# No. 81-1623

# In the Supreme Court of the United States

OCTOBER TERM, 1982

**JOHN ASHCROFT**, Attorney General of the State of Missouri, and **RALPH L. MARTIN**, Prosecuting Attorney of Jackson County, Missouri,

*Petitioners,*

v.

**PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH SERVICES, and ALLEN S. PALMER, D.O.,**

*Respondents.*

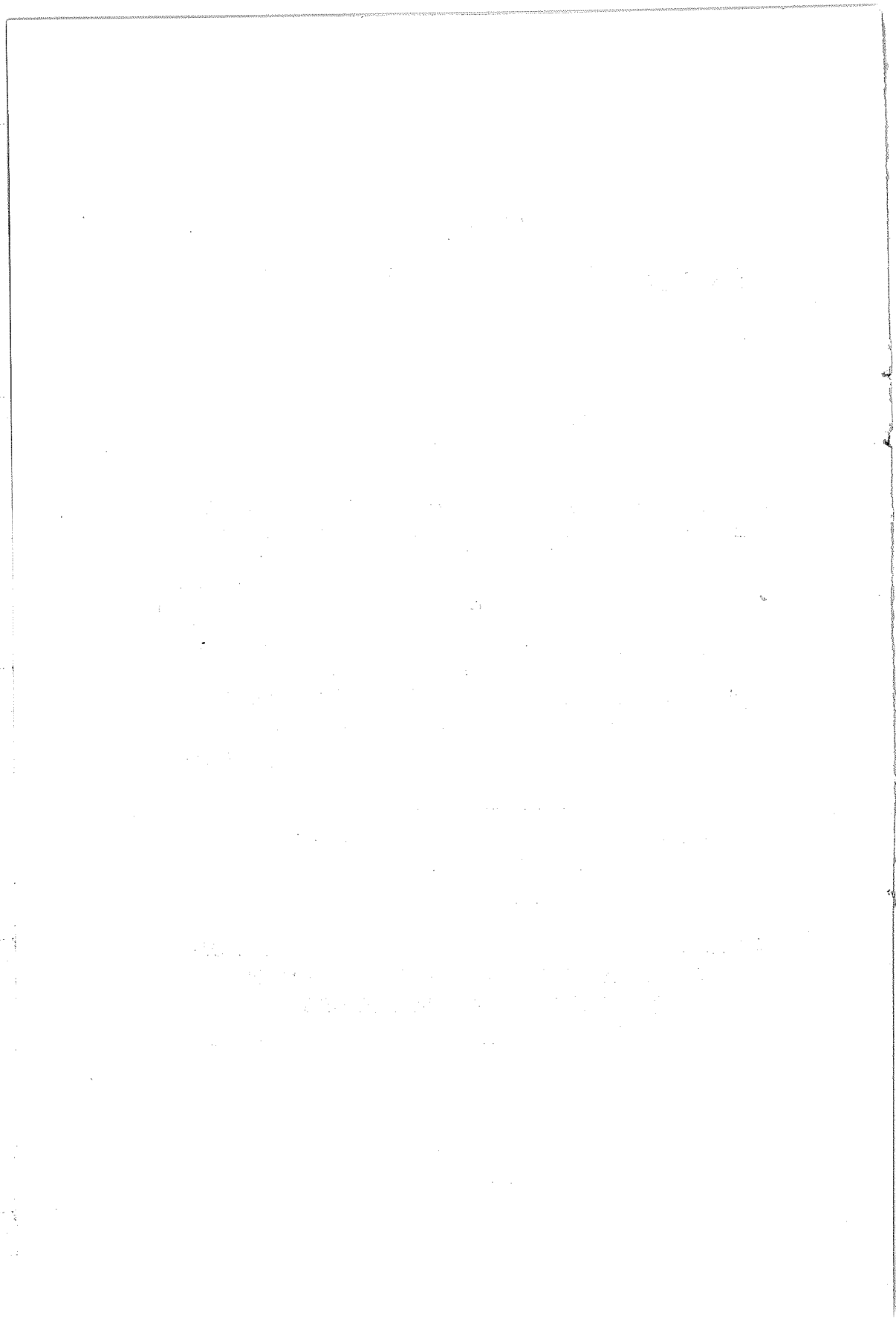
On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

## MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE OF AMERICANS UNITED FOR LIFE IN SUPPORT OF PETITIONERS

DENNIS J. HORAN
VICTOR G. ROSENBLUM
PATRICK A. TRUEMAN
THOMAS J. MARZEN
MAURA K. QUINLAN
230 N. Michigan—Suite 915
Chicago, IL 60601
312/263-5029

*Attorneys for Americans United for Life*

UNITED STATES LAW PRINTING CO., CHICAGO, ILLINOIS 60618 (312) 525-6581



## MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE

Americans United for Life hereby respectfully moves for leave to file the attached brief amicus curiae in support of petitioners in this case. Written consent of the petitioners has been obtained and filed with the Clerk of this Court. The consent of the attorney for respondents was requested but refused.

Americans United for Life (AUL) is a national educational foundation organized to promote better understanding of the humanity and value of unborn human life, and to assure equal protection under law for all members of the human family regardless of age, health, or condition of dependency. The national office of Americans United for Life is located in Chicago, Illinois. AUL is supported by thousands of Americans from every state of the union.

