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IN THE  
**Supreme Court of the United States**

OCTOBER TERM, 1988

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WILLIAM L. WEBSTER, *et al.*,  
*Appellants,*

v.

REPRODUCTIVE HEALTH SERVICES, *et al.*,  
*Appellees.*

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On Appeal from the United States Court of Appeals  
for the Eighth Circuit

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**BRIEF OF THE AMERICAN ASSOCIATION  
OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS  
(AAPLOG) AND THE AMERICAN ASSOCIATION  
OF PRO-LIFE PEDIATRICIANS (AAPLP)  
AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS**

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**INTEREST OF THE *AMICI CURIAE***

The AMERICAN ASSOCIATION OF PROLIFE OBSTETRICIANS AND GYNECOLOGISTS (AAPLOG) is a national organization of obstetricians and gynecologists founded in 1973 and dedicated to reaffirming the unique value and dignity of individual human life in all stages of development from the moment of conception. The organization is engaged in educational and research projects which enhance the goals of the organization. The AMERICAN ASSOCIATION OF PRO-LIFE PEDIATRICIANS (AAPLP) is a national educational organization comprised of pediatricians who are dedicated to fostering respect for human life at all stages of development.

## SUMMARY OF ARGUMENT

This is a facial challenge to the constitutionality of several Missouri restrictions on the performance of elective abortions. Of particular interest to these *amici* is section 188.029 of the Missouri, Revised Statutes, which requires that the physician make a determination of viability when he “has reason to believe” that the fetus is at twenty or more weeks gestational age, and that the physician “perform or cause to be performed such medical examinations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity of the unborn child. . . .”

Missouri has, in force, three other provisions which have been previously upheld and which protect the viable fetus during abortion by requiring: (1) the use of that method of abortion which will best preserve the life of the fetus (sec. 188.030.2); (2) the presence of a second physician (sec. 188.030.3), and (3) that both physicians exercise the same standard of care toward any infant born alive from an abortion as would be given to any infant intended to be born alive and not aborted (sec. 188.030.3). See *Planned Parenthood v. Ashcroft*, 462 U.S. 476 (1983); *Planned Parenthood v. Ashcroft*, 655 F.2d 848 (8th Cir. 1981). By enacting the provision challenged here, the Missouri legislature has prefaced these three provisions with the logical prerequisite that a physician who intends to perform an abortion when the physician “has reason to believe” that the fetus is of twenty or more weeks gestational age first make a determination of viability. If the physician determines in his medical judgment that the fetus is viable, the restrictions of section 188.030 become effective.

Missouri has an “important and legitimate interest” in the fetus throughout pregnancy which becomes “compelling” at viability. *Roe v. Wade*, 410 U.S. 113, 163 (1973). As the Supreme Court in *Harris v. McRae* said of the *Roe* decision, “the state interest in protecting the poten-

tial life of the [viable] fetus was found to justify a criminal prohibition against abortions, except where necessary for the preservation of the life or health of the mother.” 448 U.S. 297, 313 (1980). Since the states have not been permitted to protect the life of the viable unborn child by limiting the reasons for which post-viability abortions can be performed, the states have taken the only available recourse by attempting to regulate the method of a post-viability abortion.

If Missouri’s interest is truly “compelling,” then the State must be permitted to protect viable unborn children by requiring physicians—in their best medical judgment—to utilize standard medical technology to make objective findings as part of their determination of viability. As Justice O’Connor has observed, “recent studies have demonstrated increasingly earlier fetal viability.” *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 457 (1983). Preterm infants are surviving not only at earlier gestational ages, but with increasingly improved outcomes. Given the potential for survival of infants of twenty-four weeks gestational age, and the four week margin of error in estimating gestational age, Missouri’s requirement of determination of viability when the physician “has reason to believe” that the fetus is twenty or more weeks gestational age is reasonable. A “compelling interest” is, at a minimum, one demanding attention. By demanding attention to certain objective factors that are directly related to viability, Missouri reasonably protects its compelling interest.

The plain language of section 188.029 requires only those tests which are “necessary” to make a finding of three non-exclusive factors relevant to viability: gestational age, fetal weight, and fetal lung maturity. The courts below misread the plain language of the statute by reading into section 188.029 a requirement of a single test—amniocentesis—that is simply not required. At twenty weeks gestation, an ultrasound examination to determine gestational age is standard medical practice. It is routinely provided by the plaintiff clinics. An ultra-



sound examination can effectively provide all three designated findings of sec. 188.029.

In this facial challenge, the Appellees have failed to establish that "no set of circumstances exists under which the Act would be valid." The Missouri regulation "reasonably furthers" the State's compelling interest in viable fetal life and imposes no physical or psychological burden on the woman's decision to abort. Accordingly, sec. 188.029 should be held constitutional in its entirety, and the judgment of the court below should be reversed.

#### ARGUMENT

##### I. MISSOURI HAS A COMPELLING INTEREST IN PRESERVING THE LIFE OF THE UNBORN CHILD WHO IS REGARDED BY MEDICAL SCIENCE AS A PATIENT.

###### A. Medical Science Regards the Unborn Child As A Patient.

Missouri Revised Statutes (Mo.Rev.Stat.), section 188.029 provides:

Before a physician performs an abortion on a woman he has reason to believe is carrying an unborn child of twenty or more weeks gestational age, the physician shall first determine if the unborn child is viable by using and exercising that degree of care, skill, and proficiency commonly exercised by the ordinarily skillful, careful, and prudent physician engaged in similar practice under the same or similar conditions.

In making this determination of viability, the physician shall perform or cause to be performed such medical examinations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity of the unborn child and shall enter such findings and determination of viability in the medical record of the mother.

Mo. Rev. Stat. sec. 188.029 (1986).<sup>1</sup> The State of Mis-

<sup>1</sup> "Gestational age" is measured "from the first day of the woman's last menstrual period (LMP)." Mo.Rev.Stat. 188.015(4) (1986). This definition is consistent with standard medical practice. D. Dan-

souri enacted this statute because it has an important and legitimate interest in the life of the unborn child<sup>2</sup> throughout pregnancy that becomes "compelling," according to this Court, at viability. *Roe v. Wade*, 410 U.S. 113, 163 (1973).

