Mandatory Viability Testing and Post-Viability Abortion Restriction: The Best Way Forward in the Immediate Future?

Patrick J. Flood

The basic reality in 2002 facing those of us who want to take legislative initiatives to protect unborn children from abortion is that the Supreme Court has left us little space in which to act. In a line of decisions that reached full definition in *Webster* and *Casey* and consistent application through *Stenberg*, the Court has painted in big red letters that states, and by implication Congress, *cannot* pass laws that prevent an adult woman from having her pre-viable unborn child aborted. Once her child reaches the point of viability, the situation changes dramatically. States can then adopt laws that directly protect the child from abortion. We may not like this division of a child's life into protectible and non-protectible zones, but there is *nothing* we can do about it legislatively right now. If we do not keep that fact at the center of our attention, we will burn up our available energy, time and talent for nothing, because each time the Supreme Court will throw our work into the shredder.

Of course, we all hope that the Supreme Court will get new pro-life members and that a new majority will re-extend the zone of protectibility to all of a child's life. But that Court majority does not yet exist, and it may not exist for some time, after which other years may pass before it fully corrects the errors of 1973.

So, we should look now at what the Court has given us to work with and use it to extend legal protection to those we *can* protect. While we are waiting for the new pro-life majority on the Court, we should use the time to fill up the space the present Court has given us to work with. This means two things. First, before viability we continue to push women's right to know laws, public funding cutoffs, and the like. Second, and this

is the focus of this paper, we need to see what we can do to protect viable children.

In Massachusetts we have developed a legislative proposal that if enacted could protect a significant number of babies from 20 weeks gestation. There is no reason to think that it would be overturned in court. It might even attract some support from less radical pro-abortion legislators. I am going to discuss substance and then process, but both only very briefly. The details and rationale are contained in the attached research memorandum, text of the bill, and my testimony.

SUBSTANCE

Testing: Some babies are viable at 20 weeks. The Court will not allow across-the board *restriction* at 20 weeks, but it will allow viability *testing* that early, and probably earlier. It should begin at around 18 weeks. Our bill calls for 16 in order to allow for legislative negotiation, but moving to 18 or 20 would not disturb the integrity of its structure or otherwise weaken it.

Second Opinion: The weakness of the viability testing laws we now have in seven states is that they do not require a confirming second opinion from a qualified independent physician. Since the first opinion is usually going to come from the abortionist, who has an interest in performing the abortion, there could be reason to lack confidence in the assessment. An independent second opinion is crucial. At a point during pregnancy when the baby could be viable *if* the length of pregnancy has been accurately determined beforehand, the baby may not yet have *established* a protectible constitutional interest but clearly *might have* such an interest. It cannot be an undue burden to establish the fact that determines which legal rules will apply to that child–the pre-viability rules or the post-viability rules. And this is what requires the second opinion. This also has some positive benefit for the pregnant woman, who will have more confidence in the reliability of the information she has been given.

Limitation to Physical Health after Viability: Some pro-lifers dismiss post-viability restrictions as meaningless because of the required "health" exception, which was defined in "anything goes" terms in the

1973 *Doe* decision. These critics assume that the definition is beyond challenge. Why? The Court has never explicitly restated the definition. Pro-lifers have fixated on overturning *Roe* to the neglect of *Doe.* Since 1973 six states have enacted laws limiting post-viability abortions to threats to the mother's life or physical health and none has been struck down by the Court. In the *Stenberg* decision on partial-birth abortion (2000), Justice Breyer's majority opinion dealt at great length with the need for a health-exception without once mentioning anything but physical health concerns related to the mother.

We can also cite the pro-abortion Senators who have twice rallied behind a physical-health limitation (albeit in an effort to sidetrack the partial-birth abortion ban in 1997 and 1998–but they *are* on record). The American College of Obstetrics and Gynecology also backed the 1997 bill.

Second opinion after viability: This should not be a big problem. No one can raise an undue burden argument. Nine states have a second-opinion rule, most of them specifying an independent physician. None has been tossed out by the Supreme Court. The point here is to verify that there is a genuine and serious risk to the mother's life or physical health. So, a second opinion makes sense for the same reasons as in the case of the viability determination. The bill as a whole needs all four of these elements to achieve its purpose. No state has this combination at the moment.

PROCESS

Since the goal was to protect as many viable unborn children as possible, I began in 1998 by searching the medical and pro-life literature for information on the earliest known premature infants who survived for any period. I also asked doctors, medical researchers, and pro-life organizations for data. The logic is that if one or two children have survived at *X* weeks, then any child of that age could be viable.

