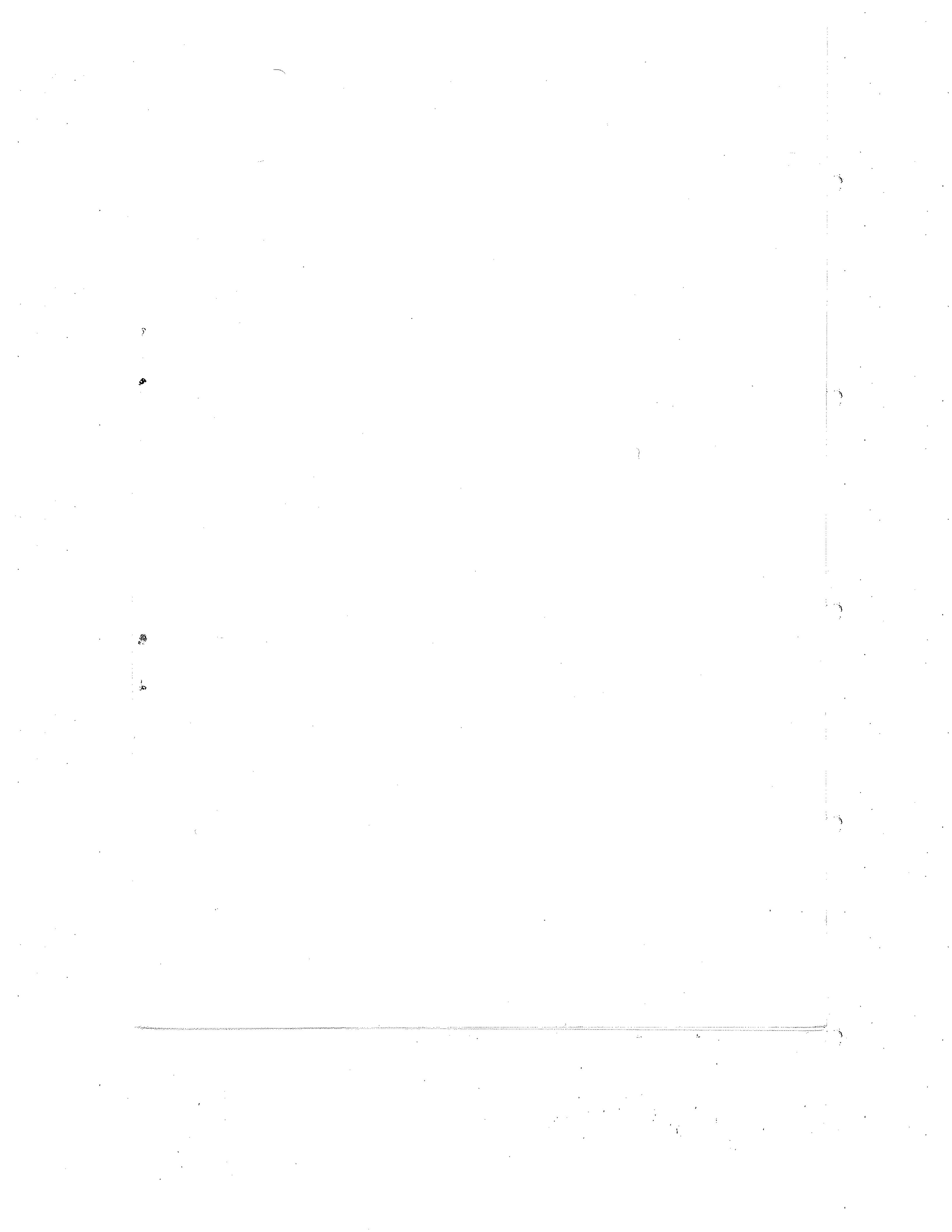

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the complications of late-term abortions when they arise, mandatory hospitalization requirements are "reasonably relate[d]" to the preservation of maternal health. Thus, under the *Roe* test, the Virginia hospitalization requirement is constitutional as applied to Simopoulos. It serves the State's "compelling interest" in maternal health and "reasonably relates" to the preservation of maternal health.

This Court should adhere to the standards it announced in *Roe* for evaluating the constitutionality of post-first trimester regulation of abortion on behalf of maternal health. Members of this Court have often recognized a critical distinction between statutes designed to obstruct the free exercise of a fundamental right and those which seek to enhance the exercise of that fundamental right. In *Connecticut* v. *Menillo,* 423 U.S. 9, 10 (1975), this Court stated that the abortional right of *Roe* was a "right to an abortion . . . under safe, clinical conditions." When the State attempts to promote its compelling interest in maternal health by enacting laws that enhance maternal health through requirements that abortions be performed under safe conditions, then the "narrowly drawn" requirement is inappropriate. It would require statutes that recognize fine-line distinctions between individual differences in physician skills, clinic facilities, and patient circumstances that would be virtually impossible for the State to specify, much less administer. It would also transform the courts into medical review boards required to re-evaluate statutes with the publication of each new medical study.

Appellant's suggestion that the independent decisions of private hospitals to refuse to provide unrestricted post-first trimester abortion services can be imputed to the State by virtue of a law that merely requires that abortions be performed in hospitals is without merit. The independent

decisions of private hospitals are constitutionally irrelevant.

This Court's most recent decisions defining the limits of ''state action'' are clearly contrary to any claim of ''state action'' in such circumstances. The State can be held responsible for a private decision only when it exercises coercive power or provides significant encouragement. Hospitalization requirements neither coerce nor significantly encourage hospitals to restrict the provision of abortion services. Therefore, the decisions of private hospitals and the consequences that flow from those decisions may not be deemed to be those of the State or of its hospitalization requirement.

Finally, any claim that a State's ''conscience clause'' law effectively limits the availability of midtrimester abortion services must fail for similar reasons. The mere existence of such a law is not sufficient to justify holding the State responsible for conscience-based decisions of private individuals or institutions. A state law may not be stricken simply because private parties refuse to provide services that would otherwise be available.