Medical science, however, has an interest in the unborn child from a much earlier point in prenatal development. Medical science affirms that human life begins at conception. K. Moore, *The Developing Human: Clinically Oriented Embryology* 1, 13 (3d ed. 1982); E. Blechschmidt, *The Beginning of Human Life* 16-17 (1977). This is the traditional understanding of American medicine since at least the early nineteenth century. 1 J. Beck, *Elements of Medical Jurisprudence* 462-64 (11th ed. 1860); A. Dean, *Principles of Medical Jurisprudence* 37-41, 123-31 (1854); S. Farr, *Elements of Medical Jurisprudence*, in T. Cooper, *Tracts on Medical Jurisprudence* 40 (1819). The unborn child who is adversely affected by alcohol in the first month of pregnancy is the same child who suffers intellectual disabilities at four years. Streissguth, et al., *IQ at Age 4 in Relation to Maternal Alcohol Use and Smoking During Pregnancy*, 25 *Develop. Psych.* 3 (Jan. 1989). Since the time of the *Roe* Court's pro-

forth & J. Scott, *Obstetrics & Gynecology* 263 (5th ed. 1986); Pritchard, MacDonald, & Gant, *Williams Obstetrics* 139 (17th ed. 1985); C. Pauerstein, ed. *Clinical Obstetrics* 121 (1987).

<sup>2</sup> Throughout this brief, we use the terms "unborn child" and "fetus" interchangeably. Although "fetus" is a medical term, derived from Latin, that describes the developing unborn of any viviparous animal, the common law and medical jurisprudence have traditionally used the term "child" or "unborn child" to refer to the unborn offspring of human parents at any time of pregnancy. See e.g., *Black's Law Dictionary* 559 (5th ed. 1979); *Hall v. Hancock*, 32 Mass. (15 Pick.) 255, 257 (1834); W. Lambarde, *Eirenarcha, or of the Office of Justices of Peace* 217-18 (1581 ed.) (DaCapo Press Reprint 1970); M. Dalton, *The Countrey Justice* 213 (1618 ed.) (Walter J. Johnson Inc. reprint 1975); E. Coke, *Third Institutes of the Laws of England* 50 (1644) ("childe"); 1 W. Blackstone, *Commentaries on the Laws of England* 129 (University of Chicago Paperback 1979); 4 Blackstone 198 ("child").

nouncements about the potentiality of human life, a new medical discipline has emerged: fetology. This science treats the unborn child as a distinct patient.

Indeed, the fetus is no longer dealt with as a maternal appendage ultimately to be shed at the whim of biologic forces beyond control. Instead, the fetus has achieved the status of the second patient, a patient who usually faces much greater risks of serious morbidity and mortality than does the mother.

Pritchard, MacDonald, & Gant, *Williams Obstetrics* 267 (17th ed. 1985) (hereinafter "*Williams Obstetrics*"). "[T]he status of the fetus has been elevated to that of a patient who should be given the same meticulous care by the physician that we long have given the pregnant woman." *Id.* at 139. See generally, A. Kurjak, ed. *The Fetus as a Patient* (1985); Harrison, Golbus & Filly, *The Unborn Patient: Prenatal Diagnosis and Treatment* (1984); E. Volpe, *Patient in the Womb* (1984).

Medical technology for the child *in utero* has advanced greatly, developing surgery and treatment for previously untreatable conditions.<sup>3</sup> Medical technology also has moved the line of viability earlier in pregnancy. In *Roe*, the Court found that "[v]iability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." 410 U.S. at 160 (footnote omitted). Viability may now occur as early as twenty-two weeks, with substantial potential of viability at twenty-four weeks. Nwaesei, et al., *Preterm birth at 23 to 26 weeks' gestation: Is active obstetric management justified*, 157

<sup>3</sup> See generally, Watts, *Intraperitoneal Fetal Transfusion Under Direct Ultrasound Guidance*, 71 *Ob. & Gyn.* 84 (1988); Baraitser, et al., *Prenatal Treatment of Fetal Hydrops*, 6 *Prenatal Diagnosis* 109 (1986); Michejda, *Present Status of intrauterine treatment of hydrocephalus and its future*, 155 *Am. J. Ob. Gyn.* 873 (1986); Benacerraf, *In Utero treatment of a fetus with diaphragmatic hernia complicated by hydrops*, 155 *Am. J. Ob. Gyn.* 817 (1986); Berkowitz, *Intravascular transfusion in utero: The percutaneous approach*, 154 *Am. J. Ob. Gyn.* 622 (1986).

*Am. J. Ob. Gyn.* 890 (1987). Missouri may take into account these tremendous advances in medical science and technology and regulate to protect those fetuses who may survive the abortion procedure.

**B. The Lives of Premature Unborn Children Who Might Be Preserved By Mo. Rev. Stat. section 188.029 Have Been Enhanced By Recent Advances in Medical Science.**

In recent years, great strides have been made in the medical and nursing management of very low birth weight (VLBW) infants, leading to an increasing survival rate. Paneth, et al., *Newborn intensive care and neonatal mortality in low-birth-weight infants: A population study*. 307 *New Eng. J. Med.* 149 (1982); Kitchen, et al., *Collaborative study of very-low-birth-weight infants: Techniques of perinatal care and mortality*, *Lancet* 1: 1454 (June 26, 1982). There has been "an impressive fall in the neonatal mortality rate among the very low-birthweight and extremely low-birthweight [less than 1001 g] infants . . . in centres around the world." Skouteli, et al., *Predictors for Survival and Normal Neurodevelopmental Outcome of Infants Weighing Less Than 1001 Grams at Birth*, 27 *Dev. Med. & Child Neuro.* 588 (1985).

A significant percentage of these children survive with little or no permanent disability. One short-term follow-up study "concluded that there has been an increase in the proportion of healthy survivors with a relatively low permanent handicap rate of 6% to 8% of all VLBW newborns." Eilers, et al., *Classroom Performance and Social Factors of Children With Birth Weights of 1250 Grams or less*, 77 *Pediatrics* 203 (1986) (citing Stewart, et al., *Outcome for infants of very low birthweight: Survey of world literature*, *Lancet* 1: 1038 (May 9, 1981)). Long-term follow-up has yielded equally encouraging results. One study of 60 VLBW survivors at age five years

and beyond showed that 74% had no important disability; 17% had a mild or moderate disability; only 9% were severely disabled. Rickards, et al., *Extremely-low-birthweight infants: neurological, psychological, growth and health status beyond five years of age*, 147 Med. J. of Austl. 476 (1987). An important finding was that severe disability was less prevalent at five years (9%), than at the two-year review (15%). *Id.* at 481. Even though a fetus may be "preivable" (defined as including any fetus estimated to be under 500 grams birthweight or under 22 weeks gestational age), "all delivery room staff [must] be prepared for the possibility of the delivery of a liveborn viable fetus. When this occurs, appropriate pediatric intervention *must* be made, independent of prior obstetric decisions." Myers, *Hospital Guidelines for Fetal Viability Assessment and Postdecision Responsibilities*, 54 Mount Sinai J. Med. 191, 192 (1987) (emphasis in original).

