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WHERE ARE WE NOW:
The Supreme Court Decisions Ten Years After *Roe v. Wade*

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Introduction

Barely ten years after the Supreme Court's sweeping decision in *Roe v. Wade,* which legalized abortion virtually on demand throughout all nine months of pregnancy, the Court handed down a trio of opinions that reaffirmed its original abortion rulings. On June 15, 1983, the Court ruled on challenges to abortion regulations in Missouri, Ohio, and Virginia. A six member majority of the Court struck down substantial portions of the requirements on the ground they unreasonably infringed upon a woman's constitutional right to obtain an abortion.

The Court's action left few legislative doors open. Informed consent provisions— the real heart of abortion regulation and deterrence—were invalidated wholesale. Minor statutory changes may still slip through the cracks. But legislative efforts to give a pregnant woman full information about her abortion decision have been shut down.

The 1983 cases are not total defeats. The obvious victory is the forceful dissent of the sole woman on the Court: Justice Sandra Day O'Connor. Joined by Justices Rehnquist and White, her strong stand may signal that the reversal of *Roe v. Wade* is near. Two more pro-life votes would ensure the demise of *Roe.*

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I.
THE MAJORITY OPINION

A. City of Akron v. Akron Center for Reproductive Health

In the lead case, *City of Akron v. Akron Center for Reproductive Health,* Justice Lewis Powell, writing for six members of the Court, explicitly reaffirmed *Roe v. Wade,*[1] relying on the doctrine of *stare decisis.*

In so endorsing *Roe,* the Court apparently felt unconstrained to explain or justify the actual legal reasoning and constitutional foundations of that decision. This, despite the Court's thinly veiled acknowledgement of the fierce political and academic controversy generated by *Roe:*

> Legislative responses to the Court's decision have required us on several occasions, and again today, to define the limits of a State's authority to regulate the performance of abortions. And arguments continue to be made, in these cases as well, that we erred in interpreting the Constitution.[2]

The support for *Akron* was thus founded not in the Constitution, but strictly on the precedent of *Roe.*

The keystone of the opinion was the majority's apparently unwavering and unshaken belief in the integrity and high standards of the medical profession, including those professional associations which may have a pecuniary interest in expanding abortion rights. The Court emphasized as central to a woman's abortion right, "that her physician be given 'the room he needs to make his best medical judgment '. . . [It] encompasses both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion."[3]

The "room" that the physician "needs to make his 'best medical judgment'" is a large space indeed. Any regulation which the Court deemed, in its medical wisdom, to "depart from accepted medical practice"[4] or "place a significant obstacle in the path of women seeking an abortion"[5] was stricken.

Prior to evaluating particular provisions of the Akron ordinance, the Court clarified its standard of review. It noted two state interests which might justify state regulation of abortions. The first is an "important and legitimate interest in protecting the potentiality of human life,"[6] which becomes compelling only at fetal viability. Secondly, the State also has a legitimate interest in the woman's health, which does not become compelling until "approximately the end of the first trimester. . . Until that time, a pregnant woman must be permitted, in consultation with her physician, to decide to have an abortion and to effectuate that decision "free of interference by the State."[7]

Consequently, in the first trimester, a state may require that an abortion be performed only by a physician. In addition, "Certain regulations that have no significant impact on the woman's exercise of her right may be permissible where justified by important state health objectives."[8] Examples are the reporting requirements upheld in *Planned Parenthood of Central Mo. v. Danforth,*[9] and the pathological examination requirement, upheld in the companion case, *Planned Parenthood Ass'n of Kansas City, Mo. v. Ashcroft.* However, "even these minor regulations . . . may not interfere with physician-patient consultation or with the woman's choice between abortion and childbirth."[10]

Second-trimester regulations of the abortion procedure must "reasonably relat[e]"[11] to maternal health. However, "the determinative question should be whether there is a reasonable medical basis for the regulation."[12] The regulation must not "depart from accepted medical practice." The Court seemed to regard whatever norms are set by the National Abortion Federation (which Powell described as "an organization of abortion providers and people interested in the pro-choice movement"), the American College of Obstetrics and Gynecology (ACOG), and the American Public Health Association as the chief evidence of what constitutes "accepted medical practice."

Furthermore, if the regulation does not meet accepted medical practice during part of the trimester, it "may not be upheld simply because it may be reasonable for the remaining portion of the trimester."[13] It was on this basis that the Court struck down Akron's second-trimester hospitalization requirement. The main burden on the woman was stated to be "additional cost," although the Court also recognized an additional health risk due to the delay in finding available facilities.