The Virginia hospital requirement is, therefore, constitutional as applied to Simopoulos and should be upheld.

ARGUMENT

I.

INTRODUCTION

This brief addresses the question of whether Virginia's mandatory hospitalization requirement for second trimester abortions is constitutionally permissible. Although this Court specifically acknowledged the State's right to legislate in this manner in *Roe* v. *Wade,* 410 U.S. 113, 163 (1973), the Appellant here challenges the Virginia law under which he was convicted for performing a late-term saline abortion outside of a hospital.

Because maternal health risks from abortion increase as the pregnancy progresses, at least 23 States have adopted statutes or regulations that require hospitalization for abortions performed after the first trimester.[1]

[1] Alabama Rules, Regulations & Standards for Abortion or Reproductive Health Centers §302.2; Cal. Health & Safety Code §25951 (West 1982); Conn. Pub. Health Code Regs. Sec. 19-13-D54; Del. Code Ann. tit. 24 §1790 (1980); Hawaii Rev. Stat. §453-16(a) (1976); Idaho Code §18-608 (1979); Ill. Rev. Stat. ch. 38 §81-24 (1982); Ky. Rev. Stat. Ann. §311.760(2) (Baldwin 1981); Mass. Gen. Laws Ann. ch. 112, §12 Q (West 1982); Mich. Admin. Code R. 325.3851 (1976); Mo. Ann. Stat. §188.025 (Vernon 1982); Mont. Code Ann. §50-20-109(1)(b) (1981); N.C. Gen. Stat. §14-45.1(b) (1981); North Carolina Regulation 10 NCAC 3E. 0101 (1980); N.D. Cent. Code §14-02:1-04(2) (1981); Or. Rev. Stat. §435.415 (1981); 18 Pa. Cons. Stat. §3209 (1982); Rhode Island Rules and Regulations for Termination of Pregnancy §603.1 (1973); S.D. Codified Laws Ann. §34-23A-4 (1977); Tenn. Code Ann. §39-301(e)(2) (1975); Utah Code Ann. §76-7-302(2) (1981); Va. Code §18.2-73 (1982); Wash. Rev. Code Ann. §39.02.070 (1979).

Thus, a large number of States, relying on this Court's decision in *Roe,* have pursued their compelling interest in the protection of maternal health through hospitalization requirements. These States concluded that hospitalization enhances maternal health because hospitals are better equipped to handle the complications of late-term abortions when they arise. Their conclusions comport with the rationale of *Roe* v. *Wade,* are based on sound medical evidence, and warrant judicial deference.

II.

UNDER THE ROE v. WADE STANDARD FOR TESTING ABORTION RELATED STATUTES FURTHERING MATERNAL HEALTH, THE VIRGINIA STATUTE IS CONSTITUTIONAL AS APPLIED TO SIMOPOULOS.

In *Roe* v. *Wade,* this Court specifically acknowledged the State's right to further its compelling interest in maternal health by requiring that second trimester abortions be performed in hospitals:

> It follows that, from and after [the end of the first trimester], a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; 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.

410 U.S. 113, 163 (1973).

While requiring that the State have a "compelling interest" to regulate in this manner, the Court did not use

the "narrowly drawn" requirement typically applied in strict scrutiny analysis. Instead, it required only that the regulation be "reasonably relate[d] to the preservation and protection of maternal health." *Id.*

Hence, the Court adopted a hybrid test: the State must have a "compelling" reason for wishing to reach the "end" it seeks, yet its statute need only "reasonably relate" to that compelling interest. The "means" by which it seeks to protect its compelling interest need not be "narrowly drawn."

Under this test, the Virginia hospitalization requirement is certainly constitutional as applied to Simopoulos.[2] It serves a compelling interest in maternal health, and it is reasonably related to mitigating maternal health problems that may result from abortion.

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[2] *Simopoulos* v. *Virginia* is not a class action. A ruling on the constitutionality of the Virginia post-first trimester abortion hospitalization requirements must, therefore, be limited to the constitutionality of their application to the conduct of Simopoulos. "Embedded in the traditional rules governing constitutional adjudication is the principle that a person to whom a statute may be constitutionally applied will not be heard to challenge that statute on the grounds that it may conceivably be applied unconstitutionally to others, in other situations not before the Court." *Broadrick* v. *Oklahoma,* 413 U.S. 601, 610 (1973). *See H.L.* v. *Matheson,* 450 U.S. 398, 405-407 (1981) (unemancipated, immature minor lacks standing to challenge facially a state statute that requires parental notice for all minors, including mature and emancipated minors).

Justice Stevens would have permitted a facial challenge in *H.L.* v. *Matheson* because it was a class action in which the appellant represented all minor women. 450 U.S. at 420-421. (Stevens, J., concurring in the judgment). Since this case is *not* a class action, however, Simopoulos cannot facially challenge the Virginia hospitalization requirement even under Justice Stevens's rationale.

A.

Virginia Has A Compelling Interest in Maternal Health Because Maternal Mortality From Saline Abortion Exceeds Maternal Mortality From Childbirth.

In *Roe* v. *Wade,* this Court held that

> [w]ith respect to the State's important and legitimate interest in the health of the mother, the "compelling" point, in the light of present medical knowledge, is at approximately the end of the first trimester. This *is so because of the now-established medical fact . . . that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth.*

410 U.S. 113, 163 (1973) (emphasis added).

Thus, the State's interest in maternal health becomes "compelling" when the maternal mortality rate arising from abortion is greater than the maternal mortality rate arising from childbirth.

According to the most recent available official national statistics, maternal mortality for saline abortion during the period of gestation at which Simopoulos induced the extrahospital saline abortion for which he was convicted exceeds maternal mortality for normal childbirth.