Next, I reviewed the relevant judicial decisions and state laws and consulted with some attorneys. Then I consolidated everything into a research memorandum that I circulated to the officers and senior staff of our state pro-life organization, inviting comments. I was at the time a

member of the board of directors. Feedback was positive, so I asked an attorney-member of the board to cast the bill in appropriate statutory language for filing with the legislature. I presented the proposal to the Board for endorsement, after which I visited my pro-life state senator and a few pro-life state representatives to seek sponsorship. They filed the bill, and several months later a hearing was scheduled. I assembled a panel of two medical doctors and a research biochemist; at the hearing, I summarized the bill and the main arguments for it and then each of my colleagues spoke on a different aspect according to their specialties.

Like almost all new bills on abortion, this one was sent to a study committee instead of being reported out for a floor vote. I continued to contact legislators by mail or in person as occasions arose during the next year and a half. I also stayed in close touch with our pro-life legislative lobbyist. In autumn 2000 our pro-life organization lined up sponsors and re-filed the bill for the 2001-2002 session. Once again I assembled a panel, this time including one medical doctor (the other was giving a pro-life speech on that day) and a fellow political scientist and author. The hearing in May 2001 went well. I thought the committee was more receptive this time. At both hearings I submitted a three-page written statement and an attachment or two. I followed up with several letters to the co-chairmen, both of whom are pro-life, enclosing some additional material, including the research memo found herewith. No abortion-related bills were brought to a floor vote during the legislative session. We will re-file the bill in the next session. It sometimes takes two or more sessions to build momentum; meanwhile the lobbying effort and testimony have great educational value.

RECOMMENDATION

I hope that this approach will be seen as offering a solid practical possibility to save unborn lives. In a state that already has a law incorporating one or more of these elements, the others can fill current gaps and form an integrated legal framework. Although the bill should have a severability clause just in case one provision is overturned, the several components are mutually reinforcing. Viable unborn children have protectible interests, and they deserve a chance; state legislators can

give them that chance by adopting a bill like the one outlined here.

RESEARCH MEMORANDUM:
PROPOSED LAW ON VIABILITY TESTING AND POST-VIABILITY ABORTION
(S.926/H.845)

TITLE: "An Act to Regulate Abortion after Viability"

GENERAL PURPOSES: To give practical effect to the state's Constitutional right to protect the interest of a viable unborn child in continuing to live by restricting abortion of a child after viability. The bill would fill a gap in current Massachusetts law by establishing a legal framework and procedures for medical determination of viability and by modifying legal rules for abortion of a viable child.

SPECIFIC PURPOSES: To require a physician to perform adequate tests to ascertain the viability of an unborn child before performing an abortion on an unborn child of 16 or more weeks of gestation, dating from the onset of the pregnant woman's last menstrual period (LMP). To require a confirming second opinion from an independent physician as to viability. To proscribe abortions after viability except when continuation of pregnancy would threaten the mother's life or impose on her a substantial risk of grave impairment of her physical health. To require a confirming independent second opinion as to these threats if the unborn child has been determined to be viable. Second opinions as to viability or risk to the mother would not be required in a medical emergency requiring immediate action.

DEFINITIONS

Viability–in S.926/H.845 viability is defined as "the ability of an unborn child to live outside the womb of the mother with or without artificial means of life support."[i]

Gestational age is generally defined in medical literature as dating from the first day of LMP; an unborn child at 18 weeks of gestation, therefore, means a child 18 weeks after LMP. Federal courts have

ordinarily used this definition in dealing with abortion cases, and it is used in this way in this memo.[ii]

WHAT THE BILL WOULD DO

Testing. In order to perform an abortion on a pregnant woman 16 weeks or more after the onset of her LMP, a physician would first have to perform tests to establish the viability or non-viability of the unborn child. It should be reflected in the legislative history that the intent is that testing would be by ultrasound or the latest generally available diagnostic technology combined with physical examination and other clinical information in accordance with standards of good medical practice.

Second Opinion. Except in a medical emergency requiring immediate action, a second concurring opinion as to viability or non-viability of the unborn child would be required from a qualified physician not affiliated with the abortion provider. If the child is determined to be viable, no abortion could be performed unless two physicians agreed that continuation of the pregnancy would threaten the mother's life or impose on her a substantial risk of grave impairment of physical health.[iii]

Viability. Massachusetts law, which currently imposes some restrictions on abortion after 24 weeks of gestation, would now also include a specific restriction on abortion *after viability*, absent the aforementioned risks to the mother's life or physical health.[iv]

Health. The bill would delete "mental health" from the risks justifying abortion *after viability*. Abortions after viability could not be performed unless "necessary to save the life of the mother or if continuation of the pregnancy would impose on her a substantial risk of grave impairment of her physical health."