In this, the Court rejected the State's "reasonable health regulation" defense. At the time of enactment of the ordinance, second-trimester hospitalization was recommended by the American Public Health Association and the American College of Obstetricians and Gynecologists. *After* trial, the ACOG abandoned its position and the high Court relied on that new "present medical knowledge"[14] to "convincingly undercu[t] Akron's justification for requiring that *all* second-trimester abortions be performed in a hospital."[15]

The dissenters perceptively observed that the majority's reliance on changing medical technology would "necessitate [the Court's] continued functioning as the nation's *'ex officio* medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States.'"[16] As discussed below, the Court's reliance on advances in medical technology may ultimately prove to be the undoing of *Roe.*

The Akron informed consent provision required that certain information be given the woman considering an abortion: confirmation of the fact and stage of pregnancy, characteristics of the unborn child, physical and psychological risks of the abortion procedure, and alternative agencies. According to the Court, this exercise of the State's interest — protecting the health of the pregnant woman—went "beyond permissible limits":

> First, it is fair to say that much of the information required is designed not to inform the woman's consent but rather to persuade her to withhold it altogether . . . An additional, and equally decisive, objection to [the informed consent requirement] is its intrusion upon the discretion of the pregnant woman's physician.[17]

The Court concluded that the "lengthy and inflexible list of information" unreasonably placed "obstacles in the path of the *doctor* upon whom [the woman is] entitled to refer for advice in connection with her decision."[18]

The general requirement that the woman be told of the particular risks of her pregnancy and the abortion techniques to be used, and general instructions on proper post-abortion care was found to be consistent with the Court's interpretation of informed consent in *Planned Parenthood of Central Mo. v. Danforth.*[19] Nonetheless, the Court invalidated the provision since it required the

physician to personally describe the health risks. "[T]he critical factor is whether she obtains the necessary information and counseling from a qualified person, not the identity of the person from whom she obtains it."[20]

Thus, while legislatures may "describ[e] the general subject matter relevant to informed consent for a pregnant woman," they may not require that an abortion-performing physician give information he does not regard as "relevant to her personal decision" or place him in an "undesired and uncomfortable straitjacket." The "precise nature and amount of this disclosure [must be left] to the physician's discretion and 'medical judgment'"[21]

The Court's ruling in favor of a physician's discretion reaffirmed its great confidence in the medical profession:

> This Court's consistent recognition of the critical role of the physician in the abortion procedure has been based on the model of the competent, conscientious, and ethical physician. We have no occasion in this case to consider conduct by physicians that may depart from this model.[22]

However, the Court observed in the companion case, *Planned Parenthood Ass'n v. Ashcroft,* that "not all abortion clinics, particularly inadequately regulated clinics, conform to ethical or generally accepted medical standards."[22]

Akron's 24-hour waiting period was held unconstitutional by the Court as "arbitrary" and "inflexible." The trial court found that the waiting period would increase both the cost and risk of the abortion procedure. Such mandatory delay, the high Court stated, interfered with the physician's discretion in the exercise of his medical judgment.

The Court also struck down Akron's requirement that minors under 15 must have parental consent or a court order in order to obtain an abortion, on the ground that the procedures did not fully comply with Powell's plurality opinion in *Bellotti v. Baird (II).*[23] However, a provision which did meet the *Bellotti (II)* requirements was upheld.

Finally, the Court struck down Akron's requirement that abortion-performing physicians "insure that the remains of the unborn child are disposed of in an humane and sanitary manner," on the grounds that the meaning of "humane" is uncertain and therefore unconstitutionally vague for a criminal statute.

B. Planned Parenthood Ass'n of Kansas City, Mo. v. Ashcroft

Justice Powell was joined in his opinion by Chief Justice Burger, and by the rest of the panel concurring in various parts, and dissenting in part.

Missouri's second-trimester hospitalization requirements were similar to those at issue in *Akron,* and were held unconstitutional for the same reasons. Secondly, Missouri's parental consent requirement provided for a judicial alternative consistent with *Bellotti (II),* and was therefore held constitutional.

A more hotly-contested issue was the Missouri requirement that a second physician be present at a post-viability abortion. His stated role was to give medical attention to a child that survives the abortion. The plaintiff challenged this provision on the ground that no viable fetus could survive a dilatation and evacuation (D & E), a dismemberment procedure. Justice Powell questioned the likelihood of any significant number of post-viability D & E abortions, strongly attacking the credibility of Dr. Crist, the one medical witness who described

them as a post-viability method of choice.