This case, like others presently to be considered by this Court, involves consideration of several broad areas of abortion regulation, including the health regulation of first trimester abortions (specifically through the requirement of pathology reports), the health regulation of post-first trimester abortions (specifically through the hospitalization requirement), and the protection of live-born children in post-viability abortions (specifically through the requirement that a second physician attend the procedure). This Court's decision will have a profound effect nationally on the validity of abortion regulations, and thus is of central importance to the class of unborn children, as well as the class of children aborted alive, all of whose interests AUL seeks to promote.

# TABLE OF AUTHORITIES

*Cases*

*Other Authorities*

PAGE

# In the Supreme Court of the United States

OCTOBER TERM, 1982

## No. 81-1623

**JOHN ASHCROFT, Attorney General of the State of Missouri, and RALPH L. MARTIN, Prosecuting Attorney of Jackson County, Missouri,**

*Petitioners,*

v.

**PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., NAIM S. KASSAR, M.D., REPRODUCTIVE HEALTH SERVICES, and ALLEN S. PALMER, D.O.,**

*Respondents.*

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

# BRIEF AMICUS CURIAE OF AMERICANS UNITED FOR LIFE IN SUPPORT OF PETITIONERS

## INTEREST OF THE AMICUS

Americans United for Life (AUL) is a national educational foundation organized to promote better understanding of the humanity and value of unborn human life, and to assure equal protection under law for all members of the human family regardless of age, health, or condition of dependency. The national office of Americans United for Life is located in Chicago, Illinois. AUL is supported by thousands of Americans from every state of the union.

The Board of Directors and Officers of Americans United for Life include the following:

Should this Court apply strict scrutiny, the hospitalization requirement remains constitutional. Complication rates for abortion increase dramatically after the first trimester. Hospitals possess such vital facilities as blood banks and intensive care units available on a 24-hour basis. This allows for maximum treatment capacities, and a hospitalization requirement thus directly furthers the staate's compelling interest in maternal life and health.

The abortion regulations at issue before this Court are well within constitution limits, and represent the state's pursuit of legitimate, indeed compelling interests. They must be upheld.

## ARGUMENT

### I.

### STRICT SCRUTINY IS NOT THE APPROPRIATE STANDARD OF REVIEW FOR THE CHALLENGED PROVISIONS.

Respondents challenge Missouri's statutory post-abortion pathology report requirement, its post-first trimester abortion hospitalization requirement, and its requirement that a second physician be present for post-viability abortions. Review begins with the threshold question of whether the regulations at issue impinge upon any fundamental right. *Maher* v. *Roe,* 432 U.S. 464, 470 (1977). If they do, strict scrutiny is appropriate. *Id.* If not, the regulations face "the less demanding test of rationality." *Id.* at 478.

#### A. Strict Scrutiny Is Only Appropriate When Legislation Substantially Burdens the Woman's Freedom to Decide.

Whether abortion regulations impinge upon a woman's right to choose—i.e., whether they trigger strict scrutiny —depends upon whether such regulations "substantially limit access to the means of effectuating that decision." *Carey* v. *Population Services International,* 431 U.S. 678, 688 (1977). Such substantial burdens* on the abortion

* By "substantial burden" is meant a state-imposed restriction on the exercise of a right which is sufficiently burdensome so as to constitute an impingement, thus triggering strict scrutiny. To withstand strict scrutiny, the restriction must be justified by a sufficiently compelling interest. Otherwise, the restriction constitutes an "undue burden" and is unconsitutional. An "insubstantial burden" is a restriction with an impact that is insufficient to trigger strict scrutiny.

right appear only in certain limited contexts, viz., total prohibitions, *see Roe* v. *Wade,* 410 U.S. 113 (1973), regulations "almost tantamount to a prohibition," *see Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52, 92, 102 (1976) (concurring opinions of Stewart, J., and Stevens, J.), and absolute third-party vetoes, *see, e.g., Bellotti* v. *Baird,* 443 U.S. 622, 643 (1979) (*Bellotti II*).

Strict scrutiny is not required merely because some individuals will be "discouraged" from exercising a specific choice. *See Whalen* v. *Roe,* 429 U.S. 589, 602-603 (1977). In such a case, there is no absolute or near absolute prohibition. Nor is there a blanket third-party veto. Therefore, it cannot "be said that any individual has been deprived of the right to decide independently." *Id.* at 603.

Similarly, a substantial burden on the abortion decision is not created by a statutory requirement merely because it might increase the cost of an abortion. In *Danforth,* this Court held that recordkeeping and reporting requirements, which certainly add to the cost of an abortion, did not have a "legally significant impact or consequence on the abortion decision," 428 U.S. at 81, and thus did not trigger strict scrutiny. *See also Connecticut* v. *Menillo,* 423 U.S. 9 (1975) (requirement that a licensed physician perform the abortion). These cases make it clear that strict scrutiny should be "invoked only when the state regulation *entirely frustrates or heavily burdens* the exercise of constitutional rights in this area." *Carey* v. *Population Services International,* 431 U.S. 678, 705 (1977) (Powell, J., concurring in part and concurring in the judgment) (emphasis added).