While the discussion below argues that all of the foregoing proposals find ample support in Supreme Court decisions, the statute includes a severability clause, in case any of its provisions is later ruled unconstitutional.

RATIONALE

Testing. In its *Webster*[v] and *Casey*[vi] decisions, the Supreme Court established viability as the point beyond which states can restrict abortion. In *Casey* the Court explicitly recognized that advancing medical technology had already lowered the usual age of viability to 23 or 24 weeks LMP and that further scientific advances might push it to an even earlier point. The Court emphasized that in individual cases viability might already occur earlier than 23 weeks and that therefore viability should be determined in each individual case.[vii]

While the Court spoke of "the attending physician" as having an important role in the task of determining viability, it is clear from the context that the Court simply intended to emphasize the individual character of each case as contrasted with the alternative of having the states or the Court itself fix a particular gestational age as uniformly determinative of viability.[viii] The Court did *not* preclude the state from establishing a legal framework and procedures to determine individual viability; in fact, in *Webster* the Court specifically upheld a provision of the Missouri statute that required viability testing at 20 weeks of gestation before an abortion could be performed.

Missouri did not declare that an unborn child *is* viable at 20 weeks; rather, the state recognized that, absent a test, there could be errors in estimating the age and stage of development of an unborn child and that such errors could affect a judgment as to viability. Missouri therefore said that it was reasonable to require viability testing at four weeks *before* the usual date of viability. The Court agreed. In *Webster* the Supreme Court upheld "what is essentially a presumption of viability at 20 weeks, which the physician must rebut with tests indicating that the unborn child is not viable prior to performing an abortion."[ix]

The Court in *Webster* thereby accepted that a state could restrict the abortion of an unborn child *before* 24 weeks gestation if that child were determined to be viable. In *Casey* the Court affirmed that this determination could establish viability even before 23 weeks. (See below, "The Medical Profession and Post-Viability Abortion.") In addition to Missouri, six other states–Arizona, Pennsylvania, Kansas, Louisiana, Ohio, and Alabama–have since enacted mandatory viability testing statutes.

The Supreme Court has overturned state laws *uniformly* restricting abortion at dates *earlier* than 23 weeks, that is, without viability testing. In rejecting without comment Utah's appeal of the decision of the Tenth Circuit Court of Appeals in *Jane L. v. Bangerter*, the Supreme Court in 1997 upheld the Appeals Court's 1996 finding that Utah had impermissibly determined that *all* unborn children at 20 weeks *are* viable, and thus may not be aborted. The Appeals Court said that, absent a determination of viability in each individual case, a woman might impermissibly be denied the right to abort a non-viable unborn child in some instances.[x]

Given the Supreme Court's recognition that viability can occur before 23 weeks, if there are cases of children born at 20 weeks who survived, we can argue that, if one child can survive at 20 weeks LMP, then potentially any child *could* be viable at this age. I have been able to locate information about two children born at 20 weeks, and I am confident that further research would yield more cases.[xi] Cases at 21 weeks are somewhat more numerous. Examples include:

Kenya King, born at 21 weeks on June 16, 1985, in Plantation FL.[xii]
Suzanne South, 21 weeks, July 1971, Bethesda Hosp., Cincinnati OH.[xiii]
Kelly Thorman, 21 weeks, March 1971, St. Vincent Hosp., Toledo OH.[xiv]

Cases of 22-week (LMP) viable children are becoming much more common. In their 1991 sourcebook J. C. and Barbara Willke cite these three cases as examples:

Tracy La Branch, 22 weeks, March 1972, Michigan.[xv]
Ernestine Hudgins, 22 weeks, February 1983, San Diego.[xvi]
Melissa Murray, 22 weeks, June 1983, Victoria TX.[xvii]

A study by the Infant and Child Health Studies Branch of the National Center for Health Care Statistics, based on data collected from 1989-1991, showed that the survival rate at 22 weeks LMP was already 14.8%, or better than one in seven children. At 23 weeks, it was 24.8%, or one in four.[xviii] These figures have undoubtedly advanced in the past decade.