The most recently calculated official rate of maternal mortality arising from childbirth (that for 1978) is 9.6 deaths per 100,000 live births. U.S. National Center for Health Statistics, *Vital Statistics of the United States* (Table No. 111) (1980). The most recently calculated official rate of maternal mortality arising from the use of saline instillation (that for 1972-1978) is 13.9 deaths per 100,000 saline abortions. Centers for Disease Control, U.S. Dept. of Health and Human Services, *Abortion Sur-*

veillance 1978, at 49 (Table 23) (1980).[3] The average rate of maternal mortality arising from the use of saline instillation at 16-20 weeks of gestation—the time period at which Simopoulos estimated the pregnancy of the minor he aborted[4]—is 17.6 deaths per 100,000 saline abortions. *Id.* (Week-by-week saline abortion mortality rates are not indicated by the Centers for Disease Control report.)

Thus, "in light of present medical knowledge" (*Roe,* 410 U.S. at 163), the method of abortion used by Simopoulos, at the period of gestation when he used it, carries a

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[3] Separate figures for the saline maternal mortality rate for 1978 are not given. The average of the yearly maternal mortality rates arising from childbirth for the years 1972-1978 (the same years for which saline mortality statistics are available) is 13.5 deaths per 100,000 live births—still less than the 13.9 rate for post-first trimester saline instillation and significantly less than the 17.6 rate for the gestational period during which Simopoulos induced the abortion for which he was convicted. *See infra,* n. 4. (Calculation based on statistics from U.S. National Center for Health Statistics, *supra* p. 7, at Table 111.) Even if it were hypothesized that the mortality rate for saline instillation declined in the years from 1972 to 1978, it is important to note that the mortality rate from childbirth has steadily declined during the same period—from 18.8 in 1972 to 9.6 in 1978 (*id.*), a decline of 48.9%.

[4] Simopoulos's records indicated a five month pregnancy, Joint Appendix [hereinafter "J.A."] 249, the equivalent of 20 weeks. The minor he aborted told him she was "about 22 weeks pregnant" (J.A. 268) and the autopsy report on the fetus estimated a gestational age of 5½ months (J.A. 315) or 22 weeks. The average rate of maternal mortality arising from the use of saline instillation at 21 weeks of gestation or greater is 17.1 deaths per 100,000 saline abortions, Centers for Disease Control, *supra* p. 7, at 49 (Table 23) —which is, of course, greater than either 9.6 or 13.5, the rates of maternal mortality arising from childbirth for 1978 and for 1972-1978 respectively.

maternal mortality rate greater than that of childbirth.[5] It follows that, as applied to the circumstances of this case, the State's interest in maternal health is compelling.

B.

As Applied To Simopoulos, Virginia's Hospitalization Requirement Reasonably Relates To The Preservation And Protection Of Maternal Health.

1. The "Reasonable Relationship" To Maternal Health Test Established By Roe v. Wade Is Appropriate And Should Not Be Reversed.

Under *Roe,* when the State's interest in maternal health is compelling, "a State may regulate the abortion procedure to the extent that the regulation *reasonably relates* to the preservation and protection of maternal health." 410 U.S. at 163 (emphasis added). Despite this explicit formulation of the "means" branch of the test to be employed for laws enacted to protect maternal health, Simopoulos

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[5] The maternal mortality rate associated with all forms of abortion at 16-20 weeks is 15.2 deaths per 100,000 abortions. The average mortality rate for all forms of abortion for the weeks subsequent to the first trimester is also 15.2. Centers for Disease Control, *supra* p. 7, at 49 (Table 23). Both abortion mortality rates exceed comparable maternal mortality rates ascsociated with childbirth—whether the most recent rate (9.6 for 1978) or the average of the yearly rates for 1972-1978 (13.5).

The Brief for Appellant at 41 n. 73 cites two individual studies that use much smaller patient populations in an effort to claim that the mortality rate for saline instillation is 6.5 deaths per 100,000 saline abortions. Surely, Virginia may rely on official Centers for Disease Control statistics, which encompass the greater experience of the entire national population.

now urges upon this Court a requirement that such laws must be *"narrowly drawn."* Brief for Appellant at 35 (emphasis added).

Such a reversal of *Roe* v. *Wade* would be unwarranted.

As Justice Stevens wrote for the Court in *Jones* v. *Helms,* 101 S.Ct. 2434, 2443 (1981), "[If a law] does not infringe upon . . . fundamental rights . . . the State need not employ the least restrictive, or even the most effective or wisest, means to achieve its legitimate ends." A regulation that genuinely advances maternal health does not "infringe upon fundamental rights" because *Roe* v. *Wade* "recognized only [Roe's] right to an abortion under *safe, clinical conditions.*" *Connecticut* v. *Menillo,* 423 U.S. 9, 10 (1975) (emphasis added) (upholding application of a criminal abortion statute against a nonphysician even in the first trimester).

Similarly, Justice Powell, writing for the Court in *San Antonio Independent Sch. District* v. *Rodriguez,* 411 U.S. 1, 17 (1973), noted the "critical distinction" between "legislation which 'deprived,' 'infringed,' or 'interfered' with the free exercise of some . . . fundamental personal right" and legislation "the thrust [of which] is affirmative and reformatory and, therefore, should be scrutinized under judicial principles sensitive to the nature of the State's efforts and to the rights reserved to the States under the Constitution." In their concurring opinion in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52, 90 (1976), Justices Powell and Stewart applied this concept to abortion-related legislation, noting the difference between provisions "aimed at thwarting a woman's decision to have an abortion" and those "aimed at ensuring that the abortion decision is made in a knowing, intelligent, and voluntary fashion" to explain the lower level of

scrutiny the Court employed in upholding Missouri statutory informed consent requirements.[6]

In *Widmar* v. *Vincent,* 102 S.Ct. 269, 279 n. 3 (1981), Justice Stevens, concurring in the judgment, aptly noted the disadvantages associated with the imposition of a "narrowly drawn" means test. Quoting Justice Blackman's concurrence in *Illinois Elections Bd.* v. *Socialist*