Medical practice and evolving technology thus support intervention to preserve the lives of premature infants born alive. Through section 188.029, Missouri has sought to protect its compelling interest in the lives of viable unborn children.

**II. THE PLAIN LANGUAGE OF MO. REV. STAT. SECTION 188.029 REQUIRES TESTING FOR VIABILITY THAT REASONABLY FURTHERS MISSOURI'S COMPELLING INTEREST IN PROTECTING THE LIFE OF THE VIABLE UNBORN CHILD.**

The plain language of Mo.Rev.Stat. section 188.029 indicates that it was enacted to provide objective, medical factors for the physician in making his assessment of viability in accordance with sound standards of medical practice. The second sentence provides that—in making the determination of viability when the physician "has reason to believe" that the fetus is of twenty or more weeks gestational age—"the physician shall perform or

cause to be performed such medical examinations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity of the unborn child and shall enter such findings and determinations of viability in the medical record of the mother." This provision provides substantial flexibility for the attending physician. First, he may perform the tests himself or he may delegate that responsibility. *Cf. City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416, 448 (1983). Second, no particular kind of test is specified by weeks of gestation. Third, the physician is not required to administer any specific test for each of the factors. Rather, he may choose from "such tests as are necessary to make a finding" on all three factors. If one test or examination yields a finding for all three factors, that test is sufficient. The emphasis is on the end—making "a finding"—and not on the means—particular tests.

It is a familiar practice of legal interpretation that "necessary" is a word that "must be considered in the connection in which it is used, as it is a word susceptible of various meanings." *Black's Law Dictionary* 928 (5th ed. 1979). Under section 188.029, it is not "necessary" for the physician or his agent to make the best finding, a finding derived from the most sophisticated medical technology, the most detailed finding, or the most comprehensive finding. And, it should be quite obvious, the plain language does not make it necessary to use a test that will yield no finding. A test or examination that is futile to make a finding cannot, within the realm of logic, be considered "necessary to make a finding" within the plain language of section 188.029.

This relaxed standard affords flexibility to the physician within the context of developing medical technologies, in different locations, with different costs. The flexible standard corresponds admirably both to the array of tests or examinations that are available today to

make a finding of gestational age, weight, and lung maturity and to the certainty that new tests or examinations will be developed in the future for making a finding on these three factors. At twenty or more weeks gestation, certain tests are available in standard, current medical practice that can yield a finding on all three factors. If only one test is performed and a finding of previability (immaturity) is made, the results may be a "false positive" and the fetus being aborted might actually be viable. The state has a compelling interest in protecting these viable fetuses by requiring findings on more than one factor; false positives may be eliminated and maturity revealed.<sup>4</sup> At twenty weeks gestation, certain tests

<sup>4</sup> The importance of considering all three factors is underscored by disagreement in the medical literature as to any single factor being determinative of viability. "[I]n infants weighing [less than] 1000 gm at birth, birth weight rather than gestational age is the more important variable influencing survival." Amon, et al., *Obstetric variable predicting survival of the immature newborn ([less than] 1000 gm): A five-year experience at a single perinatal center*, 156 Am. J. Ob. Gyn. 1380 (1987) (footnote omitted). This finding differs from Yu et al., *Prognosis for infants born at 23 to 28 weeks' gestation*, 293 Brit. Med. J. 1200 (1986): "Gestation, not birth weight, however, is the parameter that must be used by the obstetrician as a guide to making critical decisions about the care of the mother and fetus. Gestation is a better predictor of outcome because of the inherent inaccuracies in clinically or sonographically estimating fetal weight." *Id.* (footnote omitted). See also, Walker and Patel, *Mortality and morbidity in infants born between 20 and 28 weeks gestation*, 94 Brit. J. Ob. Gyn. 670, 673 (1987): "This gives support to the widespread use of ultrasound scans in early pregnancy. Since obstetricians have to manage pregnancies on the basis of gestational age, and since the occurrence of problems in mid-trimester can seldom be predicted, confirmation of gestational age early in all pregnancies is important." In a group of 1338 very preterm and/or very-low-birthweight infants, "the best obstetric estimate of gestational age was a better predictor of neonatal mortality than birthweight." Verloove-Vanhorick et al., *Neonatal Mortality Risk in Relation to Gestational Age and Birthweight*, *Lancet* 1:55 (Jan. 11, 1986). "Although birth weight and gestational age have been shown to be major determinants of neonatal survival,

that are available later in gestation may be futile to make a finding. As gestation progresses, other tests become available to make a finding. Conversely, at twenty weeks gestation, certain tests or examinations are available that may be less accurate than other tests as gestation progresses. However, at each point in gestation at twenty weeks or later, medical practice currently provides tests or examinations that can make a finding on each of these three factors. Section 188.029 requires no more. Since each of these three factors is related to viability, and since infants born alive at 22-24 weeks may be viable, section 188.029 "reasonably furthers" Missouri's compelling interest in the life of the viable unborn child.

### III. THE COURT OF APPEALS FAILED TO APPLY THE CORRECT STANDARD OF REVIEW IN THIS FACIAL CHALLENGE TO THE FETAL VIABILITY TESTING PROVISIONS OF MO. REV. STAT. SECTION 188.029.

It is a settled principle of statutory construction that absent clear evidence of a contrary legislative intention, a statute should be interpreted according to its plain language. *Burlington Northern Railroad Co. v. Oklahoma Tax Comm.*, 107 S.Ct. 1855 (1987); *Landreth Timber Co. v. Landreth*, 471 U.S. 681, 685 (1985). The application of the plain meaning is particularly important in a facial challenge to the constitutionality of a state statute because the language is challenged on its face and

the challenger must establish that no set of circumstances exists under which the Act would be valid. The fact that the [] Act might operate unconstitu-

gestational age better reflects fetal maturation and is therefore more likely to be a better predictor of outcome." Nwaesei, et al., *Preterm birth at 23 to 26 weeks' gestation: Is active obstetric management justified?*, 157 Am. J. Ob. Gyn. 890, 894-95 (1987).

tionally under some conceivable set of circumstances is sufficient to render it wholly invalid, since we have not recognized an "overbreadth" doctrine outside the limited context of the First Amendment.

*United States v. Salerno*, 107 S.Ct. 2095, 2100 (1987). Finally, this Court has held that "the elementary rule is that every reasonable construction must be resorted to in order to save a statute from unconstitutionality." *DeBartolo Corp. v. Florida Gulf Coast Bldg. & Const. Trades*, 108 S.Ct. 1392, 1397 (1988). This canon applies even to the construction of state abortion statutes. *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 493 (1983).