According to a January 1998 CBS News/New York Times poll, 56% of the American people favor "requiring a test to make sure an unborn child is not developed enough to live outside the womb before the woman could have an abortion."[xix]

Current Massachusetts law prohibits a physician from performing an abortion after 24 weeks unless the physician determines that the procedure is "necessary to save the life of the mother" or "continuation of the pregnancy will impose on (the mother) a substantial risk of grave impairment of her physical or mental health."[xx] In debating a pro-abortion bill in May 1993, the Massachusetts House approved an amendment to add the words "or viability, whichever occurs earlier" after the phrase "24 weeks."[xxi] Because this and other amendments were not acceptable to the main bill's pro-abortion sponsors, the bill as amended was not put to a final vote. Still, the House is on record as having supported this important change concerning viability.

THE MEDICAL PROFESSION AND POST-VIABILITY ABORTION

In an August 1998 article in the *Journal of the American Medical Association*, Doctors Janet Gans Epner, Harry Jonas, and Daniel Seckinger say that "the time between 20 and 27 weeks [LMP] is a 'gray zone' in which some fetuses may be viable and others are not."[xxii] They base this conclusion on findings by the American College of Obstetricians and Gynecologists (ACOG) and the American Academy of Pediatrics, on a separate multi-center study on the topic reported in the ACOG journal, and on the latest (20th) edition of the standard medical text *Williams Obstetrics*.[xxiii]

Drs. Epner, Jonas, and Seckinger also summarized AMA recommendations on late-term abortion, adopted by the AMA House of Delegates in June 1997. The AMA emphasized its growing concern over post-viability abortions by resolving "to work with ACOG to develop clinical guidelines for induced abortion after the 22nd week of gestation and (with) the American Academy of Pediatrics to develop clinical guidelines with respect to fetal viability during gestation and its impact on this procedure."[xxiv] The AMA's concern with establishing guidelines for abortions after 22 weeks LMP points to a recognition that a notable

percentage of premature infants born at that age are surviving. ACOG, which has usually resisted restrictions on abortion, stated in 1997 that it "is opposed to abortion of the healthy unborn child that has attained viability in a healthy woman."[xxv]

The risk of maternal mortality from abortion at 16-20 weeks LMP is at the same level as the risk of mortality from childbirth, about 6 per 100,000 cases. (This is an average of this five-week period; since risk rises with each week, it would appear that the crossover-point with risk of death from childbirth is around 18 weeks LMP.) Risk of death from abortion rises rapidly after 20 weeks; at 21 weeks it is 16.7 per 100,000 procedures.[xxvi] According to Drs. M. L. Sprang and Mark Neerhof, mortality increases 30% with each passing week of gestation after 20 weeks.[xxvii] The risk of maternal morbidity also increases sharply with advancing gestational age.[xxviii] Legislation to reduce risks to the life and physical health of the pregnant woman by restricting post-viability abortions should be seen as desirable and appropriate by all, including pro-choice advocates.

THE UNDUE BURDEN STANDARD

Testing Requirement. In its *Casey* decision (1992) the Supreme Court said that "an undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability."[xxix] Note that the undue burden standard applies only before viability.

To argue that the requirement for viability testing is an undue burden would be to beg the essential question, which is to determine whether the child is or is not viable and therefore whether an abortion may be performed without regard to risks to the mother's life or health. The Supreme Court has said that expense or inconvenience do not in themselves constitute an undue burden.

The use of ultrasound equipment is now routine among obstetricians and gynecologists, regardless of their views on abortion, and is near-universally available. As with most technological innovations, its early high cost has dropped as its use and availability have spread; it is not a costly, sophisticated, or invasive medical test. It is typically covered

by insurance, and on a need basis it could be covered by public funds.

Why start the testing requirement at 16 weeks of gestation? 16 weeks provides a generous margin of safety for the child, given that there is sometimes initial uncertainty about how long a pregnancy has lasted, until a careful evaluation is undertaken with the aid of contemporary technology (usually ultrasound). As noted above, in 1988 Missouri mandated that testing begin at 20 weeks because this was four weeks earlier than the then-usual 24-week time of viability. The present bill proposes 16 weeks because technology continues to push the date of viability earlier.

However, it might be objected that if a pregnancy has actually lasted only 16 weeks LMP, there is no reasonable possibility that the child is viable because there is as yet no case on record of a child surviving at that age. Thus, this argument would continue, the "four-week early" parallel with Missouri is stretched a bit too far and, while Missouri's 20-week rule makes sense, 16 weeks is so early in the pregnancy that viability cannot reasonably be expected, even allowing for the march of technology and possible initial uncertainty about the exact length of the pregnancy. Thus the 16-week rule could open the statute to an "undue burden" challenge.