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[6] The Brief Amici Curiae of Certain Law Professors argues that "the right to decide to terminate a pregnancy and the right to effectuate that decision, require the vigorous protection from governmental intrusions that only strict scrutiny, applied to *every* direct interference or burden, affords." *Id.* at 44 (emphasis in original), citing *Schad* v. *Borough of Mount Ephraim,* 452 U.S. 61, 68 (1981). In *Schad,* the Court wrote, "[As] is most often the case, the standard of review is determined by the nature of the right assertedly threatened or violated rather than by the power being exercised or the specific limitation imposed." *Id.* But the amici law professors are wrong to imply that "the right to decide to terminate a pregnancy and the right to effectuate that decision" are coterminous with the constitutional "right assertedly threatened or violated." "*Roe* did not declare an unqualified 'constitutional right to an abortion.' . . . Rather the right protects the woman from *unduly burdensome* interference with her freedom to decide whether to terminate her pregnancy." *Maher* v. *Roe,* 432 U.S. 464, 474 (1977) (emphasis added). Among the qualifications of that right are that the abortion be "performed . . . under safe, clinical conditions," as *Menillo* made clear (423 U.S. at 10), and that "this important decision has in fact been made by the person constitutionally empowererd to do so," as made clear in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52, 66 (1976) (*quoting* the district court judge dissenting in part and concurring in part, 392 F.Supp. 1362, 1374 [1975]). It is wholly appropriate, therefore, for this Court to follow its precedents in *Roe, Jones* and *Rodriguez* establishing a lesser level of scrutiny for state regulations that are directed at the enhancement, rather than the impedence, of the exercise of a fundamental constitutional right.

Workers Party, 440 U.S. 173, 188-189 (1979), he observed that a requirement that a law use the "least drastic means" to achieve its end "is a slippery slope and also a signal of the result the Court has chosen to reach. A judge would be unimaginative indeed if he could not come up with something a little less 'drastic' or a little less 'restrictive' in almost any situation, and thereby enable himself to vote to strike legislation down."

A holding by this Court reversing *Roe* v. *Wade* by requiring regulations that genuinely further maternal health to be "narrowly drawn," to be neither "overinclusive" nor "underinclusive," and to use only the "least restrictive means" to achieve their ends would produce a chaotic situation. Women could conceivably undergo abortions performed by expert nonphysicians in relative safety. Thus, although contrary to this Court's holding in *Menillo,* under a "narrowly drawn" requirement the State would be compelled to permit expert nonphysicians to perform abortions. Similarly, whenever it established regulations to protect maternal health the State would be required to promulgate different standards for different physicians depending on their varying degrees of skill—perhaps continuing to require physicians of lesser ability to perform abortions in hospitals, while permitting more proficient physicians to perform them in clinics. The degree of the doctor's skill would dictate the degree to which his or her clinic could be required to be equipped. Moreover, each individual woman's physical condition would dictate the setting in which the State could specify that she must obtain an abortion—the State could require only that certain women in certain situations at certain stages of pregnancy must have their abortions performed in hospital settings or

by specialists.[7] Obviously, such fine distinctions would be virtually impossible for the State to specify, much less administer.

Furthermore, the extremely refined case-by-case analysis required by the "narrowly drawn" test would transform the courts into medical review boards, re-evaluating statutes with the publication of each new medical study, acting effectively as legislative committees or administrative hearing boards. Such a situation might perhaps be justified if the legislation at issue were based solely upon interests clearly adverse to the exercise of a fundamental constitutional right. But it would be perverse, counterproductive, and unjustified in the case of legislation genuinely designed to enhance the exercise of such a right.

Considerations of law and policy thus demand that when it has been established that an abortion law genuinely serves the State's interest in maternal health—an interest congruent with that of the pregnant woman—then the Court should apply the "reasonable relationship" test specified by *Roe* v. *Wade,* and not the "narrowly drawn" test suggested by Simopoulos, certain amici, and the

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[7] An example of the impossible rigor with which the "narrowly drawn" test can be applied is provided by the First Circuit's invalidation of abortion informed consent requirements partly on the ground that *some* of the women to whom information is required to be conveyed *might* already be aware of that information. *Planned Parenthood League of Massachusetts* v. *Bellotti,* 641 F.2d 1006, 1016 (1st Cir. 1981). The court apparently reasoned that unless the State somehow arranges simultaneously to provide each item of information to all those women who are not yet aware of it and to withhold each item from all those women who are already aware of it, its informed consent regulations are not "narrowly drawn." The court did not explain how the State might discover whether or not a woman is aware of the information without providing it to her in some form in the first place.

plaintiff in *Planned Parenthood Ass'n. of Missouri* v. *Ashcroft,* 655 F.2d 848 (8th Cir. 1981), *cert. granted,* 102 S.Ct. 2267 (1982).

2. The Virginia Hospitalization Requirement Meets The "Rational Relationship" Test.

At trial, Simopoulos's own witnesses testified that saline instillation has the potential for serious complications and that the full resources of a hospital can be advantageous in dealing with them. Dr. Harold Schulman noted that saline instillation can lead to blood clotting problems. "[B]ecause of the danger that's inherent in this whole process," Dr. Schulman sends his own saline patients to the hospital for their saline-induced labor. *Simopoulos* v. *Commonwealth,* 277 S.E.2d 194, 202-203 (1981). Another defense witness, Dr. Thomas Gressinger, testified that hypernatremia is a risk when saline is instilled too rapidly, and that the saline process "should be closely supervised." *Id.* at 203. Because a hospital "is set up for close supervision," he sends his own patients there. *Id.*

Major complications of saline amniocentesis abortion include coagulopathy, hemorrhage, transfusion, cervical and uterine rupture, seizures secondary to eclampsia, hysterotomy, hysterectomy, peritonitis, fever, nausea, vomiting, diarrhea, and retained placenta. McDonald & Aaro, *Medical Complications of Induced Abortions,* 67 Southern Med. J. 560 (1974); Walton, *Immediate Morbidity on a Large Abortion Service,* N.Y. State J. Med. 919 (April 15, 1972); Sehgal, Parr & Haslett, *Clostridium Infection After Intra-amniotic Hypertonic Saline Injection for Induced Abortion,* 8 J. Reprod. Med. 67 (1972).