In *Planned Parenthood v. Ashcroft*, this Court upheld the constitutionality of Missouri's requirement of the attendance of a second physician at the abortion of a viable fetus. Mo.Rev.Stat. section 188.030.3 (1986). Section 188.030.3 requires that both physicians "take all reasonable steps in keeping with good medical practice . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the mother." This Court held that "the State's compelling interest in protecting a viable fetus justifies the second-physician requirement even though there may be the rare case when a physician may think honestly that D & E is required for the mother's health. Legislation need not accommodate every conceivable contingency." 462 U.S. at 485 n.7.

Viable fetuses will be in immediate and grave danger because of their premature birth . . . By giving immediate medical attention to a fetus that is delivered alive, the second physician will assure that the State's interests are protected more fully than the first physician alone would be able to do. And given the compelling interest that the State has in preserving life, we cannot say that the Missouri requirement of a second physician in those unusual circumstances where Missouri permits a third-

trimester abortion is unconstitutional. Preserving the life of a viable fetus that is aborted may not often be possible, but the State legitimately may choose to provide safeguards for the comparatively few instances of live birth that occur.

*Id.* at 485-86.

Section 188.029 is a logical precursor to the second physician requirement upheld in *Ashcroft* and is sustained by the same medical and legal understanding. It is manifestly justified by Missouri's compelling interest in the viable fetus. By requiring findings on three non-exclusive factors that are directly related to fetal viability, are not deemed to be conclusive determinants of viability, and are made through methods that are consistent with standard medical practice, section 188.029 "reasonably furthers" Missouri's compelling interest in the life of the viable unborn child. *Ashcroft*, 462 U.S. at 486.

The courts below, however, applied an erroneously heightened standard of review, which not only disregarded this Court's holding in *Ashcroft* but completely failed to apply the normal standard of review in a facial challenge to the constitutionality of state legislation. With the narrow exception of First Amendment claims of protected speech, plaintiffs rarely prevail on a facial challenge. *New York State Club Ass'n. v. City of New York*, 108 U.S. 2225, 2233 (1988) (quoting *City Council v. Taxpayers for Vincent*, 466 U.S. 789, 798 (1984)). By failing to apply the proper standard of review to this facial challenge, the courts below applied a stricter standard of review to this state abortion statute than is commonly applied to legislation touching core First Amendment speech. Cf. *Frisby v. Schultz*, 108 S.Ct. 2495 (1988). The State is not required to address and answer every possible application of the law to any imaginable circumstance. The courts below erred by failing to up-

hold the second part of section 188.029 insofar as it "reasonably furthers" Missouri's compelling interest in the life of the viable unborn child. Like the second physician requirement upheld in *Ashcroft*, the determination of viability when the physician "has reason to believe" that the unborn child is of twenty or more weeks gestation in section 188.029 may be applied in cases in which the physician subsequently finds that the fetus is not viable. But, based on the unrebutted medical testimony that an error of plus/minus four weeks can be made in the determination of gestational age, the courts below held that a determination of viability when the physician "has reason to believe" that the unborn child is of twenty or more weeks gestation is reasonably related to the state's compelling interest in the viable fetus. The courts below erred by failing to apply this same analysis to the second part of section 188.029. Because both parts of section 188.029 "reasonably further" Missouri's "compelling interest" in the viable unborn child, both parts of section 188.029 are constitutional.

**IV. THE DETERMINATION OF GESTATIONAL AGE, FETAL WEIGHT, AND LUNG MATURITY IS DIRECTLY RELATED TO THE DETERMINATION OF VIABILITY AT TWENTY OR MORE WEEKS GESTATION AND REASONABLY FURTHERS MISSOURI'S COMPELLING INTEREST IN THE LIFE OF THE VIABLE UNBORN CHILD.**

Requiring a determination of viability when the physician "has reason to believe" that the fetus is of twenty or more weeks gestational age "reasonably furthers" Missouri's compelling interest in the life of a viable unborn child, because there is a substantial potential for error in the clinical determination of gestational age by last menstrual period (LMP). At the trial in this case, medical testimony from witnesses both for the plaintiffs

and for Missouri admitted the substantial potential for error in this determination. There is a four week or greater potential for error in predicting gestational age based upon the information provided by the patient (T.II-48 (Hern)). Dr. Maulik agreed that if a physician estimated a twenty week fetus based on information provided by the patient, "in fact the fetus could be as little as 16 weeks old or as much as 24 weeks old." (T. I-55). In addition, there was also testimony that the use of sonography (despite its cost) is good medical practice for a woman believed to be twenty weeks and that fetuses at twenty-four weeks are viable (T. I-55, T. I-61). Dr. Crist testified that sonography and manual examination of the uterus were used to determine fetal age at 20 weeks and that ultrasonography and a "normogram" were used to estimate fetal weight at twenty weeks gestation (T.I-99; T.II-65 (Widdicombe)). These tests are *standard medical practice*, according to this testimony.

This testimony is supported by substantial medical literature. It is well known that the clinical assessment of gestational age is prone to inherent inaccuracy and the degree of inaccuracy can be quite large. "Clinical assessment of gestational age is fraught with error because the LMP is uncertain in 20% to 40% of gravidas." D. Danforth & J. Scott, *Obstetrics & Gynecology* 263 (5th ed. 1986) (hereinafter "Danforth"); C. Pauerstein, ed., *Clinical Obstetrics* 268 (1987) (hereinafter "Pauerstein"). One study found that "even when the LMP is reported with certainty, in 15% of pregnancies the clinically assessed gestational age will vary by at least 3 weeks from the age assigned to the newborn by careful pediatric examination." *Id.* It is important, and standard medical practice, to have an accurate assessment of gestational age. Section 188.029, therefore, directly enhances the determination of accurate gestational age at twenty or more weeks gestation.

**A. Gestational Age Is Directly Related to the Determination Of Viability at Twenty or More Weeks Gestation and Can Be Determined By A Standard Ultrasound Examination.**

A standard text on obstetrics provides: "Precise knowledge of the age of the fetus is the imperative for ideal obstetric management." *Williams Obstetrics* at 246. Indeed, one of the "major goals" of prenatal care is to "determine the gestational age of the fetus." *Id.* at 247, 249; Danforth at 366. "[B]ecause duration is one of the most important parameters to be considered when clinical judgments are being made, an accurate determination of gestational length is one of the important functions of prenatal care." Danforth at 365.