Justice Powell wrote that the presence of the second physician reasonably relates to the State's compelling interest in protecting the life of a viable fetus. "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 then the first physician alone would be able to do."[24]

The Missouri statute also required that a pathologist examine and report upon all tissue removal after surgery, including abortion. Certain problems, such as fatal ectopic pregnancies and pre-cancerous growths, can only be discovered through pathological examination.[25] The requirement was found to be one which conformed to accepted medical practice related to the State's interest in protecting women's health and was a "relatively insignificant burden" on the woman's abortion decision.

Justice Blackmun, joined by Justices Brennan, Marshall, and Stevens, attacked those provisions upheld by Justic Powell's opinion. Citing statements in the American College of Obstetricians and Gynecologists (ACOG) and National Abortion Federation standards, he argued that "generally accepted medical standards" require only that a *physician,* not a pathologist, perform a pathological examination, and maintained that the requirement might increase the cost of abortions by as much as $40. Arguing that legislative enactments to serve the post-viability compelling State interest in "the potentiality of human life" must be "narrowly drawn to express only the legitimate State interests at stake." Justice Blackmun emphasized that both the District Court and the Court of Appeals had found creditable Dr. Crist's testimony that for maternal health reasons D & E abortions were sometimes necessary after viability. Therefore, he wrote, the provision unconstitutionally required a second physician even when the use of D & E precluded the possibility of live birth. Justice Blackmun reiterated " 'that the woman's life and health must always prevail over the fetus' life and health when they conflict.' "[26] Finally, he maintained his opposition to the requirement of any form of parental or judicial consent for a minor's abortion.

C. Simopoulos v. Virginia

In this appeal from the Supreme Court of Virginia, the Court affirmed by an 8-1 vote the conviction of an obstetrician-gynecologist for performing a second-trimester abortion outside of a licensed hospital. Dr. Simopoulos, the appellant, operated an unlicensed abortion clinic in violation of Virginia law. His conviction arose out of his performance of a second-trimester saline abortion on a 17-year-old woman who was five months pregnant.

Simopoulos raised two issues which were briefly disposed of by the Court. First, the Court rejected his argument that the State had the burden of proving lack of medical necessity beyond a reasonable doubt. Second, the Court viewed as "meritless" the appellant's contention that "the prosecution failed to prove that his acts in fact caused the death of the fetus."[27]

Simopoulos also launched a broad attack on the validity of the Virginia state hospitalization requirements as applied to second-trimester abortions. He essentially argued that those requirements were no different in substance from those reviewed in *Akron* and *Ashcroft.*

The Court recognized that the Virginia law was distinguishable from the regulations at issue in *Akron* and *Ashcroft.* Although the Virginia abortion statute did not define "hospital," reference to another statute made it clear that clinics or "outpatient . . . hospitals" were included within the definition of "hospital." The Court observed that, "Thus, under Virginia law, a second-trimester abortion may be performed in an outpatient surgical hospital provided that facility has been licensed as a 'hospital' by the State."[28]

The Court further noted that "On their face, the Virginia regulations appear to be generally compatible with accepted medical standards governing outpatient second-trimester abortions,"[29] consistent with the State's legitimate and compelling interest in protecting the woman's health and safety.

The Court emphasized in closing that the Virginia second-trimester regulation, unlike the provisions challenged in *Akron* and *Ashcroft,* "leaves the method and timing of the abortion precisely where they belong—with the physician and the patient."[30]

Justice O'Connor, in an opinion joined in by Justices White and Rehnquist, concurred in part and in the judgment, but did not agree that the constitutional validity of the hospitalization was contingent on the trimester in which it was imposed. "Rather, I believe that the requirement in this case is not an undue burden on the decision to undergo an abortion."[31]

Justice Stevens dissented on the ground that "hospital" might be interpreted to apply only to a full-service, acute-care hospital facility, and thus be unconstitutional in light of *Akron* and *Ashcroft.* He would have remanded for reconsideration.

II.
JUSTICE O'CONNOR'S DISSENT

In a dissent joined by Justices White and Rehnquist, Justice Sandra Day O'Connor laid bare the fallacies of both the majority opinion and its precedent, *Roe v. Wade.* Finding that "The *Roe* framework . . . is clearly on a collision course with itself,"[32] Justice O'Connor challenged the Court's reliance on shifting medical technologies and standards of practice.