Virginia does not require that post-first trimester abortions must be performed in a general hospital; an outpatient surgical hospital is sufficient to satisfy the statute. This requirement that late-term abortions must

be performed either in a general hospital or in an outpatient facility inspected and evaluated to ensure that it conforms to the Department of Public Health's Rules and Regulations for the Licensure of Outpatient Hospitals in Virginia (1977) is reasonably related to the protection of maternal health. Outpatient hospitals operated in accord with Virginia's Rules are better equipped to prevent, to identify, and to treat complications arising from saline abortions than a physician's office or unlicensed clinic.

One extremely serious complication of saline abortion is clostridium infection, which can be fatal within 24 to 48 hours. Sehgal, Parr & Haslett, *supra* p. 14; Strum, Tade & Shires, *Post-abortal Septicemia Due to Clostridium Welchii Treatment with Exchange Transfusion,* 122 Archives Internal Med. 73 (1968); Lee, Hills & Brudenell, *Management of Abortion Complicated by Clostridium Welchii Infection and Acute Renal Failure,* 20 British J. Clin. Pract. 169 (1966). Significant portions of the Virginia Regulations (§§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, and 52.2.13) 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.

Attempting a saline abortion without confirmation that the patient is pregnant rather than having a fibroid or hydatidiform mole can have fatal consequences. Frost, *Death Following Intra-amniotic Injection of Hyptertonic Saline in a Case of Hydatidiform Mole,* 101 Am. J. Obstet. & Gynecol. 342 (1968). The outpatient surgical hospital licensing requirements provide for a pre-admission pregnancy test (§§43.6.2, 43.8.4 and, 64.1.3[a] and for sufficient time before starting the surgery to review the results of lab tests (§43.8.3).

Performance of a saline abortion is contraindicated on a woman with diabetes or renal disease. Walton, *supra* p. 14 at 920. Under Rules §§43.6.2 and 64.1.3(e), urinalysis for blood sugar and albumin is required before an abortion is begun, thus increasing the probability that these conditions will be identified before it is too late.

Hemorrhage is one of the complications of saline. Berger, Edelman & Kerenyi, *Oxytocin Administration Instillation-to-Abortion Time, and Morbidity Associated with Saline Instillation,* 121 Am. J. Obstet. & Gynecol. 941 (1975); Kerenyi, Mandelman & Sherman, *Five Thousand Consecutive Saline Inductions,* 116 Am. J. Obstet. & Gynecol. 593 (1973). Rules §§43.6.2 and 64.1.3(b) require an outpatient surgical hospital to make hemoglobin or hematocrit determinations before initiating instillation: a low blood count can contraindicate saline abortion because of the increased danger should an abortion-related hemorrhage occur.

More generally, §41.2.3 requires each outpatient surgical hospital to establish minimal criteria for evaluation of patients before admission. This assures that diagnostic screening will take place and that there will be some uniformity in the physical status of individuals prior to undergoing the abortion procedure.

Anesthesia complications are among the major problems of the abortion procedure. Messer, *Medical Indications for Pregnancy Interruption,* in Pregnancy Termination 303, 305 (1979) (Table 38-4). By insuring minimal standards of physician competency and that an experienced, licensed physician is present for monitoring functions during the administration of anesthetics and in the recovery period, Rules §§43.1.1 and 43.1.2 increase the probability that severe complications from anesthesia can be avoided or alleviated.

Another set of Rules relate to the early and accurate identification of complications. Rule §43.9.2 requires a minimum period in the recovery room of 60 minutes for each patient; Rule §43.9.4 requires that patients be released for discharge only by a physician; Rules §§43.9.3 and 42.2.3 require that a physician and a registered nurse be on the premises throughout operation and recovery, and that a licensed nurse trained in emergency procedures supervise the recovery room. During and following the abortion procedure complications such as hyper- or hypotension, bleeding, nausea, vomiting, confusional states or headaches could be reasonably monitored by the registered nurse on duty during the time the facility is in use. This would go a long way toward identifying and alleviating such complications. (Fever, which is not necessarily present immediately following the abortion procedure, is an important clinical sign of infection and would be detected during the recovery period through monitoring by a registered nurse.) The required one-hour recovery period is a reasonable and necessary minimum. Kerenyi, Mandelman & Sherman, *supra* p. 16, report, "One of the patients first developed shortness of breath and hypotension. In the absence of hemorrhage, the diagnosis of amniotic fluid embolism was entertained. Blood drawn subsequently confirmed hypofibrinaginemia. *Within an hour* she developed the clinical picture with nose and gum bleeding and uterine hemorrhage." (Emphasis added.)

The third and perhaps the most important set of Rules relate to the ability to treat complications when they do occur. One of the most serious complications associated with saline instillation, hypernatremia, can occur when the salt solution is injected not only into the amniotic sac, but also into maternal tissue close to a blood vessel. Cameron & Dayan, *Association of Brain Damage with Therapeutic Abortion Induced by Amniotic Fluid Replacement,* 5494 Br. Med. J. 1010 (1966).

Resultant hypernatremia can lead to convulsions, sometimes producing aspiration of stomach contents into the lungs and subsequent asphyxiation. Rule §43.51 provides for a suction apparatus to deal with this possibility. This condition and others leading to difficulty in breathing can be treated properly if the facility has the oxygen supplies required by §43.51. Similarly, hemorrhaging could produce cardiovascular collapse, necessitating the resuscitation equipment also required by §43.51.