A reasonable case can thus also be made for 18 (or possibly even 19) weeks. This is closer to the actual 20-week beginning of the "gray zone in which some fetuses are viable and some are not…." mentioned earlier and still takes account of the two key factors of advancing technology and imprecision of initial estimates of pregnancy length.[xxx] There is of course solid precedent for legislating a 20-week testing rule, but this would risk missing some children who may have actually reached 20 weeks and who may have been viable but whose gestational age had been underestimated; some of these children may have been aborted, in ignorance of whether they were or were not viable, even though they were in fact within the zone.[xxxi]

SECOND OPINION ON VIABILITY

If the test itself is not an undue burden, what about the independent second opinion? It is hard to construe a second opinion requirement as placing an "undue burden" on the abortion decision because second

opinions before surgery are now routine in the U.S., are almost always covered by health insurance, and are even frequently mandated by insurers. It is generally agreed that a second opinion is beneficial for a patient's health when a surgical procedure is being considered. Abortions done after 16 weeks are almost without exception surgical procedures.

It may be objected that requiring a pregnant woman to seek a second opinion is an undue burden because she may not be able to get an appointment promptly with a second physician and that while she is waiting for this her unborn child continues to mature and, if not already viable, he or she may reach viability. It may also be objected that a delay would be an undue burden because any risks to the mother's life or physical health from abortion tend to increase markedly from 20 weeks on. Beginning the viability testing requirement before 20 weeks meets these objections. But, to repeat, it is also relevant that conducting tests to determine viability cannot be an undue burden since that standard applies only before viability and the purpose of the test is precisely to establish the facts on that point. An independent second opinion is *necessary* to assure confidence in the evaluation. If a legal standard is related to the existence of a fact, then it cannot be legal to rule out an action whose sole purpose is to establish whether or not that fact exists.

Certainly the law would intend that the second opinion be obtained promptly since the aim of the second-opinion and testing requirements is to *verify* viability or non-viability. To ensure the availability of a prompt independent second opinion, the Commonwealth could provide for an expedited second examination including sonogram at public hospitals or state public health facilities if an individual is unable to obtain an early appointment with a physician. This is not an unmanageable problem, but legislators should address it if it cannot be resolved through executive action under existing statutes.

A situation could arise in which the two physicians disagree on the issue of viability. The bill does not attempt to resolve this question directly, and it need not do so because in case of such disagreement it would be up to the pregnant woman considering an abortion to decide if she wants to obtain a third medical opinion to resolve it. She currently

has this right anyway, of course, and she would retain it unchanged.

POST-VIABILITY

With regard to risks to the mother's life or health once viability has been established, since 1973 nine states have adopted laws requiring a concurring second (or in some cases third) opinion before a post-viability abortion.[xxxii] None of these provisions has been declared unconstitutional by the Supreme Court. This is no doubt because, as noted earlier, the Supreme Court has said that the "undue burden" standard applies to abortions *before viability*, not after. If the child is viable, the state's efforts to protect him or her by definition do not violate the undue burden standard.[xxxiii]

There can be disagreement between two physicians about the nature and seriousness of risk to the mother's life or physical health. In other medical situations, especially those involving prospective surgery, such differences are usually resolved by seeking a third opinion. The pregnant woman would of course have the option to seek such an opinion. If she could not afford it, or if her insurance declined to pay for it, the state should cover the cost, since a third opinion obtained in order to comply with a law should be paid for by the state. None of the proposed changes would impose criminal or civil penalties on pregnant women.

THE HEALTH DEFINITION

On September 17, 1998 ten pro-choice U.S. Senators (Durbin, Collins, Snowe, Lieberman, Landrieu, Graham, Bingaman, Inouye, Torricelli, and Mikulski) introduced a bill to ban all abortions after viability unless "continuation of the pregnancy would threaten the mother's life or risk grievous injury to her physical health." The bill would require an independent second physician to certify these risks in writing.[xxxiv] The *Boston Globe* reported that the bill was "similar to a proposal made last year by Senate Democratic leader Thomas Daschle that...required one medical opinion."[xxxv] Like the Durbin/Collins/Snowe proposal, Daschle's bill also eliminated the mental health exception. Senators Kennedy and Kerry voted for the Daschle bill.[xxxvi] Although neither bill

was adopted (because at the time the Senate was considering the partial-birth abortion ban), both bills represent major changes from previous pro-choice positions on second opinions and on the definition of health.