> As the medical risks of various abortion procedures decrease, the point at which the State may regulate for reasons of maternal health is moved further forward to childbirth. As medical science becomes better able to provide for the separate existence of the fetus, the point of viability is moved further back toward conception.
>
> The *Roe* framework is inherently tied to the state of medical technology that exists whenever particular litigation ensues. Although legislatures are better suited to make the necessary factual judgments in this area, the Court's framework forces legislatures, as a matter of constitutional law, to speculate about what constitutes "accepted medical practice" at any given time. Without the necessary expertise or ability, courts must then pretend to act as science review boards and examine those legislative judgments.[33]

Justice O'Connor noted that although the question whether to reverse *Roe v. Wade* had not been raised by the parties,

> Accordingly, the Court does not re-examine [*Roe's*] holding. Nonetheless, it is apparent from the Court's opinion that neither sound constitutional theory nor our need to decide cases based on the application of neutral principles can accommodate an analytical framework that varies according to the "stages" of pregnancy, where those stages, and their concomitant standards of review, differ according to the level of medical technology available when a particular challenge to state regulation occurs.[34]

Rather than relying on the artificial "trimester" approach, with its varying degrees of state interests, the dissent would recognize the State's interest in potential human life and maternal health as compelling *throughout* pregnancy.

> *[P]otential* life is no less potential in the first weeks of pregnancy than it is at viability or thereafter . . . The choice of viability as the point at which the State interest in *potential* life becomes compelling is no less arbitrary than choosing any point before viability or any point afterward.[35]

A compelling State interest in fetal life would not guarantee the cessation of abortions. If the State asserted its interest in protection of unborn life, the courts would be faced with balancing this interest against the woman's asserted interest in preserving her health. In the end, the mother's health interest likely would prevail. At the present time, however, it is not possible to state with certainty the effect of a compelling interest in fetal life throughout pregnancy. This is a new concept, raised by the dissent, and its ramifications are not clear. The recognition of a compelling interest in fetal life, although significant, is not the preferred position, since it does not restore full personhood of the unborn.

Justice O'Connor would largely defer to legislative discretion in applying these interests; for example, she would uphold the 24-hour waiting period requirement, since it

> reasonably relates to the State's interest in ensuring that a woman does not make this serious decision in undue haste. The decision also has grave consequences for the fetus, whose life the State has a compelling interest to protect and preserve . . . The waiting period is surely a small cost to impose to ensure that the woman's decision is well-considered in light of its certain and irreparable consequences on fetal life, and the possible effects on her own.[36]

Justice O'Connor is clearly dissatisfied with the majority's failure to reexamine the constitutional basis of the abortion right: "there is no justification in law or logic for the trimester framework adopted in *Roe* and employed by the Court today on the basis of *stare decisis.*"[37]

Thus, Justice O'Connor would have upheld all the regulations challenged in the three cases before the Court, on the basis that none of them constituted an undue burden on the woman's abortion decision, and that they all bore a rational relation to a legitimate state interest. This "rational relation" standard of review is substantially less onerous than the "strict scrutiny" test employed by the majority and thus would permit much greater latitude in state regulation of abortion. Some commentators state that Justice O'Connor's preference for the

"rational relationship" test is reflective of her experience in the Arizona legislature.

Whatever the genesis of the O'Connor doctrine, the majority clearly perceived her position as equivalent to a vote for reversal of *Roe.*

> [T]he dissenting opinion rejects the basic premise of *Roe* and its progeny. The dissent stops short of arguing flatly that *Roe* should be overruled. Rather, it adopts reasoning that, for all practical purposes, would accomplish precisely that result.[38]

The "surprise" vote of Justice O'Connor signals the arrival of a new "pro-life" justice. The prospect of reversal of *Roe v. Wade* is suddenly no longer a hazy "maybe." The Supreme Court is only two votes away from a majority.

III.
THE LEGISLATIVE OUTLOOK

In light of Justice Powell's sweeping decisions and the large number of issues presented to the Court in the abortion cases, one might wonder whether any state regulations can withstand constitutional challenge. Groups such as American Civil Liberties Union may be convinced that all legislative attempts must fail, but the legislative landscape is not quite so bleak.

In deciding *Akron, Ashcroft,* and *Simopoulos,* the Court specifically addressed no less than nine separate issues. Efforts to legislate with respect to some of these issues such as "informed consent" and "second trimester hospitalization" would probably be fruitless, and efforts would best be concentrated elsewhere.