These and other possibilities justify the Rules and Regulations (§§43.5.2 and 43.5.3) that require an outpatient surgical hospital to maintain a transfer agreement with a general hospital "capable of providing full surgical, anesthesia, clinical laboratory, and diagnostic radiology service on thirty (30) minutes notice."

Disseminated intravascular coagulation (DIC) or coagulopathy is believed to occur at the rate of at least 3 per 1,000 cases in clinical practice. It has actually been found to occur in *every* saline abortion to some degree when complete coagulation profiles are performed in the laboratory. Kerenyi & Den, *Intra-amniotic Instillation of Saline and Prostaglandin for Midtrimester Abortion,* in Pregnancy Termination 254 (1979); Cohen & Ballard, *Consumptive Coagulopathy Associated With Intra-amniotic Saline Instillation and the Effect of Intravenous Oxytocin,* 43 Obstet. & Gynecol. 300 (1974). If sufficiently severe, coagulopathy may require blood transfusions and carefully monitored intravenous heparin necessitating rapid transfer to a general hospital.

A study by Csapo, *The Termination of Pregnancy by the Intra-amniotic Injection of Hypertonic Saline,* 1966-1967 Yearbook of Obstetrics and Gynecology (Greenhill ed. 1967), showed that the peak uterine pressure during saline induced abortion was sometimes greater than that

recorded during normal term delivery. This, combined with the fact that uterine contractions during saline abortion may be exaggerated, asynchronis or otherwise abnormal, makes it possible to develop such complications as uterine rupture and cervical vaginal fistula. Gordon, *Cervicovaginal Fistula as a Result of Saline Abortion,* 112 Am. J. Obstet. & Gynecol. 578 (1972). Such conditions mandate immediate laparotomy—surgery which must be done in a general hospital.

Thus, Virginia's requirement that late term abortions be performed only in a general hospital or in a facility meeting the qualifications of an outpatient surgical hospital as defined by the Rules is reasonably related to maternal health.

In *Planned Parenthood* v. *Danforth,* three members of the Court agreed that if two modes of abortion were available, then "the United States Constitution would not prevent the State legislature from outlawing the one it found to be the less safe *even though its conclusion might not reflect a unanimous consensus of informed medical opinion.*" *Id.* at 101-102 (Stevens, J., concurring in part and dissenting in part) (emphasis added); adopted by Justices Powell and Stewart, *id.* at 92 (concurring opinion). Although the testimony of the physicians called by the defendant at trial may demonstrate the absence of unanimous agreement in the medical profession that 20 week saline abortions should be confined to hospitals, there is certainly medical support for that view. Indeed, in the companion case of *Planned Parenthood* v. *Ashcroft,* the chief executive officer of plaintiff Reproductive Health Services testified that all post-first trimester abortions other than dilation and evacuation abortions should be performed in hospitals. *Planned Parenthood Ass'n* v. *Ashcroft,* 483 F.Supp. 679, 685 n. 8 (W.D. Mo. 1980).

In the words of Justice Stevens, the existence of a state's "compelling interest"—here the interest in ma-

ternal health—"compels a court, before holding a law unconstitutional, to give thoughtful attention to a legislative judgment that the law will serve that interest. . . ." *Caban* v. *Mohammed,* 441 U.S. 380, 402-403 n. 3 (1979) (Stevens, J., dissenting). This Court does not sit as a medical review board to determine which of contending medical opinions is most likely to be correct. "Although the constitutional principle at least requires a legitimate and relevant reason and . . . perhaps even a substantial reason, it does not require the reason to be one that a judge would accept if he were a legislator." *Id.* at 415.

Even if diverse medical opinion about the wisdom of consigning saline instillation abortions at 20 weeks of pregnancy to hospitals exists, therefore, the evidence of the dangers associated with saline abortion and the greater capacity of hospitals to deal with these dangers makes the Virginia hospitalization requirement one that "reasonably relates to the preservation and protection of maternal health" (*Roe,* 410 U.S. at 163) when applied to the facts of this case.

III.

CONSEQUENCES THAT FLOW FROM THE FAILURE OF HOSPITALS TO PROVIDE UNRESTRICTED POST-FIRST TRIMESTER ABORTION SERVICES ARE NOT THE RESULT OF "STATE ACTION" AND ARE, THEREFORE, CONSTITUTIONALLY IRRELEVANT.

Simopoulos suggests that when a state-imposed hospitalization requirement is coupled with a subsequent failure of private hospitals to provide abortion services, the "burden" imposed by statutory hospitalization requirements is transformed into what is tantamount to a state-imposed *prohibition* on post-first trimester abortions. Brief for Appellant, at 31, 33-34 (arguing that the Virginia law imposes a special "burden" on the right to

abortion and the right to travel because many Virginia hospitals do not provide unrestricted abortion services and some require parental consent). *See also Planned Parenthood* v. *Ashcroft,* 483 F.Supp. 679, 687-88 (W.D. Mo. 1980); *M.S.* v. *Edwards,* 488 F.Supp. 181, 194 (E.D. La. 1980). According to this line of reasoning, even if such hospitalization requirements reasonably relate to the State's interest in maternal health, they must be struck down.

This rationale is fatally defective under the "state action" decisions of this Court. The independent decisions of private hospitals to refuse to provide unrestricted post-first trimester abortion services cannot be imputed to the State by virtue of a law that merely requires that abortions must be performed in hospitals. For this reason, whether hospitals provide abortion services only under certain restrictions, such as parental consent—or, indeed, whether they provide any abortion services at all—are constitutionally irrelevant considerations.