### B. Strict Scrutiny May Not Be Invoked Merely Because Abortion Is Treated Differently Than Other Medical Procedures.

The mere differential treatment of abortion from other medical procedures does not trigger strict scrutiny. Equal protection analysis applies strict scrutiny to the disparate treatment of a suspect class of *individuals* based on their *status*. But abortion implicates no suspect class. *See Maher* v. *Roe,* 432 U.S. at 470. Moreover, differential treatment of *procedures* cannot be equated with differential treatment of *individuals*. Hence, strict scrutiny cannot be invoked under equal protection principles when abortion is treated differently than other medical procedures.

Even so, in the context of its analysis of the post-abortion pathological report requirement, the court of appeals apparently invoked strict scrutiny merely because abortion had been singled out and treated differently than other medical procedures:

> *"Where the state regulates abortions beyond its regulation of similar surgical procedures, that difference in treatment must be shown to be necessitated by the particular characteristics of the abortion procedure. See Word* v. *Poelker,* [495 F.2d 1349, (8th Cir. 1974)]." *Hodgson* v. *Lawson,* 542 F.2d 1350, 1357-58 (8th Cir. 1976) (emphasis added, footnote omitted).
>
> . . .
>
> [T]he question here is whether Missouri has shown any reason why the physicians and medical facilities performing abortions cannot make medical judgments about the desirability of a pathology report in an individual case, while physicians and medical facilities performing all other types of surgery are free to exercise their professional judgment.

*Planned Parenthood Association of Kansas City, Missouri* v. *Ashcroft,* 655 F.2d 848, 870 (8th Cir. 1981).

This Court has repeatedly rejected such an analysis. In *Planned Parenthood of Central Missouri* v. *Danforth,* the plaintiffs argued "that the State should not be able to impose any recordkeeping requirements that significantly differ from those imposed with respect to other, and comparable, medical or surgical procedures." 428 U.S. 52, 80-81 (1976). This Court rejected that argument and sustained the requirements. *Id.* The Court reaffirmed this holding in the context of consent provisions, *Bellotti* v. *Baird,* 428 U.S. 132, 148-150 (1976), and Medicaid funding, *Maher* v. *Roe,* 432 U.S. 464, 473 (1977). More recently, this Court has stressed that "the unique nature and consequences of the abortion decision" fully justifies special treatment. *Bellotti* v. *Baird,* 443 U.S. 622, 643 (1979) (*Bellotti II*). In a still more recent case, this Court dispensed of the equal protection analysis suggested by the court of appeals in the instant case:

> The guarantee of equal protection . . . is not a source of substantive rights or liberties, but rather a right to be free from invidious discrimination in statutory classifications and other governmental activity. It is well settled that where a statutory classification does not itself impinge on a right or liberty protected by the Constitution, the validity of classification must be sustained unless "the classification rests on grounds wholly irrelevant to the achievement of [any legitimate governmental] objective." *McGowan* v. *Maryland,* 366 U.S. [420, 425 (1961)].

*Harris* v. *McRae,* 448 U.S. 297, 422 (1980) (footnote omitted).

Thus, unless the Missouri regulations at issue here substantially burden the right to choose abortion, they cannot be subjected to strict scrutiny, regardless of whether they treat abortion differently than other medical procedures.

All that the state need demonstrate is that these abortion regulations are not "wholly irrelevant" to the achievement of some valid state interest in order to sustain them against an equal protection attack. Abortion regulations cannot be stricken merely because similar regulations have not been enacted with regard to other medical procedures. As this Court has held, "the Equal Protection Clause does not require that a State must choose between attacking every aspect of a problem or not attacking the problem at all. *Lindsley* v. *Natural Carbonic Gas Co.*, 220 U.S. 61 [(1911)]. It is enough that the State's action be rationally based and free from invidious discrimination." *Dandridge* v. *Williams,* 397 U.S. 471, 486-487 (1970).

### C. The Regulations at Issue Do Not Substantially Burden the Woman's Freedom to Decide; They Rationally Relate to Legitimate State Interests.

#### 1. Requirement of Second Physician.

The court of appeals applied the strict scrutiny test to Missouri's requirement that a second physician attend all post-viability abortions. Noting that this requirement would increase the expense of an abortion, the court of appeals held that "a government-imposed regulation that adds to the cost of abortion is a government-created obstacle and is subject to strict scrutiny." *Planned Parenthood* v. *Ashcroft,* 655 F.2d 848, 864 (8th Cir. 1981).

This broad holding not only conflicts with *Danforth* and *Menillo,* but also with the court of appeals' own holding that strict scrutiny is inappropriate in considering record-keeping requirements even though they raise the price of an abortion. *Id.* at 871. The second physician requirement does not prohibit abortions, as did the regulation before this Court in *Roe* v. *Wade,* 410 U.S. 113 (1973). Nor does

the provision provide for a blanket veto, as in *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976), and *Bellotti* v. *Baird,* 443 U.S. 622 (1979) (*Bellotti II*). Thus a proper analysis of the second physician requirement would address the question of whether the increase in cost is so great as to be "drastically limiting [of] the availability and safety of the desired service." *Maher* v. *Roe,* 432 U.S. 464, 472 (1977).