A. Informed Consent

Relying on its earlier decision in *Planned Parenthood v. Danforth,*[39] the Court stated that it will permit the State to "describ[e] the general subject matter relevant to informed consent for a pregnant woman."[40] However, no state may require that the woman be given specific information—information on particular medical risks or fetal development.[41] The abortion-performing doctor must be permitted to determine the "precise nature and amount" of information which will be given to the woman.

Most abortionists already describe the risks associated with abortion, albeit in very general terms, and require that the woman sign a written consent form prior to an abortion, to preclude malpractice suits. Thus, it is of little additional significance that states may only require that this kind of information be discussed in general terms.

The widespread abuses in clinic "counseling" that informed consent laws were designed to eliminate will continue unabated since the doctor or counselor, as the case may be, is now permitted to withhold any information which he feels is not "relevant to [the woman's] personal decision."[42] Obviously, it is in the counselor's and doctor's financial interest to ensure that the woman opts for the abortion. Although the Court nodded its head to the existence of widespread abortion abuse,[43] it nonetheless limited its review to state regulation of the ethical practitioner.[44] Apparently, the State cannot aim legislation at foreclosing unethical practices, where it would "unduly burden" the abortion decision. At best, "a state may require that a physician make certain that his patient understands the physical and emotional implications of having an abortion."[45] Two general types of regulation are still open:

> A state may define the physician's responsibility to include verification that adequate counseling has been provided and that the woman's consent is informed. In addition, the State may establish reasonable minimum qualifications for those people who perform the primary counseling function.[46]

Obviously, these will have little substantive impact on abortion deterrence. Therefore, it would seem that there is little to be gained by attempting to legislate in this area. One creative approach, for the daring, is the remote possibility that courts may permit states to require that the woman be told that more specific information is available upon request. And, it is unclear whether printed information regarding alternatives to abortion (including the names of agencies, the services they offer, and the manner in which they might be contacted) may be distributed.[47] It is certain that the doctor himself need not give this information. He may delegate this task to another "qualified" person.[48] In any case, as with all other regulations, such a provision should include an exception based on medical emergencies.

B. Waiting Periods

In the context of an informed consent provision a waiting period of any length seems to be impermissible. The State's purpose in requiring a waiting period is to give the woman a short period of time to consider the information which she has been given. The Court in *Akron* stated that "careful consideration of the abortion decision is beyond the State's power to require."[49] Thus, any provision which might deter or delay the abortion decision is impermissible.

Assuming that states are permitted to provide a woman with printed information on alternatives to abortion, it is possible that a very brief waiting period—perhaps an hour or two—may be upheld. The State could argue that this would permit the woman to contact those agencies if she so desires. Otherwise, the woman would be denied any realistic opportunity to benefit from the information she had obtained.

At present, though, it seems highly unlikely that any waiting period will be upheld.

C. Post-First Trimester Hospitalization Requirements

The Court has indicated that it will carefully scrutinize all health regulations. Any regulations which do not conform to "accepted medical practices" will be found unconstitutional.[50] The Court's reliance on currently accepted medical practice makes it virtually impossible and totally impracticable to legislate in this area. Justice O'Connor recognized this when she stated that under the majority's opinion:

> The State may no longer rely on a "bright line" that separates permissible from impermissible regulation, and it is no longer free to consider the second trimester as a unit and weigh the risks posed by all abortion procedures throughout that trimester. Rather, the State must continously and conscientiously study contemporary medical and scientific literature in

order to determine whether the effect of a particular regulation is to "depart from accepted medical practice" insofar as particular procedures and particular periods within the trimester are concerned.[51]

Indeed, the *Akron* experience amply demonstrates the inherent difficulty of conforming to the Court's strictures. In 1978, when the City of Akron enacted its ordinance requiring that post-first trimester abortions be performed in hospitals, that requirement conformed to the standards set by the American College of Obstetricians and Gynecologists (ACOG). Moreover, it was a permissible health regulation explicity mentioned by the Court in *Roe v. Wade,*[52] and reaffirmed by the Supreme Court in *Gary-Northwest Indiana Women's Services, Inc. v Orr.*[53] It was not until 1982, well after the Akron ordinance was challenged, that the ACOG standards were changed to permit D & E procedures in outpatient clinics during the first part of the second trimester.

Accordingly, it appears that states would be well advised to refrain from legislating in this area. Even if a law complies with accepted medical practice at the time of its enactment, it will only be a matter of time before professional association standards relied on by the Court, such as those of the National Abortion Federation, are changed.