Narrowing the scope of health risks that would allow abortion of a viable child to those which involve "grave impairment of the mother's physical health" is a departure from the virtually all-inclusive definition of health articulated in *Doe v Bolton*.[xxxvii] However, since 1973 the Court has given only perfunctory attention to its *Doe* definition. It has never forcefully and explicitly restated it in the way it has reaffirmed elements of the central holding of *Roe.* Since 1973 six states have adopted provisions limiting post-viability abortions to risks to maternal life or *physical* health, and none has been overturned by the Supreme Court.[xxxviii] Even in *Casey* (1992) the Court upheld a definition of "medical emergency" that encompassed only risks to life or physical health, rejecting the argument that such a formulation was too narrow. And in 1997 the American College of Obstetricians and Gynecologists supported the physical health limitation in the Daschle bill mentioned above.[xxxix] In striking down state partial-birth abortion bans in *Stenberg v. Carhart* (2000), the Supreme Court gave as one reason the absence of a health exception; however, that argument was framed and expressed *entirely* in terms of the mother's physical health. When the life of a viable unborn child is at stake the Court can be expected to continue to let stand a legislative definition of health limited to physical health, as it has done so far.

APPENDIX 1: TESTIMONY ON S.926/H.845 BEFORE THE JOINT COMMITTEE ON THE JUDICIARY (MAY 17, 2001) BY PATRICK FLOOD, ADJUNCT PROFESSOR OF POLITICAL SCIENCE AT THE UNIVERSITY OF MASSACHUSETTS AMHERST

Mr. Chairman, The U.S. Supreme Court has said that a state may protect unborn children after viability by restricting abortion after that point.[xl] It has also acknowledged that thanks to medical technology viability is occurring earlier and earlier in pregnancy. The Court has said that in these early cases viability must be determined by medical evaluation on an individual basis.[xli] In

Massachusetts hundreds of abortions a year are performed on unborn children who could be viable. However, we have no legal requirement for viability testing. This bill fills that gap by requiring that tests be performed to find out whether an individual unborn child is in fact viable and also by restricting abortion of all *viable* children.

An article in the August 1998 *Journal of the American Medical Association* found that "the time between 20 and 27 weeks is a 'gray zone' in which some fetuses may be viable and others are not."[xlii] In support of this finding the authors cite specialist committees of the American College of Obstetricians and Gynecologists and the American Academy of Pediatrics as well as a standard obstetrical text and recent clinical studies. The AMA Journal article uses the standard method of measuring gestation from the onset of the pregnant woman's last menstrual period, or LMP. There are a number of press reports in recent years of children born prematurely at very early ages who have survived, some as early as 20 weeks LMP.

Mr. Chairman, if even one child is viable at 20 weeks, then potentially *any* child at that stage could be viable. There should be a legal requirement to find this out before ending the life of such a child. At least five states have such a law, and this requirement has been upheld by the Supreme Court.[xliii] It is important to start testing early enough. We think 16 weeks is reasonable. However, other states have chosen slightly different starting dates.

In order to increase confidence in the results of the tests, the bill requires a concurring second opinion by an independent physician, except in an emergency requiring immediate action. Second opinions before surgery are routine today. Virtually all insurance policies cover them, and some even require them. This would also alleviate concern stemming from the fact that the first opinion is very often going to come from the physician who would perform the abortion. The Supreme Court's "undue burden" standard for abortion regulation applies only before viability. It cannot therefore apply to tests to determine the existence of viability.

If the unborn child is found to be viable, this bill would restrict abortion to cases of threat to the life of the mother or substantial risk of grave impairment of her physical health. This would remove mental health risk as a ground to abort a viable child. Six states have adopted such a provision since 1973, and none has been overturned by the Supreme Court.[xliv] And when the Court objected last year to the absence of a health exception for partial-birth abortion, its objections referred exclusively to physical health. The American College of Obstetricians and Gynecologists supported a physical health limitation in a bill on post-viability abortion in the U.S. Senate in 1997.[xlv] That bill was supported by

both Senators Kennedy and Kerry.[xlvi] These developments reflect the general public understanding of the term "health" in the context of pregnancy.

Finally, Mr. Chairman, after viability the bill would require a concurring second opinion as to the existence of risks to the mother's life or physical health, except in case of emergency requiring immediate action. A second opinion here makes sense for the same reasons as for viability, and could be made by the same independent second physician. Nine states require a second opinion for post-viability abortions.[xlvii]

Many viable unborn children in Massachusetts today are left unprotected against abortion by our current statute. We could protect them and give them a chance. They deserve a chance. Thank you, Mr. Chairman.

APPENDIX 2: FACTS IN BRIEF: MASSACHUSETTS ABORTION STATISTICS

There were 27,714 reported abortions in Massachusetts in 1998.