Post-viability abortions, with their high attendant risks, will almost certainly be performed in a hospital. Given the easy availability of pediatricians in a hospital setting, it is unlikely that the requirement that a second physician attend the abortion procedure will so increase the relative cost of the abortion as to preclude women from choosing to have an abortion. Hence, the regulation does not significantly limit a woman's access to abortion, and cannot be said to place a substantial burden on the woman's right to choose.

Indeed, the second doctor requirement cannot properly be said to implicate the right to abortion at all. It is intended to provide assistance to infants born alive *after* termination of pregnancy, and thus relates to abortion in, at most, a very indirect fashion. The second physician requirement is an *infant care regulation,* not an abortion regulation.

Surely, this Court would not hold that a state requirement that a physician (as opposed to a mid-wife) must attend childbirth in order to assure proper medical attention to newborns "burdens" the right to childbearing. It would not hold that a state requirement that every newborn child must be examined by a physician or that certain drugs or vaccinations must be provided to the child "burdens" the right to childbearing. Neither should it hold

that a state requirement that a second physician be available during a post-viability abortion to assist a surviving child "burdens" the right to choose abortion.

"The remaining question then is whether the [second physician provision] is rationally related to a legitimate governmental objective." *Harris* v. *McRae,* 448 U.S. 297, 324 (1980). Certainly, the state maintains a most compelling interest in the life and health of any infant person born alive as the result of an attempted abortion. The presence of a second physician with the specific duty to care for a child surviving a post-viability abortion significantly furthers this interest since it may be presumed that the physician who attempts to kill the fetus before birth would not actively seek to assist a surviving infant.*

**2. Pathology Reports.**

The court of appeals held that the requirement of pathology reports for all abortions, like the second physician requirement, increased the cost of an abortion. 655 F.2d at 869. As already noted, strict scrutiny does not apply simply because a regulation raises the cost of an abortion. *See Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52 (1976); *Connecticut* v. *Menillo,* 423 U.S. 9 (1975). In *Danforth,* this Court disclaimed the need for strict scrutiny and upheld cost-increasing recordkeeping requirements because they, like the pathology reports at issue here, "can be useful to the State's interest in protecting the health of its female citizens, and may be a resource that is relevant to decisions involving medical experience and judgment." *Id.* at 81 (footnote omitted).

---

* The record clearly indicates the need for a second physician to provide proper care for a child aborted alive. *See* testimony of Dr. Crist. Tr. 431, 435 (woman has a right to a dead fetus; never attempts to save fetus).

Since a minor cost increase is the only effect of this provision on the woman's decision, strict scrutiny should not be applied.

When examined under the rational basis test, the pathology report requirement is clearly constitutional. The state has an "important and legitimate interest in the health of the mother." *Roe* v. *Wade,* 410 U.S. 113, 163 (1973). "[P]athology reports are useful and even necessary in some cases," and "may warn of serious, possibly fatal disorders." *Planned Parenthood* v. *Ashcroft,* 655 F.2d at 870.

As illustrated in the Appendix, pathology reports are crucial in the detection of life-threatening conditions. Without regular pathology reporting, the incidence of maternal deaths from abortion will increase. Complications that pathology reports can detect include uterine perforation, rupture of maternal organs, incomplete abortions, infection and excessive bleeding. Each can lead to maternal death. The report can also warn of such urgent and potentially lethal conditions as ectopic pregnancy, hydatidaform mole (degenerate pregnancy), and choriocarcinoma (a highly malignant cancer). *See* Appendix.

Maternal mortality is a concern central to the right recognized in *Roe,* 410 U.S. at 163 (strength of state interest proportional to mortality rate for abortion and childbirth). Pathology reports, which directly and efficiently reduce the number of abortion deaths, serve the legitimate and compelling state interest in maternal life and health.

### 3. Hospitalization Requirement.

Similar considerations support the constitutionality of the post-first trimester hospitalization requirement. Like the pathology report requirement, this provision aims to enhance maternal health and reduce maternal deaths. It

does not prohibit abortions. It does not provide for an absolute third-party veto, nor does it so increase the cost of an abortion that it would drastically limit access to abortion. Therefore, it cannot be said to substantially burden the woman's decision to have an abortion. Hence, the hospitalization requirement is not subject to strict scrutiny.*

Under the rational basis test, the hospitalization requirement is clearly constitutional. The state has a legitimate—indeed compelling—interest in maternal health after the first trimester. *Roe* v. *Wade,* 410 U.S. 113, 162 (1973). Hospitals, with their superior treatment facilities —including intensive care units, blood banks, and various other equipment (all available 24 hours a day), as well as sizable staffs, including a wide variety of experts and specialists—provide an environment which is especially conducive to the protection of maternal health. Therefore, the post-first trimester hospitalization requirement is rationally related to the legitimate and compelling state interest in maternal health and is constitutional.