Although licensing regulations for outpatient surgical facilities which closely resemble Virginia's may be permissible now, they are subject to the same vagaries as general hospitalization requirements. The Virginia requirements were upheld in *Simopoulos* because they "appear[ed] to be generally compatible with accepted medical standards governing outpatient second-trimester abortions."[54] Thus, changing medical standards will necessitate constant monitoring and revisions in the laws.

The Court has charged the National Abortion Federation with the responsibility of setting standards for its own maintenance. Regulations which fail to adopt those standards will be found unconstitutional. Thus, the abortion providers have been given the task of policing themselves. Under these circumstances, it would seem more desirable to propose strict reporting laws that keep track of maternal morbidity and mortality rather than attempt to legislate specific time periods for hospitalization or specific licensing requirements. If accurate reporting were strictly enforced, future "medical standards" set by abortion providers could be more carefuly scrutinized to ensure that they conform to good medical practice.

D. Humane and Sanitary Disposal

The Court struck down this part of the Akron ordinance on the grounds that the term "humane" was unconstitutionally vague. The Court did suggest, however, that a carefully drawn regulation would further the State's "legitimate interest in proper disposal of fetal remains."[55] A law which adequately defines "humane disposal" and demonstrates that the purpose of the law is "to preclude the mindless dumping of aborted fetuses on garbage piles," would in all likelihood be upheld.

E. Parental Consent and Parental Notice

In *Akron,* the Court struck down a law requiring that minors under age 15 have parental consent prior to an abortion. The City of Akron did not provide

for a judicial procedure whereby those minors could obtain judicial waiver of the consent requirement if they were "mature" enough to make the abortion decision on their own or when the court felt that an abortion would be in their "best interests." In striking down this provision, the Court stated:

> Akron may not make a blanket determination that *all* minors under the age of 15 are too immature to make this decision or that an abortion never may be in the minor's best interests without parental approval.[56]

The Court made it perfectly clear that its earlier decision in *Bellotti v. Baird*[57] will continue to be the law of the land with respect to parental involvement in a minor's abortion decision. The *Ashcroft* court specifically upheld the Missouri parental consent law which contained the requisite judicial mechanism allowing a minor to go into court and have parental consent waived if she demonstrates that she is "mature" or an abortion would be in her "best interests."

The Court also cited with approval its decision in *H.L. v. Matheson,*[58] dealing with the less restrictive parental notice requirement. In *Matheson,* a majority of the Court indicated that a similar judicial waiver mechanism would be necessary for a notice law to be upheld.

It is apparent, then, that state laws protecting the rights of parents to notice of and consent to their minor daughter's abortion decision will be upheld if properly and narrowly drafted. However, such a statute must contain a judicial waiver mechanism which ensures that the proceeding will be confidentially and expeditiously carried out. As with other regulations, an exception for medical emergencies is necessary.

Although the Court struck down a mandatory waiting period in the setting of an informed consent provision in *Akron,* a short waiting period should be upheld in the context of parental notice and consent. The Court's invalidation of the concept of informed consent makes a waiting period for that purpose somewhat unnecessary. By contrast, the Court upheld the concept of parental involvement. Thus, the purpose of a waiting period in that situation—to give parents some time to consult with their daughter regarding the advisability of an abortion—remains valid. If the State were not permitted to require some waiting period, then the intent of the statute would be totally frustrated. A doctor could notify the minor's parents five minutes before the abortion and prevent them from having any input in their child's decision.

Opponents of parental involvement have claimed that waiting periods are impermissible in cases where parents have already been notified of the impending abortion and are in agreement that it should be performed. A well-drafted statute can meet this objection by providing for waiver of the notice requirement if the parents indicate that they have already been notified, such as by signing a notarized statement to that effect. This has the added benefit of making the waiting period flexible.

F. Reporting Requirements

The Court seems to be willing to allow the State to mandate reporting requirements that are "reasonably related to generally accepted medical standards" if those requirements "further important health-related state concerns."[59] In *Ashcroft,* the Court upheld a Missouri law requiring that all tissue removed during an abortion be submitted to a pathologist for

examination. The statute also required the pathologist to file a report of his findings with the State Division of Health and the abortion facility or hospital in which the abortion was performed.