State action analysis is also crucial to the proper resolution of the hospitalization requirements at stake in *Planned Parenthood* v. *Ashcroft* and *Akron Center for Reproductive Health* v. *City of Akron,* 651 F.2d 1198 (6th Cir. 1981), *cert. granted,* 102 S.Ct. 2266 (1982), as well as the waiting period requirement at issue in *Akron.* Lower courts have frequently held 24-hour and 48-hour waiting periods unconstitutional on the basis of holdings that the delay they place upon the effectuation of the abortion decision consists not only of the statutory period, but also of additional days added by private abortion clinics' scheduling methods or locations. For example, in *Women's Medical Center of Providence* v. *Roberts,* 530 F.Supp. 1136, 1146 (D. R.I. 1982), the court concluded, "Although a mere twenty-four hour delay by itself may

not increase the risk of an abortion to a statistically significant degree, . . . the mandatory wait may combine with other scheduling factors such as doctor availability, work commitments, or sick leave availability, to increase the actual waiting period to a week or more.'' *See also Planned Parenthood League of Massachusetts* v. *Bellotti,* 641 F.2d 1006, 1014 (1st Cir. 1981) (''combination of a woman's schedule and the schedule of her abortion clinic may often serve to produce 'a substantially longer delay' than [statutory period of] 24 hours''); *Charles* v. *Carey,* 627 F.2d 772, 785 (7th Cir. 1980) (''in light of other practical limitations on women's access to abortions . . . the 24 hour mandatory waiting period produces in many cases a substantially longer delay''); *Women's Services* v. *Thone,* 636 F.2d 206, 210 (8th Cir. 1980) (''only abortion clinics in Nebraska are in the Omaha area and, therefore, the waiting period would increase . . . the time necessary for an abortion, especially for women from western Nebraska''); *Leigh* v. *Olsen,* 497 F.Supp. 1340, 1347 (D. N.D. 1980) (''It does not appear that the 48 hour waiting period would cause a significant increase in morbidity but the risks . . . would be increased if . . . required to wait four days[;] [b]ecause [plaintiff's physician] does not work on weekends, a patient may have to wait four days, from Thursday to Monday, before the abortion is performed.''); *M. S.* v. *Edwards,* 488 F.Supp. 181, 212 (E.D. La. 1980) (24-hour waiting period unconstitutional; ''delays will be three to five days because of weekends and because some clinics are not open five days a week''); *Women's Community Health Center* v. *Cohen,* 477 F.Supp. 542, 550-51 (D. Me. 1981) (''mandatory 48-hour waiting period in practice will delay some abortions . . . perhaps as long as a week, because of scheduling difficulties at the abortion facility and in the patient's life'').

Delays created by the operating schedules or the location of private clinics, or by women choosing abortions, cannot be fairly imputed to the State, however, for the purpose of determining the degree of burden created by such waiting period requirements.

Sound constitutional adjudication requires close attention to what consequences flow from "state action" and what consequences flow from unrelated private decisions and conduct. The former may be conceived as "burdens" on the right to abort, while the latter lack constitutional significance. Particularly close attention to this distinction is warranted in the present context since hospitalization requirements have typically been attacked as "burdensome" because of the limited abortion access that may result from *private* decisions to fail to provide abortion services.

A.

The Hospitalization Requirement Does Not Transform Hospitals' Actions Into State Actions.

The right to abortion arises under the Fourteenth Amendment (*Roe* v. *Wade,* 410 U.S. at 153), and the Fourteenth Amendment applies only as against the State. "That Amendment erects no shield against merely private conduct, however discriminatory or wrongful." *Shelley* v. *Kraemer,* 334 U.S. 1, 13 (1948). Thus, only "state actions" can be said to violate or "burden" the right to abort.

The independent decisions of hospitals to refuse to provide unrestricted abortion services are not the decisions of the State. They are *private* decisions. "[C]onstitutional standards are invoked only when it can be said that the State is responsible for the specific conduct . . . when . . . the complaining party seeks to hold the State liable for

actions of private parties." *Blum* v. *Yaretsky,* 102 S.Ct. 2777, 2786 (1982). Simopoulos maintains "the fact that the Commonwealth first channels all second trimester abortions into the hospitals, and then imposes felony sanctions on those who cannot or do not use the hospital," makes Virginia constitutionally accountable for the actions of hospitals that fail to make abortion unrestrictedly available. Jurisdictional Statement at 20. But in *Blum,* when the State of New York channelled all Medicaid patients seeking nursing home care through physicians who could determine whether such care was "medically necessary" and hence eligibile for Medicaid, this Court did not impute to the State the actions of the physicians in making such determinations. "We cannot say that the State, by requiring completion of a form [making a determination about medical necessity], is responsible for the physician's decision." *Blum,* 102 S.Ct. at 2787. *Accord Moose Lodge No. 107* v. *Irvis,* 407 U.S. 163, 173 (1972) (State's issuance of liquor license to private club, coupled with state prohibition of the sale of liquor without a license, did not make club's refusal to serve black guest "state action").

"[T]he inquiry must be whether there is a sufficiently close nexus between the State and the challenged *action* . . . so that the *action* . . . may be fairly treated as that of the State itself." *Jackson* v. *Metropolitan Edison Co.,* 419 U.S. 345, 351 (1974) (emphasis added). Here, there is no nexus at all between a state statute prohibiting post-first trimester abortions outside of hospitals and the independent decision of hospitals not to perform abortions.

It follows, therefore, that neither the failure of hospitals to provide abortion services nor the consequences that flow from such failure may be imputed to a state law that requires hospitalization for abortion.

A ruling to the contrary would lead to extraordinary results. If requirements that post-first trimester abortions may be performed only in hospitals made decisions of hospitals not to perform abortions "state action," it would be equally true that the requirement that abortions at any stage of pregnancy may be performed only by physicians would make any private physician's refusal to perform an abortion "state action." This would lead to the striking of physician-performance requirements—although they have been upheld in *Roe,* 410 U.S. at 164, and in *Connecticut* v. *Mennilo,* 423 U.S. at 10—in areas where many of the practicing physicians are anti-abortion just as Simopoulos contends in this case that state hospitalization requirements must be stricken in areas where hospitals fail to provide abortion services.