## II.

## EVEN UNDER STRICT SCRUTINY ANALYSIS, THE PROVISIONS ARE CONSTITUTIONAL.

Even were this Court to apply strict scrutiny and require a "compelling state interest," these provisions should be upheld. In its general form, the "compelling

---

* *Roe* indicated that a hospitalization requirements might be acceptable after the first trimester. 410 U.S. at 163. This implies that such a requirement could reasonably relate to the state's compelling interest in maternal health. This does not necessarily imply that a hospitalization requirement must always be subjected to strict scrutiny.

interest'' standard states that the ''legislative enactments must be narrowly drawn to express only the legitimate state interests at stake.'' *See Roe* v. *Wade,* 410 U.S. 113, 155 (1973), and cases there cited.

The specific context of abortion rights produces a specific interpretation of the ''narrowly drawn'' requirement. With respect to the state's interest in potential human life, the statute is ''narrowly drawn'' even if the state goes so far as to proscribe all abortions except those performed to preserve the life or health of the mother. *Id.* at 163-164. With respect to the state's interest in maternal health, a regulation is narrowly drawn if it ''*reasonably relates* to the preservation and protection of maternal health.'' *Id.* at 163 (emphasis added).

## A. The State's Compelling Interest in the Life of Infant Persons Justifies the Second Physician Requirement.

### 1. The State Has a Compelling Interest in Actual Human Life.

The state possesses a ''legitimate interest in protecting the potentiality of human life.'' *Roe* v. *Wade,* 410 U.S. 113, 162 (1973). Throughout pregnancy, abortion ''is inherently different'' from other medical procedures ''because no other procedure involves the purposeful termination of a potential life.'' *Harris* v. *McRae,* 448 U.S. 297, 325 (1980). After viability the state's interest becomes ''compelling,'' and, because of the unique importance of this interest, the state ''may go so far as to proscribe abortion . . . except when necessary to preserve the life or health of the mother.'' *Roe* v. *Wade,* 410 U.S. at 163-164.

But when an infant is born or aborted alive, the state's interest becomes complete. At birth, the child becomes a

citizen and a full person under the Constitution. The child receives the full protection of the civil and criminal laws of the states.

The child protected by the second physician requirement possesses *actual,* not just potential human life. The rights under the Constitution of infants who survive abortion are equal to those of their mothers. Certainly, any "right to abortion" in this context cannot be deemed superior to the right of children to continued life. It is even more certain that whatever indirect effect a state law to protect the life of such infants might have on an abortion practice is outweighed by the ultimate state interest in protecting the lives of its citizens.

### 2. The Second Physician Requirement Is Narrowly Drawn.

Even if this Court finds that the second physician requirement substantially burdens the right to abortion, this regulation withstands strict scrutiny. A requirement that a second physician attend the abortion procedure is a far less significant burden on the abortion right than the total prohibition of post-viability abortions (except to preserve life or health) permitted by this Court. Moreover, the health of the women is not impaired in the slightest, and may even be enhanced by the presence of a second doctor. If an emergency situation should arise, this second physician will be available to provide instant assistance in treating the woman. The presence of the second physician also frees the first physician to concentrate all his efforts on the woman—efforts that might otherwise be divided were a live birth to ensue. Finally, were the women to enter a near-hopeless condition, the first doctor need not face the agonizing dilemma of choosing between devoting his

energies to preserving the mother's life, despite a poor prognosis, and working to save the child so that at least one of the two would survive.

The court of appeals held this provision to an unnecessarily high standard of precision by holding that it is overbroad for failing to account for circumstances where it is improbable that any child will survive an abortion. 655 F.2d at 865. *Roe* clearly indicates that in the context of post-viability abortions, the "narrowly drawn" requirement is satisfied if a "life or health" exception to an otherwise absolute prohibition is included. 410 U.S. at 163-164. Under the proper standard of review, which respects the vital state interest in the actual life of infant persons, the second doctor requirement is clearly constitutional.

### 3. The Requirement of a Second Physician Is Not Overbroad: An Abandoned D & E Procedure Might Produce a Live Birth.

Even under a stricter version of the "narrowly drawn" requirement, the second physician requirement is constitutional. The Eighth Circuit held the second physician provision to be impermissibly overbroad. 655 F.2d at 865. The court reasoned that since some doctors would employ the dilatation and evacuation (D & E) technique after the point of viability, and since a D & E is "always" fatal to a viable unborn child, the state had "no possible justification for a second physician during a D & E procedure." *Id.* at 865.

This reasoning is faulty because it is based on the unarticulated, false assumption that a D & E procedure, when attempted, *always* continues at least to the point of fetal destruction. Uncontradicted expert testimony indicated that "when a D & E *is performed* on a viable fetus there is

no chance of survival." *Id.* at 865 (emphasis added). Challengers of the statute did not assert, however, because they could not assert truthfully, that whenever a D & E is attempted, it is completed without complications that might require abandonment of the D & E procedure *before* the death of the fetus. Such complications allow for the possibility of infant survival and justify the attendance of a second physician.