Accurate knowledge of gestational age is important for several reasons. "Knowledge of dates is essential in the management of pregnancy because gestational age forms the X-coordinate of many graphs pertaining to the evaluation of fetal status." Danforth at 263. In addition, "[a]ccurate information about maturity is needed by the obstetrician deciding whether to prematurely abbreviate a pregnancy, for example, or perform a repeat cesarean section." *Id.* "The degree of maturity attained is pivotal in making the decision to abbreviate a particular pregnancy for the benefit of mother or fetus." Pauerstein at 268; *Williams Obstetrics* at 602. Inaccurate estimation of fetal age can contribute "to the development of respiratory distress syndrome (RDS) in the newborn with a resultant increase in perinatal morbidity and mortality." *Id.* Dr. Maulik testified for the plaintiff in the district court that "viability is a correspondent of gestational age." (T. I-30) Accurate knowledge of gestational age is, therefore, directly related to the state's compelling interest in the life of the viable fetus.

Several methods can be used "with reasonable accuracy" to determine gestational age. Danforth at 365. These include: estimation of the date of the last menstrual pe-

riod (LMP), manual examination, maternal perception of fetal movement (quickening), measurement of fundal height, and ultrasound or sonography. Both Dr. Maulik (T.I-30, I-35) and Dr. Crist (T.I-101) testified at trial that determination of gestational age by menstrual history is the least reliable method. A pelvic examination is also "unreliable as a method for dating." Danforth at 365. In the first trimester, even under "ideal conditions," a pelvic examination can be inaccurate to plus/minus 2 weeks. Danforth at 263. Moreover, if the uterus is retroverted (turned backward in relation to the pelvic axis) "as it is in approximately 30% of women, the accuracy of fetal age determination deteriorates to [plus or minus] 4 weeks." *Id.* The plaintiffs' witness, Dr. Maulik, testified in the district court that the pelvic exam was "not very accurate." (T. I-31). Another method—maternal perception of quickening—is useful only as a "rough estimate" of gestational age. Danforth at 365. Another method involves the measurement of fundal height—the length from the top of the uterus to the pubic symphysis. This is used to measure pregnancy primarily in the second trimester, when the pregnancy is more advanced. Where the physician is making regular, periodic measurements, the height of the fundus, although not a precise measurement of gestational age, may corroborate other clinical estimations of gestational age. Danforth at 365-66.

Finally, it has become standard medical practice to use ultrasound to determine gestational age at approximately 20 weeks gestation when gestational age is uncertain:

The accurate determination of gestational age is one of the most important goals of prenatal care. It is reasonable for the obstetrical care provider to ask at about 20 weeks, "Am I confident of this patient's gestational age?" If not, ultrasound should be used

to determine the gestational age prior to the third trimester.

Danforth at 366. *See also id.* at 262 (Table 15-1). “When gestational age cannot be clearly identified, sonography is likely to be of considerable value.” *Id.* at 249. “Ultrasoundography has become an integral part of the assessment of age and health of the fetus.” R. Creasy & R. Resnik, *Maternal-Fetal Medicine: Principles and Practice* 210 (1984) (new 1989 edition forthcoming) (hereinafter “Creasy & Resnick”). The use of sonography to determine gestational age is also standard abortion practice. Hern, *Abortion Practice* 207 (1984).

The district court found that “it is standard medical practice to determine ‘gestational age’ by ultrasound examination and fetal skull measurements whenever it appears that a woman is at least 20 weeks pregnant.” 662 F.Supp. at 422. Indeed, the court found that such an examination to determine gestational age is “performed on every woman seeking a second trimester abortion” at the plaintiff, Reproductive Health Services. *Id.* at 422 n.43. *See also* T.II-6, 23-24, 47-48 (Hern).

With the use of ultrasound, at least five fetal parameters (measurements) are used to determine gestational age at 20 weeks or later.<sup>5</sup> These include: measurement of

<sup>5</sup> *See generally*, Goldstein, et al., *Ultrasonographic assessment of gestational age with the distal femoral and proximal tibial ossification centers in the third trimester*, 158 Am. J. Ob. Gyn. 127 (1988); Goldstein, et al., *Ultrasound Assessment of fetal intestinal development in the evaluation of gestational age*, 70 Ob. Gyn. 682 (1987); Hadlock, et al., *Estimating fetal age using multiple parameters: A prospective evaluation in a racially mixed population*, 156 Am. J. Ob. Gyn. 955 (1987); MacGregor, et al., *Underestimation of Gestational Age by Conventional Crown-Rump Length Dating Curves*, 70 Ob. Gyn. 344 (1987); Mercer, *Fetal foot length as a predictor of gestational age*, 156 Am. J. Ob. Gyn. 350 (1987); Reece et al., *Embryonic trunk circumference: A new biometric parameter for estimation of gestational age*, 156 Am. J. Ob. Gyn. 713 (1987); Campbell, et al., *Routine Ultrasound Screening for the Prediction of Gestational Age*, 65 Ob. Gyn. 613 (1985).

the crown-rump length (CRL), the biparietal diameter (BPD), femur length (FL), fetal head circumference (HC), and the abdominal circumference (AC). Pauerstein at 268-72. *See also* T.I-29-44, 55-71 (Maulik), T.I-97-108, 116-121 (Crist). Measurement of crown-rump length, biparietal diameter “and possibly femur length are the most accurate indicators of fetal age before 26 weeks of gestation.” Danforth at 269. The plaintiffs’ witness, Dr. Maulik, testified in the district court that “from 15 weeks to 24 weeks, we will use measurements of the fetal head, fetal skull to be precise, and also the fetal thigh measurements” and head circumference. (T.I-34). The standard use of ultrasound to determine gestational age when the fetus is believed to be of twenty or more weeks gestation indicates that section 188.029 is in complete accord with standard medical practice.

Nevertheless, in a manner akin to “divide and conquer,” the lower courts invalidated the second and third required findings of fetal weight and lung maturity. Then—having reduced the non-exclusive findings from three to one—the courts refused to sever and uphold the remaining required finding of gestational age by relying on the dictum in *Colautti v. Franklin*, 439 U.S. 379, 388-89 (1979) that legislatures cannot “proclaim one of the elements entering into the ascertainment of viability . . . as the determinant of when the State has a compelling interest in the life or health of the fetus.” 851 F.2d at 1074-75; 662 F.Supp. at 423. Aside from the fact that it was the lower courts, and not Missouri, which thereby designated only one finding, the plain language of section 188.029 does not even make the gestational age finding the sole, conclusive, or determinative factor in assessing viability. Rather, it merely requires a finding of gestational age as a part of the physician’s assessment of viability (“[i]n making this determination”). Thus, the dictum in *Colautti* simply does not apply to section 188.029. Accordingly, the court of appeals erred in



striking the determination of gestational age in section 188.029. That judgment should be reversed.