The prior decisions of this Court, however, preclude such results. "Our precedents indicate that a State normally can be held responsible for a private decision only when it has exercised coercive power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State." *Blum,* 102 S.Ct. at 2786. But, obviously, post-first trimester hospitalization requirements neither coerce nor significantly encourage hospitals to refuse to provide unrestricted abortion services. Thus, the decisions of hospitals to fail to provide abortion services and the consequences that flow from these decisions may not be deemed to be those of the State or of a state hospitalization requirement.

The action of the Court in *Planned Parenthood* v. *Danforth,* 428 U.S. at 75-79, voiding a statutory ban on saline abortions partly because the alternative prostaglandin method of post-first trimester abortion was not available in Missouri, is not to the contrary. There is a fundamental distinction between the near impossibility of obtaining what the *Danforth* Court found to be only an experimental

technique—and thus effectively tantamount to a physically nonexistent technique—and whatever difficulty may be experienced in obtaining a physically possible technique that providers simply choose not to use. For the purposes of "state action" analysis, this difference is essentially one of causation. A state law that, in effect, prohibits abortion except when it is performed in a particular manner that is physically impossible is the direct and proximate cause of the resultant unavailability of abortions. But when a state law justifiably requires that abortions be performed in a particular manner that *is* physically possible and those with the capacity to perform it choose not to do so, then their choice introduces an intervening and supervening cause, and the resultant unavailability of abortions cannot be ascribed to the state law. When the impact on abortion availability follows directly from the law's interaction with the irreducible physical facts (as was the case with Missouri's ban on saline abortions), then the result may fairly be imputed to the State. When, however, the impact on abortion availability is wholly dependent on the separate decisions of private actors exercising independent volition (as is the case with Virginia's hospitalization requirement), then the result may not be imputed to the State.

It must be concluded, therefore, that the reasoning the *Danforth* Court applied to Missouri's saline ban has no application to this case. Since state laws that restrict abortion to hospitals do not require or even encourage hospitals to fail to provide abortion services, any "burdens" on the exercise of the right to abortion that might result from hospital decisions to abstain from abortion practices cannot be imputed to such hospitalization requirements. Consequences that flow from the failure of hospitals to provide abortion services are the result of private action, not "state action."

B.

The Virginia "Conscience Clause" Law Does Not Render Private Hospitals' Refusals To Provide Abortions Actions That May Be Imputed To The State.

Simopoulos argues that the hospitalization requirement "drastically limits" a Virginia woman's access to midtrimester abortion services because "[t]he Commonwealth also authorizes hospitals to prohibit performance of all abortions. Va. Code Sec. 18.2-75." Jurisdictional Statement at 15. The existence of a Virginia "conscience clause" law that protects individuals and the institutions they operate from being coerced to participate in an activity that may profoundly offend deeply held ethical beliefs does not, however, transform the conscience-based decisions of private individuals and the institutions they operate into "state action" that burdens the abortion right. "Mere approval of or acquiescence in the initiatives of a private party is not sufficient to justify holding the State responsible for those initiatives under the terms of the Fourteenth Amendment." *Blum,* 102 S.Ct. at 2786.

In *Jackson* v. *Metropolitan Edison* this Court considered a claim that a termination of electrical service by a private utility under rules specifically approved and authorized by the Pennsylvania Utility Commission constituted state action subject to review under the Fourteenth Amendment's due process clause. The Court squarely held that the State Commission's approval of the applicable utility termination rules "where the commission has not put its own weight on the side of the proposed practice by ordering it, does not transmute a practice initiated by the utility and approved by the commission into 'state action.' At most, the Commission's [action] amounted to no more than a determination that a Pennsylvania utility was authorized to employ such a practice if it so desired. [The private

party's] exercise of the choice allowed by law where the initiative comes from it and not from the State, does not make its action in doing so 'state action' for purposes of the Fourteenth Amendment.'' 419 U.S. at 357 (footnote omitted).

The situation in *Jackson* is precisely analogous to the Virginia conscience clause law, which in no way urges or compels any private individual or institution to choose to exercise the choice the statute authorizes.

Arguments that post-first trimester hospitalization requirements and ''conscience clause'' laws ''prohibit'' or ''burden'' exercise of the right to abortion because hospitals themselves fail to provide convenient, inexpensive, or expeditious abortion services must, therefore, be disregarded as constitutionally irrelevant. A state law may not be stricken simply because private parties willfully refuse to provide a service that would otherwise serve public health interests.

CONCLUSION

This Court should adhere to the standards it announced in *Roe* v. *Wade* for evaluating the constitutionality of post-first trimester state regulations of abortion on behalf of maternal health.

Because maternal mortality from saline instillation at the period in pregnancy when Simopoulos performed the abortion for which he was convicted exceeds maternal mortality from childbirth according to the most recent available official national statistics, Virginia's interest in maternal health is ''compelling'' under *Roe*. There are significant complications potentially associated with saline abortions and the requirements Virginia specifies for outpatient sur-

gical hospitals may reasonably be said to decrease the risk of the development of those complications or to increase the chance that they will be controlled if they do occur. Thus, the Virginia law that prohibited Simopoulos from performing a 20 week saline abortion outside such a licensed facility or a general hospital "reasonably relates to the preservation and protection of maternal health" (410 U.S. at 163) and is, therefore, constitutional under *Roe* v. *Wade.*

Since regulations that genuinely advance maternal health enhance rather than impede the liberty recognized in *Roe,* the Court should not overturn *Roe* and require that such regulations be "narrowly drawn." Nor should the Court, contrary to the principles of *Blum* v. *Yaretsky* and of its other "state action" precedents, impute to Virginia the independent decisions of private hospitals concerning whether or under what conditions to provide abortions.

Because the Virginia hospital requirement is constitutional under this Court's clearly articulated precedents, Simopoulos's conviction should be affirmed.

Respectfully submitted,

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