This situation would arise, for example, when cervical dilatation (a procedure preliminary to extraction of the child from the womb) results in laceration of the ascending branch of either uterine artery. Lowensohn & Hibbard, *Laceration of the ascending branch of the uterine artery: A complication of therapeutic abortion,* 118 Am. J. Obstet. Gynecol. 36 (1974). This is a major complication often necessitating hysterectomy (removal of the uterus). A study of this complication noted that laceration and subsequent bleeding can preclude the anticipated abortion procedure and lead instead to a hysterectomy. *Id.* at 37-38. Were such a complication to arise in a post-viability D & E, the result would be effectively a Caesarian section delivery of a live child. The authors noted that such a "catastrophic injury is always possible, even in the hands of skilled and experienced surgeons." *Id.* at 36. Another study, noting the laceration complication, reported an incidence of cervical injury "ranging as high as 7.1/100 abortions." Cates, Jr., Schulz, Gold & Tyler, Jr., *Complications of Surgical Evacuation Procedures for Abortions After 12 Weeks' Gestation,* in Pregnancy Termination 206, 211 (1979). Thus, the possibility of such a situation arising is very real.

Other instances in which a D & E procedure might be abandoned before destruction of the child include those cases in which the mother dies or enters a life-threatening

> *Roe* [v. *Wade,* 410 U.S. 113 (1973)] teaches that a State cannot restrict a decision by a woman, with the advice of her physician, to terminate her pregnancy during the first trimester because neither its interest in maternal health nor its interest in the potential life of the fetus is sufficiently great at that stage. But the insufficiency of the State's interest in maternal health is predicated upon the first trimester abortion being as safe for the women as normal childbirth at term, and that predicate holds true only if the abortion is performed by medically competent personnel under conditions insuring maximum safety for the woman. *See* 410 U.S. at 149-150, 163.

*Connecticut* v. *Menillo,* 423 U.S. at 10-11.

Thus, any regulation which provides for basic "conditions insuring maximum safety for the woman" finds support in a compelling state interest, and this analysis proceeds in identical fashion, whether the regulation applies only after the first trimester or throughout pregnancy.* In both instances, the regulation will be upheld if it contributes to maternal safety and overturned if it "comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting" the abortion right--i.e., if the legislation is not "narrowly drawn." *Planned Parenthood* v. *Danforth,* 428 U.S. at 79; *see also Doe* v. *Bolton,* 410 U.S. 179, 194 (1973).

**1. Pathology Reports.**

Were this Court to strictly scrutinize the pathology report requirement, the statute would find sufficient justification in the state's interest in maternal health. Regular pathology reports constitute "conditions insuring maxi-

* Of course, not every health regulation falls into this category. Only those regulations that would provide for essential care which serve to decrease the *mortality* rate of abortion procedures find justification in a compelling state interest in all three trimesters.

mum safety for the woman'', as illustrated in the Appendix. Pathology reports can identify, for example, such serious and possibly fatal complications as uterine perforation (puncture of the womb), and can warn of otherwise undiagnosed and subsequently lethal conditions such as ectopic (tubal) pregnancy. *See* Appendix. Thus, this safety measure forms a part of the predicate without which the state's interest is no longer insufficient. *Connecticut* v. *Menillo,* 423 U.S. at 10-11.

In *Roe* v. *Wade,* this Court held that a woman might be hospitalized after the first trimester of pregnancy because of the excess maternal mortality arising from abortion after that time. 410 U.S. at 163. Similarly, the state might properly require pathology reporting because of the excess maternal mortality that would occur absent such reports.

Moreover, a pathology reporting requirement is especially desirable for abortions, simply because of the special problems that accompany this procedure. Abortion has been a medical procedure associated with an unusually high incidence of abusive practices. *See, e.g., The Abortion Profiteers,* Chicago Sun-Times, 1978 (special reprint). The Sun-Times series revealed widespread shoddy practices, including failure to obtain proper pathology reports. One clinic neglected to preserve tissue samples for analysis. *Id.* at 25, col. 4. Other clinics sought pathology reports, but handled the specimens ''so carelesly that the reports it gets back may be meaningless.'' *Id.* at 26, col. 2. In an article exposing 12 maternal deaths following Chicago clinic abortions between 1973 and 1978, the Sun-Times consulted abortion experts:

> ''A microscopic exam is essential,'' said Dr. Paul Szanto, Chicago's dean of pathology and director of Cook County Hospital's pathology division. ''Even

> with a microscope, it happens over and over again that we cannot see [the true signs of pregnancy]."
>
> Dr. Willard Cates Jr., who oversees abortion surveillance for the National Center for Disease Control in Atlanta, believes pathological reports are so important that no clinic should allow a patient to leave the premises without one.
>
> "You can't let a woman walk out of an abortion clinic without an immediate review of the specimen," Cates said.
>
> Without that lab analysis, he said, "You can't be certain that the woman was pregnant, or that you got all the fetal remains, or whether she had an ectopic pregnancy."

*Id.* at 26, col. 3.

This Court has referred to improper abortion practices on several occasions. *See, e.g., Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52, 91 n.2 (1976) (Stewart, J., concurring); *Bellotti* v. *Baird,* 443 U.S. 622, 641 n.21 (1979) (*Bellotti II*) (minors may resort to "incompetent or unethical" abortion clinics). These problems reinforce the need for legislative control over clinic practices, and supplement the medical grounds for pathology reports (*see* Appendix) already acknowledged by the court of appeals. 655 F.2d at 670. Clearly, this health measure directly furthers and is reasonably related to the state's compelling interest in the pregnant woman's life and health, and it thus survives strict scrutiny.