Age of Baby	Number
0-8 weeks	15,559
9-13 weeks	8,584
14-18 weeks	1,599
19-24 weeks	705
25+ weeks	2
Unknown	1,265

The foregoing chart was prepared by Massachusetts Citizens for Life from data obtained from the Massachusetts Department of Public Health. Additional statistics concerning the age of the mother, facility type, type of abortion procedure, complications, marital status, number of previous induced abortions, and number of previous live births, are found on page 126 of the *Pro Life Reference Journal 2001*, published by Massachusetts Citizens for Life (The Schrafft Center, 529 Main Street, Boston, MA 02129). The *Pro Life Reference Journal* is available in many libraries (ISSN 1097-6728) and from the publisher.

Author's comment: For purposes of the proposed Act, the most relevant figures in the chart are the 705 abortions performed from 19 through 24 weeks of gestation and the 2 performed after that stage. It is clear from the scientific evidence alluded to in the conference paper and the testimony before the

legislature that there is good reason to believe that some, probably many, and perhaps most of these babies were viable at the time their lives were forcibly ended. Enactment of the bill could therefore be expected to save hundreds of children's lives annually in the state. It is impossible to say anything definite about the 1,265 babies aborted in the "unknown" category but questions naturally occur about their possible viability too.

NOTES

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i. This closely parallels the U.S. Supreme Court's definition of viability as "the capacity for meaningful life outside the womb, albeit with artificial aid." *Roe v Wade* 410 US 113 (1973).

ii. For instance, U.S. Court of Appeals for the Tenth Circuit, in *Jane L. v Bangerter* (102 F. 3d 1112) (1996).

iii. It follows that if two physicians disagree on viability but agree in writing that continuation of pregnancy threatens the mother's life or imposes on her a substantial risk of grave impairment of physical health, and that no other medical solution is available that would not increase risk to the mother, an abortion could be performed. Other hypothetical situations are addressed below in the discussion of "The Undue Burden Standard" and "Post-Viability."

iv. If an abortion is to be performed on a *viable* child at any age, all legal provisions presently applicable to abortions performed after 24 weeks would presumably apply (regarding, for example, method chosen, efforts to preserve the life and health of the child, written consent, record-keeping, and the like). If not, the pertinent sections of the current statute might need to be amended.

v. *Webster v. Reproductive Health Services* 492 US 490, 515 (1989).

vi. *Planned Parenthood of Southeastern Pennsylvania v. Casey* (505 US 833) (1992).

vii. *Planned Parenthood v. Casey*.

viii. *Planned Parenthood v. Casey*.

ix. *Webster v. Reproductive Health Services.*

x. *Jane L. v. Bangerter* (102 F. 3d 1112) (1996).

xi. Marcus Richardson, 20 weeks, January 1972, University Hospital, Cincinnati, Ohio, and Melissa Cameron, 20 weeks, December 1983, Sault Ste. Marie Hospital. Cited in J. C. and Barbara Willke, *Abortion: Questions and Answers* (Cincinnati: Hayes Publishing, 1991), p. 61.

xii. *Miami Herald*, October 4, 1985. *Medical World News,* November 11, 1985. *The New York Times,* March 18, 1989. See also Willke, p. 61

xiii. Ibid.

xiv. Ibid.

xv. *Battle Creek Enquirer,* in Willke, *Abortion: Questions and Answers*, p. 61. See also J. C. and Barbara Willke, *Why not Love Them Both? Questions and Answers about Abortion* (Cincinnati: Hayes Publishing Co., 1997), p. 92.

xvi. *Washington Post,* in Willke, *Abortion: Questions and Answers*, p. 61.

xvii. *Houston Post,* in Willke, *Abortion: Questions and Answers*, p. 61.

xviii. Cited in *The New York Times,* May 16, 1997. See also M. Hack and A. A. Fanaroff, "Outcomes of Extremely Low-birth-weight Infants between 1982 and 1988," *New England Journal of Medicine* 321 (1989) 1642-47. However, the data in the latter reflect the impact of technology now 15-20 years old.

xix. *The New York Times* January 16, 1998.

xx. Massachusetts General Laws, cited without specific reference in Massachusetts Citizens for Life *Pro-Life Reference Journal 2001*, p. 208.

xxi. H.3239 was the pro-abortion bill.

xxii. Janet E. Gans Epner PhD, Harry S. Jonas MD, Daniel L. Seckinger MD, "Late-term Abortion," *JAMA* 280/8 (August 26, 1998).