In upholding this law, the Court noted that:

> As a rule, it is accepted medical practice to submit *all* tissue to the examination of a pathologist. This is particularly important following abortion, because questions remain as to the long-range complications and their effect on subsequent pregnancies.[60]

It is interesting to note, in view of possible legislation in this area, that the Court seemingly digressed from its absolute deference to ACOG standards. When this case went to trial, ACOG's standards "recommended that a 'tissue or operative review committee' should examine 'all tissue removed at obstetric-gynecologic operations.'"[61] These standards, like those relating to post-first trimester hospitalization, recently had been modified to make an exception to the general rule requiring tissue examinations for abortion procedures.[62] Although the Court recognized this fact, it refrained from striking the statute as it did in *Akron.* Instead, it upheld the regulation because ACOG's "change in policy was controversial within the College."[63]

The Court apparently was swayed by the lack of consensus within ACOG on this point, and considered this factor sufficiently important to allow the Court to disregard the formal position taken by ACOG in setting its standards.

If lack of consensus within the medical community can be the justification for reasonable regulation based on either view, there is much to be gained from enacting strict reporting requirements that will form an adequate statistical basis on which the medical community may rely in setting standards of practice. It is clear that statistical analysis can be slanted to reach wanted results. However, detailed reporting will lessen the adverse effects of faulty statistics presently advanced by those supporting abortion without regulation. At a minimum, those who are sincerely interested in protecting the health of womens rather than the economic interests of abortion-performing doctors, can rely upon the reported information to draw their own conclusions. This lack of agreement within the medical community, based on accurate and detailed reporting, may provide flexibility for subsequent health-related legislation.

G. Regulations Pertaining to Viable Children

In dealing with post-viable abortions, the Court did not retreat from its *Roe v. Wade* position holding that states must permit any abortion deemed necessary to preserve the life *or health* of the woman. However, the Court seems inclined to uphold state regulations designed to protect viable children during the abortion procedure and live born children immediately thereafter.

In *Ashcroft,* the Court upheld Missouri's requirement that a second physician be present during post-viable abortions to care for the child if he is born alive. The Supreme Court reversed the lower court rulings which had invalidated this law because there was no justification for requiring a second physician during D & E abortions since there is no chance that a child will survive.[64]

The Missouri law that was upheld also set forth the standard of care that physicians must use when an abortion of a viable child is contemplated. Both the

doctor performing the abortion and the second physician were required to "take all reasonable steps in keeping with good medical practice . . . to preserve the life and health of the viable unborn child; provided that it does not pose an increased risk to the life or health of the woman."[65] The second physician must also "take control of and provide immediate medical care for a child born as a result of the abortion."[66]

Accordingly, state mandated standards of care toward the viable child during the course of an abortion are permissible; provided they do not require that the doctor performing the abortion increase the risk to the mother's health.

In addition, states may also require that immediate medical care be given to a child who survives an abortion since the "State legitimately may choose to provide safeguards for . . . instances of live birth that occur."[67]

Of course, the second physician requirement must be waived when a medical emergency requires this.

H. Other Legislation

Although the Supreme Court's most recent decisions have clarified many issues concerning abortion, there are others which have yet to be decided. It appears that a carefully drafted spousal notice statute may be upheld if it waives notice when the husband is not the father of the child.[68]

In the areas of funding, legislation which restricts government funding of abortions is permissible.[69] Under *Harris v. McRae,* legislation which promotes governmental funding of maternal care and childbirth services is another avenue for encouraging childbirth.[70]

Also, laws that treat the unborn child as a person in situations unrelated to abortion can and should be enacted. Feticide statutes make the unborn child a "person" for purposes of state homicide codes. Thus, those who intentionally kill the child in the course of committing a felony against his mother may be held criminally liable.

In the area of tort law, many states have enacted legislation which permits suits for wrongful death even though the unborn child was not viable when the injury occurred. Laws should also allow suits for negligence that has caused prenatal injuries. And, legislation prohibiting recovery for "wrongful birth" based on the claim that a person was negligent for having failed to abort a child should be enacted.

In addition, laws can prohibit nontherapeutic experimentation on live children before and after an abortion. One final area where legislative inroads may be made is in promoting research aimed at reducing the age of viability and at increasing our knowledge and understanding of the unborn child. This should help to erode the myth that the unborn child is not a fellow human being who should be protected under our laws.

CONCLUSION

In its three recent decisions, the Court left open the door for some state protection of the viable fetus. In *Ashcroft,* for example, the Court permitted the additional cost of requiring a second physician at a post-viability abortion. Meticulously worded regulations which promote the chance of survival of a viable unborn child without increasing the risk to the mother's health are within the realm of possibility. Other carefully drafted legislation might enhance the protection of the unborn: grants may encourage medical research to push back the age of viability; accurate statistical reporting could clarify the actual risks of abortion.