### 2. Hospitalization Requirement

*Roe* specified that a hospitalization requirement would be a permissible state regulation of post-first trimester abortions. 410 U.S. at 163. The court of appeals nonetheless overturned this requirement merely because one of the several procedures used for second and third

trimester abortions, dilatation and evacuation (D & E), was not found to be widely available within hospitals and was not found to be "safer" when performed in a hospital than when performed outside a hospital. 664 F.2d at 687, 689. But this holding is tantamount to requiring that a statute must be "perfectly drawn" in order to "reasonably relate" to maternal health. Such a standard would permit no regulation of abortions at all, except on a case-by-case basis. Even a physician requirement would be unreasonable, since, for example, fourth-year medical students at a high caliber urban medical school might well be more competent to perform abortions than rural podiatrists would be.

Moreover, since the state cannot know in advance when complications will arise which require a hospital environment, the state can only weigh the competing interests of safety and convenience. If the resultant legislation so balances these interests as to be reasonably related to maternal health, then the legislation withstands strict scrutiny.

The Constitution does not require that abortion health regulations correspond perfectly to state interests in every instance. Rather, the legislative enactment must be evaluated as a whole, to see if it will "serve" or "enhance" the state interest offered as a justification. *Planned Parenthood of Central Missouri* v. *Danforth,* 428 U.S. 52, 75 (1976). Regulations that serve the state's interest in maternal health need only be "reasonably related" to that interest to survive constitutional attack. *Roe* v. *Wade,* 410 U.S. at 163. Hence, the lower court in this case should have compared *generally* the safety of hospitalized abortion after the first trimester with non-hospitalized second and third trimester abortion, rather than singling out D & E abortion for special treatment. Such a comparison, if

carefully conducted to control for biases,* would have provided a proper basis for determining whether the post-first trimester hospitalization requirement is reasonably related to maternal health.

The Court of Appeals for the Eighth Circuit also based its holding that the post-first trimester hospitalization requirement was unconstitutional on a finding by the district court that "second trimester D & E procedures performed at out-patient facilities are just as safe as those procedures performed in hospitals." No. 79-4142-CV-C-H, slip op. at 14 (W.D. Mo. Oct. 2, 1981). From this factual determination the court of appeals concluded that "section 188.025 is not reasonably related to maternal health and, therefore, . . . is unconstitutional." 664 F.2d at 690.

The court's conclusion, however, rests upon an incomplete understanding of the hospitalization requirement. This requirement seeks not only to reduce the risks of second trimester abortions, but also to facilitate the treatment of complications *when they arise.* Even if the *risks* of complications occurring during a second trimester D & E are identical for procedures performed within hospital or non-hospital facilities, the statutory requirement is nonetheless reasonably related to maternal health because hospitals possess superior facilities for *treatment* when complications do arise.

According to the Centers for Disease Control, Annual Summary 1978 (1980), roughly 50% of all abortions per-

---

* For example, if a woman has a late term abortion, and hence one entailing higher risks, or if a woman has medical indications for attendant complications, she will more likely have her abortion in a hospital. Thus the unanalyzed data will tend to make hospitalized abortions appear to be more dangerous than non-hospitalized abortions. In fact, it is because hospitals are safer that the woman expecting difficulties will enter hospital facilities in the first place.

formed at 13 or more weeks of gestation employ methods other than D & E. *Id.* at 43, Table 14. Of these, hysterotomy and hysterectomy procedures, being major surgery, will necessarily take place in hospitals. Intraamniotic abortifacient instillation procedures constitute the remainder of the post-first trimester abortions. With regard to these one expert, Charles A. Ballard, M.D., commented as follows: "I feel it is necessary that all amnio-infusions be performed in a hospital with a staff present at all times and with an adequate laboratory facility available (e.g., a blood bank)." *Second Trimester Abortion: A Symposium by Correspondence,* 16 J. Reprod. Med. 47, 55-56 (1976). Dr. Ballard went so far as to urge that at least for saline abortion, "these procedures should be performed by competent physicians, under a strict antiseptic regimen, *only in certain designated hospitals* with staff available 24 hours and adequate laboratory facilities." *Id.* at 56 (emphasis added).

Dr. Ballard based his opinion on the existence of "the potential complications of infection, hemorrhage, consumptive coagulopathy, etc." *Id.* at 56. His study did not discuss the D & E procedure, but another report noted that the "most common complications associated with D & E are infection and hemorrhage," Cates, Jr., Schulz, Gold & Tyler, Jr., *Complications of Surgical Evacuation Procedures for Abortions After 12 Weeks' Gestation,* in Pregnancy Termination 206, 210 (1979), and that consumptive coalgulopathy is "a rare, though serious, complication associated with D & E." *Id.* at 211. Since the same complications which make hospitalization imperative for other post-first trimester procedures occur with D & E procedures, it follows that hospitalization is appropriate for D & E abortions as well.