**B. Fetal Weight Is Directly Related to the Determination of Viability at Twenty or More Weeks Gestation and Can Be Determined By A Standard Ultrasound Examination.**

Section 188.029 also provides that the physician "shall perform or cause to be performed such medical examinations and tests as are necessary to make a finding of the . . . weight . . . of the unborn child . . ." The determination of fetal weight is directly related to determining the viability of the unborn child at 20 or more weeks gestation.<sup>6</sup> For example:

Antenatal prediction of birth weight has proven to be especially useful in the management of women at high risk for premature delivery. The reason is related to the fact that in approximately 35% of preterm infants exceeding 1000 g, clinical estimates of weight can be quite low, leading the physician to assume falsely that the chances of survival for the fetus are minimal. At present, accurate determination of birth weight even in the range of 750 g to 1000 g is important because the perinatal outcome of very low birth weight infants managed in modern intensive care neonatal centers has markedly improved.

Danforth at 274. See also, McCormick, *The Contribution of Low Birth Weight to Infant Mortality and Childhood*

<sup>6</sup> See generally, Verloove-Vanhorick, et al., *Neonatal Mortality Risk in Relation to Gestational Age and Birthweight*, *Lancet* 1:55 (Jan. 11, 1986); Kitchen, et al., *Outcome in infants of birth weight 500 to 999 gm: A continuing regional study of 5-year-old survivors* 111 *J. Pediatr.* 761 (1987); Shennan, et al., *Perinatal factors associated with death or handicap in very preterm infants*, 151 *Am. J. Ob. Gyn.* 231 (1985); Buckwald, et al., *Mortality and Follow-up Data for Neonates Weighing 500 to 800 g at Birth*, 138 *Am. J. Dis. Child.* 779 (1984); Kitchen, et al., *Outcome in infants with birth weight 500 to 999 gm: A regional study of 1979 and 1980 births*, 104 *J. Pediatr.* 921 (1984);

*Morbidity*, 312 *N. Eng. J. Med.* 82 (1985). This relationship is nothing new. "Estimating fetal weight and gestational age has been the subject of considerable investigative work for the past several decades in evaluating growth rate and development of the fetus at risk and when early termination of pregnancy is to be accomplished." Thompson & Makowski, *Estimation of Birth Weight and Gestational Age*, 37 *Ob. Gyn.* 44 (1971).

Several parameters are used in determining fetal weight by ultrasonography.<sup>7</sup> Generally, the same fetal parameters that are used to determine gestational age are used to determine fetal weight. With ultrasound, fetal weight may be estimated using a formula that "utilizes head circumference, abdominal circumference and femur length." Ott & Doyle, *Ultrasonically Estimated Weight and Gestational Age: Predictors of Neonatal Respiratory Distress Syndrome*, 32 *J. Repro. Med.* 915, 916 (1987). See also C. Pauerstein, ed. *Clinical Obstetrics* 268 (Ta-

<sup>7</sup> See generally, R. Creasy & R. Resnik, *Maternal-Fetal Medicine: Principles and Practice* at 218 (1984); Ott & Doyle, *Ultrasonically Estimated Weight and Gestational Age: Predictors of Neonatal Respiratory Distress Syndrome*, 32 *J. Repro. Med.* 915, 916 (1987); Ott, et al., *Accurate ultrasonic estimation of fetal weight: III. Prospective evaluation of new formulae*, 3 *Am. J. Perinatol.* 307 (1986); Chervenak, et al., *A comparison of sonographic estimation of fetal weight and obstetrically determined gestational age in the prediction of neonatal outcome for the very low-birth weight fetus*, 152 *Am. J. Ob. Gyn.* 47 (1985); Guzick, et al., *Ultrasound prediction of fetal weight in prolonged pregnancy*, 151 *Am. J. Ob. Gyn.* 783 (1985); Hadlock, et al., *Estimation of fetal weight with the use of head, body, and femur measurements—A prospective study*, 151 *Am. J. Ob. Gyn.* 333 (1985); Patterson, *Estimation of Fetal Weight During Labor*, 65 *Ob. & Gyn.* 330 (1985); Sampson, et al., *Single Ultrasonic Estimation of Fetal Weight in Utero Compared with Birth Weight*, 30 *J. Repro. Med.* 28 (1985); Tahilramaney, et al., *Ultrasonic estimation of weight in the very low-birthweight fetus: A resident versus staff physician comparison*, 151 *Am. J. Ob. Gyn.* 90 (1985).

ble 12-1) (1987). "Fetal length is one of the major determinants of fetal weight." Danforth at 272. A formula targeted to low birth weight and premature fetuses which incorporated fetal head circumference, fetal abdominal circumference, and femur length has considerable accuracy. Danforth at 273. Some physicians have found that "[a] single cross-sectional area of the fetal abdomen at the level of the insertion of the ductus venosus permits weight estimation to within 200 gm." Creasy & Resnik at 218.

Contrary to the lower courts' holdings, the requirement of a finding of fetal weight does not impose any undue burden on the physician or patient. A finding of fetal weight can be obtained from the same ultrasound test used to determine gestational age, which the district court found to be standard medical practice for women at 20 weeks gestation. 662 F.Supp. at 423 & n.45. In striking down the required finding of fetal weight, the district court (662 F.Supp. at 422) and the court of appeals (851 F.2d at 1074-75) relied on estimated costs of "\$125-250" for tests to determine fetal weight. This finding is not supported by the record and the lower courts employed an erroneous standard of review in relying on this finding. The only basis for these costs in the record is the testimony of Dr. Crist. He attributed these costs to the work of a "paranatomologist" [sic] for a "high-risk patient" later in gestation. (T.I-108)

Since medical testimony in this case—supported by abundant medical literature—indicates that the use of ultrasound is standard medical practice for a woman at twenty or more weeks gestation, any costs attributable to this standard medical practice cannot logically be attributable to Missouri's statute, nor do they support the claim that the statute imposes any burden on the physician or his patient. The same ultrasound test that

permits estimation of gestational age permits estimation of fetal weight. Thus, the district court and court of appeals applied an erroneous standard of review in disregarding the plain language of section 188.029 and in relying on such costs to strike it down.

**C. Fetal Lung Maturity Is Related to the Determination of Viability At Twenty or More Weeks Gestation And Can Be Determined By A Standard Ultrasound Examination.**

Section 188.029 also provides that the physician "shall perform or cause to be performed such medical examinations and tests as are necessary to make a finding of the . . . lung maturity of the unborn child. . . ." At twenty weeks gestation, the fetal lung is maturing. All airways in the fetal lung are accompanied by pulmonary arterial branches and all of the preacinar veins are also present at 20 weeks gestation. Creasy & Resnik at 370.