Creative legislative action may ensure some immediate protection for the unborn. The long-term strategy, of course, is a thoughtful, scholarly approach aimed at reversal of *Roe v. Wade* and restoration of full personhood to the unborn.

NOTES

1. 410 U.S. 113 (1973).
2. 51 U.S.L.W. 4767, 4768 (U.S. June 14, 1983).
3. *Id.* at 4770 (quoting *Doe v. Bolton,* 410 U.S. 179, 192 (1973)).
4. *Id.* at 4771, 4772.
5. *Id.* at 4772.
6. *Id.* at 4770 (quoting *Roe v. Wade,* 410 U.S. 113, 153 (1973)).
7. *Id.* at 4770, 4771 (quoting *Roe,* 410 U.S. at 163).
8. *Id.* at 4771.
9. 428 U.S. 52, 79-81 (1976).
10. 51 U.S.L.W. at 4771.
11. *Id.* at 4771 (quoting *Roe,* 410 U.S. at 163).
12. *Id.* at 4770, 4771 n.11. The Court rejected statistics of comparative abortion and childbirth mortality rates as irrelevant except "where the State employs a health rationale as a justification for a complete prohibition on abortions in certain circumstances." *Id.*
13. *Id.* at 4772.
14. *Id.* at 4773 (quoting *Roe,* 410 U.S. at 163).
15. *Id.* (emphasis in original).
16. *Id.* at 4778 (quoting *Planned Parenthood v. Danforth,* 428 U.S. 52, 99 (1976) (White, J., concurring in part and dissenting in part)).
17. *Id.* at 4774.
18. *Id.* at 4775 (quoting *Whalen v. Roe,* 429 U.S. 589, 604 n.33 (1977) (emphasis added).
19. 428 U.S. 52 (1976).
20. 51 U.S.L.W. at 4775.
21. *Id.* at 4774.
22. *Id.* at 4776 n.39 (references omitted).
23. 443 U.S. 622 (1979).
24. *Ashcroft,* 51 U.S.L.W. at 4785.
25. *Id.* at 4786 n.10.
26. *Id.* at 4790 (quoting *Colautti v. Franklin,* 439 U.S. 379, 400 (1979)).
27. *Simopoulos,* 51 U.S.L.W. at 4792.
28. *Id.* at 4793.
29. *Id.* at 4794.
30. *Id.*
31. *Id.*
32. *Akron,* 51 U.S.L.W. at 4778.
33. *Id.*
34. *Id.* at 4777.
35. *Id.* at 4779 (emphasis in original).

36. *Id.* at 4782.
37. *Id.* at 4778.
38. *Id.* at 4768 n.1.
39. 428 U.S. 52 (1976).
40. *Akron,* 51 U.S.L.W. at 4775.
41. *Id.*
42. *Id.*
43. *See Ashcroft,* 51 U.S.L.W. at 4786 n.12, citing "The Abortion Profiteers," Chicago Sun-Times 25-26 (Special Reprint 1978).
44. *See Akron,* 51 U.S.L.W. at 4776, n.39:

> This Court's consistent recognition of the critical role of the physician in the abortion procedure has been based on the model of the competent, conscientious, and ethical physician. See *Doe,* 410 U.S. at 196-197. We have no occasion in this case to consider conduct by physicians that may depart from this model.

45. *Id.* at 4776.
46. *Id.* (footnotes omitted).
47. *Id.* at 4775 n.37.
48. *Id.* at 4775.
49. *Id.* (citation to Court of Appeals decision omitted).
50. *Id.* at 4771.
51. *Id.* at 4777-4778 (footnote omitted).
52. 410 U.S. 113, 163 (1973).
53. 451 U.S. 934 (1981).
54. *Simopoulos,* 51 U.S.L.W. at 4794.
55. *Akron,* 51 U.S.L.W. at 4776 n.45.
56. *Id.* at 4773 (emphasis in original).
57. 443 U.S. 662 (1979).
58. 450 U.S. 398 (1981).
59. *Ashcroft,* 51 U.S.L.W. at 4786.
60 *Id.*
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.* at 4785 n.7.
65. *Id.* at 4785.
66. *Id.*
67. *Id.* at 4786.
68. *Scheinberg v. Smith,* 659 F.2d 476 (5th Cir. 1981).
69. *Harris v. McRae,* 448 U.S. 297 (1980).
70. *Planned Parenthood v. Kempiners,* No. 81-C-3332 (7th Cir. Feb. 23, 1983).