Dr. Willard Cates reports that the misestimation of gestational age contributes to the complication rate for D & E, and that routine sonography might "aid in reducing complications and deaths from D & E." *Id.* at 215. In another study Cates explains that "if routine sonography is to be performed on every woman, an ultrasound scanner" is necessary; therefore, one should keep in mind that "many hospitals already have this equipment available for managing other obstetric and nonobstretric conditions." Cates, Jr., Schulz & Grimes, *Dilatation and Evacuation for Induced Abortion in Developing Countries: Advantages and Disadvantages,* 11 Stud. Fam. Plan. 128, 130 (1980). Dr. Cates continues:

> Because D & E is riskier than curettage at earlier gestations, it should be performed in settings with proper supervision and backup facilities. However, the currently available alternatives—instillation procedures and abdominal hysterotomy—should also be performed under similar circumstances.

*Id.* at 130.

Clearly a legislature might reasonably conclude that a hospitalization requirement for all abortion after the first trimester is a proper safety regulation. "Since all methods of terminating pregnancies after 12 weeks should be performed under equivalent circumstances," as Dr. Cates indicates, *id.* at 132, it is reasonable if not imperative that the state impose a hospitalization requirement.

The hospitalization requirement is certainly a regulation reasonably related to the state's compelling interest in maternal health. As such, it is narrowly drawn and should be upheld.

## III. CONCLUSION

The Missouri regulations at issue before this Court do not substantially burden a woman's right to decide to terminate her pregnancy. Moreover, these provisions are justified by compelling state interests in the health of the mother and the actual life of infant citizens.

Wherefore, your amicus prays this Court to reverse the Court of Appeals for the Eighth Circuit, and uphold these provisions.

Respectfully submitted,

DENNIS J. HORAN
VICTOR G. ROSENBLUM
PATRICK A. TRUEMAN
THOMAS J. MARZEN
MAURA K. QUINLAN
230 N. Michigan, Suite 915
Chicago, IL 60601
312/263-5029
*Attorneys for*
*Americans United for Life*

Law Students Who Assisted in the Preparation of this Brief: Daniel Avila, Thomas J. Balch, Elizabeth Bower, Michael R. Carey, Richard Cohen, Walter M. Weber.

Medical Consultant for this Brief: Steven R. Zielinski, M.D.

# APPENDIX

physician recalled removing an elongated tube, but assumed it was part of the umbilical cord. Gangai, *An Unusual Surgical Injury to the Ureter,* 109 J. Urology 32 (1973). A pathological exam would have identified the elongated tube as part of the woman's ureter and enabled the physician to prevent the extensive bleeding that eventually occurred.

Perforation can occur in suction abortions as well. In suction abortions, the cervix is dilated, an aspirator inserted into the womb, and a powerful vacuum is created. As a result, the uterine contents are sheared from the uterine walls and sucked through the aspirator. Sometimes the vacuum may be placed too close to the wall of the bladder, which is then punctured by the abrupt suction force. In one reported suction abortion, the physician recalled seeing during suction a sudden gush of clear, yellow fluid which he assumed to be amniotic fluid but which was actually maternal urine. The patient was taken to the recovery room after the abortion in satisfactory condition, but soon thereafter was found in shock. Rous, Major & Bordon, *Rupture of the bladder secondary to uterine vacuum curettage: A case report and review of the literature,* 106 J. Urology 685 (1971). A pathologist would have detected maternal bladder lining tissue in the aspirated material, thereby allowing immediate treatment of the woman's injury.

b. Cervicovaginal fistula. This complication can occur in abortions done by amnio-instillation. Instillation abortions are performed by first removing amniotic fluid and then injecting saline, glucose or prostaglandin solutions into the amniotic sac. Each of these substances induces contractions and eventual fetal expulsion. Cervicovaginal fistula formation occurs when the cervix fails to dilate sufficiently during the contractions. Because the fetus cannot

exit through the narrow opening between the uterus and cervix, he or she is pushed through the cervical wall, thereby creating a false passage (fistula) into the vagina. Gordon, *Cervicovaginal fistula as a result of saline abortion,* 112 Am. J. Obstet. Gynecol. 578 (1972). An unrecognized cervicovaginal fistula jeopardizes the successful outcome of future pregnancies since it encourages spontaneous abortion and premature labor. *Id.* at 579. Cervicovaginal fistula formation can also be fatal. Grimes & Cates, Jr., *Fatal uterine rupture during oxytocin-augmented saline abortion,* 130 Am. J. Obstet. Gynecol. 591 (1978). Detection of cervicovaginal tissue among the products of conception examined for a pathological report would alert a physician to the possible existence of fistulas.

A fistula might also result during abortion procedures other than amnio-instillations. In this case the fistula would result from puncture of the cervix during dilatation. This complication may occur in any trimester, and would be detected by a pathologist upon the discovery of cervical tissue.

2. Delayed Complications.

a. Retained products of conception. This complication is one of the most important causes of abortion morbidity. Grimes & Cates, Jr., *abortion: methods and complications,* in Human Reproduction 796, 806 (1980). This complication occurs most often in D & C and amnio-infusion abortions. *Id.* at 806; Burnhill, *Reducing the Morbidity of Vacuum Aspiration Abortion,* in Pregnancy Termination 146 (1979). If left unremoved, fetal and placental tissue will cause infection and hemorrhage. Walton, *Immediate Morbidity on Large Abortion Service,* 72 N.Y. St. J. Med. 919, 920 (1972); Peterson, *Dilatation and Evacuation:*