xxiii. The specific citations by Epner et al. are American College of Obstetricians and Gynecologists Committee on Obstetric Practice, American Academy of Pediatrics Committee on An Unborn Child and Newborn, *Perinatal Care at the Threshold of Viability* (ACOG: Washington, DC, Nov. 1995). Committee Opinion #163. Also R. L. Cooper, R. L. Goldenberg, R. K. Creasy

et al., "A Multicenter Study of Preterm Birthweight and Gestational Age-Specific Neonatal Mortality," *American Journal of Obstetrical Gynecology* 168 (1993) 78-84. And F. G. Cunningham, P. C. MacDonald, N. F. Gant et al., eds., *Williams Obstetrics*, 20th ed. (Stamford, 1997), Ch. 34.

xxiv. Internet searches conducted on the websites of the three organizations and of the National Guidelines Clearinghouse on April 16, 2001 failed to turn up evidence that these proposed joint guidelines have yet been issued.

xxv. *ACOG Statement of Policy.* Approved by Executive Board and published in ACOG Newsletter, July 1997. Cited in M. Leroy Sprang MD and Mark G. Neerhof DO, "Rationale for Banning Abortions Late in Pregnancy," *JAMA* 280/8 (August 26, 1998).

xxvi. Alan Guttmacher Institute, *Facts in Brief: Induced Abortion* (New York: The Alan Guttmacher Institute, 1996). Also National Center for Health Statistics, *Vital Statistics of the United States, 1991.* (Washington, DC: US Public Health Service, 1991:2) and *Advance Report of Final Natality Statistics, 1991*. USPHS, Monthly Vital Statistics Report 42, 1993.

xxvii. Sprang and Neerhof, op. cit.

xxviii. Ibid.

xxix. 505 U.S. at 878.

xxx. Epner, Jonas, Seckinger, op.cit.

xxxi. Missouri, Louisiana, and Alabama use 20 weeks; Ohio law calls for testing to begin after 21 weeks; Kansas after 22 weeks; Arizona after 12 weeks; Pennsylvania after 13. Although these states do not require a confirming second opinion as to viability, this does not detract from the strong arguments for including such a provision in future laws. A second independent opinion provides confidence in the evaluation and may be advantageous to the woman's health (as well as, of course, to the child's).

xxxii. Alabama, Florida, Georgia, Idaho, Montana, North Dakota, Pennsylvania, South Carolina, and Virginia.

xxxiii. S.2497, the 1998 proposal by pro-choice U.S. Senators to restrict late-term abortions, requires a second concurring opinion by a physician as to the risks to the mother's life and physical health. By implication, this could

involve a third tie-breaking opinion.

xxxiv. S. 2497 "Late-Term Abortion Limitation Act of 1998."

xxxv. *The Boston Globe,* September 17, 1998.

xxxvi. S. 289 Amendment to H.R. 1122, introduced by Senate Democratic leader Daschle, May 15, 1997. Sen. Kennedy was a co-sponsor. The 1998 version of this bill, introduced by Senators Durbin, Collins, and Snowe with seven other co-sponsors (S.2497), included a requirement for a concurring second medical opinion for post-viability abortion.

xxxvii. "All factors–physical, emotional, psychological, familial, and the woman's age–relative to the well-being of the patient." *Doe v. Bolton* (1973)

xxxviii. Alabama, Indiana, Kansas, Ohio, Pennsylvania, and Utah.

xxxix. *American Medical News* 40/20 (May 26, 1997), p.25.

xl. *Webster v. Reproductive Health Services.* 492 US 490, 515 (1989); *Planned Parenthood of Southeastern Pennsylvania v Casey* (505 US 833) (1992).

xli. *Stenberg v.Carhart* (99-830), June 28, 2000.

xlii. Janet E. Gans Epner PhD; Harry S. Jonas MD; Daniel L. Seckinger MD, "Late-term Abortion," *JAMA*, 280/8 (August 26, 1998), pp. 724-29.

xliii. *Webster v Reproductive Health Services*. The five states are Missouri, Ohio, Kansas, Louisiana, and Alabama. After the hearing I learned that Pennsylvania and Arizona had also recently enacted mandatory viability testing. I informed key legislators of this fact by letter.

xliv. Alabama, Indiana, Kansas, Ohio, Pennsylvania, and Utah.

xlv. *American Medical News* 40/20 (May 26, 1997), p.25.

xlvi. S. 289 Amendment to H.R. 1122, introduced by Senate Democratic leader Daschle, May 15, 1997. Sen. Kennedy was a co-sponsor.

xlvii. Alabama, Florida, Georgia, Idaho, Montana, North Dakota, Pennsylvania, South Carolina, and Virginia.