Therefore, by 20 weeks the development of the airways and pulmonary vessels is complete, and with the appearance of respiratory bronchioles and icini, the lung is prepared to support extrauterine life.

*Id.* This does not mean that fetal lungs are fully mature at twenty weeks gestation, but, by providing for a "finding" of fetal lung maturity when the physician "has reason to believe" that the fetus is at twenty or more weeks gestation, section 188.029 "reasonably furthers" Missouri's compelling interest in the viable unborn child. *Ashcroft*, 462 U.S. at 486.

Fetal lung maturity, like gestational age and fetal weight, is related to fetal viability. *See generally*, Danforth & Scott at 320; *Williams Obstetrics* at 154ff; Creasy & Resnik, at 369ff. This is because immature fetal lungs may lead to respiratory distress syndrome, or RDS, which may cause infant mortality. In recent years nearly 20% of all neonatal deaths in the United States

have been attributable to RDS. Tait, *Improved Fluorescence Polarization Assay for Use in Evaluating Fetal Lung Maturity I: Development of the Assay Procedure*, 32 Clin. Chem. 248 (1986). Morbidity, however, may not be severe. See Ludman, et al., *Birth Weight, Respiratory Distress Syndrome and Cognitive Development*, 141 Am. J. Dis. Child. 79 (1987) (“[no] significant difference [in cognitive development] was found at any age between children who had and did not have RDS during the neonatal period”).

It was only thirty years ago that the cause of RDS was discovered to be the deficiency of pulmonary surfactant. *Williams Obstetrics* at 154, 769. Surfactant is a group of phospholipids (detergents) that lower surface tension in the alveoli (lung air sacs) and thus prevent complete collapse of the alveoli with expiration. In the absence of adequate amounts of surfactant, the alveoli collapse completely each time the infant exhales. As a result, each infant breath requires that as much intrathoracic pressure be generated as with the infant's first breath. This may lead to hyaline membrane (cartilage) formation in the alveoli and to exhaustion of the infant as she fights to take in air. Cruikshank, *Aminocentesis for Determination of Fetal Maturity*, 25 Clin. Ob. Gyn. 773 (1982). Maturity of the fetal lung, therefore, is reflected in the amount of surfactant produced; if there is not enough surfactant, or it is of poor quality, the alveoli collapse (a state called atelectasis) and inadequate oxygen exchange occurs, resulting in hypoxia (decreased oxygen) and cyanosis (bluish color).

The plaintiffs and the district court misread the plain language of section 188.029 as though it required a specific “test of fetal lung maturity.” The plain language is actually much more flexible. It requires “such medical examinations and tests as are necessary to making a finding of . . . lung maturity. . . .” Based upon the district court's construction, the court found that it was “clearly established that the only method to evaluate

lung maturity is by amniocentesis, an expensive procedure which all witnesses agreed would be useless and contrary to accepted medical practice until at least twenty-eight to thirty weeks of gestation.” *Id.* at 422.<sup>8</sup> This finding however, is immaterial.

There are a number of different methods in standard medical practice to determine fetal lung maturity at twenty or more weeks gestation. The most simple and most obvious is by inference. It is well known that fetal lungs do not mature until 33-34 weeks gestation. This obviously does not mean that no unborn child can survive if born at less than 33-34 weeks; it merely implies that an infant born before that time may suffer from RDS, which can lead to infant mortality. The finding of 33-34 weeks gestational age, from which this inference can be made, can be derived from an ultrasound test and the fetal parameters previously described. If an assessment of the gestational age indicates that the child is less than thirty-three weeks, a general finding can be made that the fetal lungs are not mature. This finding can then be used by the physician in making his determination of viability under section 188.029.

A second method of making a “finding” on fetal lung maturity at twenty or more weeks gestation is by ultrasound.<sup>9</sup> Ott & Doyle, *Ultrasonically Estimated Weight*

<sup>8</sup> The court's statement earlier in the proceedings—which directly contradicts this later finding—more correctly construes the plain language: “I don't think this says they have to do that, this doesn't say anything about that.” (T.I-121) Moreover, the finding is directly contrary to repeated testimony that amniocentesis would not be a “necessary” test to determine fetal lung maturity at 20-24 weeks gestation because amniocentesis would be futile to make a finding. (T.I-68-71 (Maulik), 117-118 (Crist), 136 (Pearman)).

<sup>9</sup> See generally, Kazzi, et al., *The relationship of placental grade, fetal lung maturity, and neonatal outcome in normal and complicated pregnancies*, 148 Am. J. Ob. Gyn. 54 (1984); Crawford, et al., *Ultrasonic tissue characterization of the placenta: Is it of, clinical value*, 13 J. Clin. Ultrasound 533 (1985); Gross, et al. *Sonographic*

and Gestational Age: Predictors of Neonatal Respiratory Distress Syndrome, 32 J. Repro. Med. 915 (1987) (hereinafter "Ott & Doyle"); Tahilramaney, et al., *Ultrasound in evaluation of fetal pulmonary maturity*, 10 Perinatol. Neonatal. 9 (1986); Garite, *Testing for fetal lung maturity*, 9 Perinatol. Neonatal. 85 (1985); Mullin, et al., *Ultrasound screening for Free-Floating Particles and Fetal Lung Maturity*, 66 Ob. & Gyn. 50 (1985). With the use of ultrasound, several fetal parameters "such as placental grading, free-floating particles in the amniotic fluid, echogenicity of the fetal lung, fetal lung compressibility, and maturation of the fetal gastro-intestinal tract, have been proposed as rapid, non-invasive methods of evaluating fetal respiratory maturity." Ott & Doyle at 916. This method for determining fetal lung maturity involves an examination of the increase in free-floating particles and particulate matter in the amniotic fluid, which can be seen by ultrasound. The increase in this matter has been associated with lung maturity. Mullin, 66 Ob. & Gyn. at 50.

On the potential of using an ultrasound test, the district court's reasoning is inscrutable. The district court found:

Medical experts for both plaintiffs and defendants concurred that it is standard medical practice to determine "gestational age" by ultrasound examination and fetal skull measurements whenever it appears that a woman is at least twenty weeks pregnant. Defendants have further acknowledged that no tests other than the ultrasound measurements pro-

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*free floating particles (FFP) in amniotic fluid predict mature lecithin/sphingomyelin ratio* (Paper Presented at the Third Annual Meeting of the Society of Perinatal Obstetricians, San Antonio, TX, Jan. 27-29, 1983); Fried, et al., *Echogenicity of fetal lung: Relation to fetal age and maturity*, 145 Am. J. Radiology 951 (1985); Farrell, et al., *A sensitive and specific ultrasonic sign of fetal lung maturation*, 4 J. Ultrasound Med. (suppl) 80 (1985); Zilanti, et al., *Assessment of maturity through the study of the ultrasonic image of the fetal intestine*, 4 J. Ultrasound Med. (suppl) 81 (1985).

vide information necessary to determine viability prior to at least 30 weeks gestational age. Despite such concessions, the State defends this statutory language and maintains that the section demands only those examinations which are "necessary" to make the required findings. Thus, defendants insist that there is no duty to perform an amniocentesis for lung maturity or even a fetal weight determination if these tests would be futile. However, the ultrasound exam would be mandatory.

*Id.* at 422 n.44. The court then held that "[t]his evidence" must be evaluated in light of the dictum in *Colautti* that legislatures could not "proclaim one of the elements entering into the ascertainment of viability . . ." and concluded that the "State may not dictate either the tests *or* the findings which enter into a decision whether or not a fetus is viable." 662 F.Supp. at 423. Thus, according to the court, even if an ultrasound examination could yield a finding on gestational age, weight and lung maturity, it could not be required under the standard of review derived from *Colautti*.

By construing section 188.029 to require a specific test of lung maturity, the court read into the plain language a requirement of what is merely a third method of making "a finding" on fetal lung maturity at some points in gestation—amniocentesis—but is simply not required by either the plain language of section 188.029 or by standard medical practice. *See generally, Williams Obstetrics* at 268ff. Amniocentesis involves the insertion of a needle through the mother's abdominal wall into the amniotic sac, from which amniotic fluid is withdrawn (aspiration). A variety of tests to determine fetal lung maturity may be performed on amniotic fluid withdrawn by amniocentesis. These tests analyze the presence and strength of certain biochemicals in the amniotic fluid which are related to the development of the fetal lung. Among the available amniotic tests to predict fetal lung maturity, the lecithin/sphingomyelin ratio (L/S ratio) of amniotic fluid is perhaps the most widely used. As the fetal lung

matures, the amount of lecithin in amniotic fluid increases, both absolutely, and in relation to sphingomyelin. Above a certain L/S ratio, lung maturity is very likely.

However, given the availability of ultrasound to determine gestational age and fetal weight, aminocentesis would not be medically indicated to determine fetal lung maturity until approximately thirty-two weeks gestation, if then. The L/S ratio, which tests for surfactant, is not a dispositive factor for viability. It predicts the occurrence of respiratory distress syndrome (RDS), which is related to viability, but does not exactly predict viability, because an infant with RDS may nevertheless survive with good outcome. Moreover, although a "mature" L/S ratio predicts that RDS will *not* occur with 98% certainty, an immature ratio by no means ensures that RDS *will* develop. Although functional maturity of the surfactant system usually occurs between thirty-three and thirty-seven weeks gestation in normal pregnancy—thereby allowing the finding of a good L/S ratio—it is obvious that infants can survive before this time and therefore before a good L/S ratio can be found. As a result, of the three findings specified by section 188.029, although all are related to viability, fetal lung maturity is probably the least important of the three factors in making a determination of viability.

In addition to the fact that the fetus may well be viable several weeks, even months, before the fetal lung matures, various medical indications would justify delivery even though the fetal lung is technically immature as determined by the L/S ratio. For example, early delivery may be indicated if the mother is diabetic or suffers from severe hypertension or severe hydramnios. *Williams Obstetrics* at 603. "There are times when the risk to the fetus from a hostile environment will be greater than the risk of death from respiratory distress even though the L/S ratio is less than 2." *Williams Obstetrics* at 273-74. If the intrauterine environment of the pregnant mother with diabetes deteriorates, "the

fetus most often is better off being delivered even though premature." *Williams Obstetrics* at 602.

Abortion must be considered such a circumstance. When an abortion is induced with the usual intent to end the life of the fetus, the risk of death to the infant from respiratory distress will be less than the risk of certain death from abortion.

Finally, there may be several reasons why a physician would not want to administer amniocentesis to determine lung maturity under certain circumstances in pregnancy. Amniocentesis is associated with a small risk of maternal and fetal morbidity, including "(1) trauma to the fetus, to the placenta, or, less often, to the umbilical cord or to maternal structures; (2) infection; and (3) abortion or premature labor." *Williams Obstetrics* at 268; Mullin, 66 Ob. & Gyn. 50. Some of the examples of maternal morbidity can be discounted as a "risk" where an elective abortion is proposed as the outcome of the amniocentesis, because some of these risks (e.g., premature labor) are only "risks" when the mother intends to bear the child. On the other hand, the "risks" to the fetus from amniocentesis that are considered "risks" if the mother plans to carry the pregnancy to term are not "risks" if probable death for the child from abortion is the alternative. For this reason, it is difficult to follow the reasoning of the district court that amniocentesis would be contra-indicated because of risk to the *fetus*, rendering the statute unconstitutional. 662 F.Supp. at 423. Nevertheless, true "risks" of *maternal* morbidity from amniocentesis (which, as demonstrated above, would not be indicated until at least thirty-two weeks), would reasonably be weighed by the physician.

#### V. THE COURT OF APPEALS ERRED BY FAILING TO SEVER AND UPHOLD THE CONSTITUTIONAL PROVISIONS OF SECTION 188.029.

The courts below relied on the general severability provision in the Missouri statutes, Mo.Rev.Stat. section 1.140 (1986), to uphold and sever the first sentence of

section 188.029, but refused to sever and uphold any provisions of the second sentence, on the rationale that *Colautti v. Franklin* prohibited the state from designating "either the tests or the findings which enter into a decision whether or not a fetus is viable." 662 F.Supp. at 423. Because the dictum in *Colautti* does not extend that far, the lower courts erred by disregarding their obligation to separate constitutional provisions from unconstitutional provisions "and to maintain the act in so far as it is valid." *Regan v. Time, Inc.*, 468 U.S. 641, 652 (1984); *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 502 (1985). We submit that all provisions of § 188.029 are constitutional. However, because each of the discrete findings required in § 188.029 is an independent measure of viability, § 188.029 can "function in a manner consistent with the intent of" the Missouri legislature even if one or two findings is left standing. *Alaska Airlines, Inc. v. Brock*, 107 S.Ct. 1476, 1481 (1987). For this reason, the courts erred in failing to sever and uphold each of the three findings that are constitutional.

### CONCLUSION

For the foregoing reasons, the judgment below, striking down the second sentence of Mo.Rev.Stat. § 188.029 as unconstitutional, should be reversed.

Respectfully submitted,

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