

## Abortion and the Conscience Clause: Current Status

Dennis J. Horan

Follow this and additional works at: <https://scholarship.law.stjohns.edu/tcl>



Part of the [Constitutional Law Commons](#)

---

### Recommended Citation

Dennis J. Horan (1974) "Abortion and the Conscience Clause: Current Status," *The Catholic Lawyer*: Vol. 20 : No. 4 , Article 2.  
Available at: <https://scholarship.law.stjohns.edu/tcl/vol20/iss4/2>

This Diocesan Attorneys' Papers is brought to you for free and open access by the Journals at St. John's Law Scholarship Repository. It has been accepted for inclusion in The Catholic Lawyer by an authorized editor of St. John's Law Scholarship Repository. For more information, please contact [lasalar@stjohns.edu](mailto:lasalar@stjohns.edu).

# DIOCESAN ATTORNEYS' PAPERS ABORTION AND THE CONSCIENCE CLAUSE: CURRENT STATUS

DENNIS J. HORAN\*

The abortion controversy is currently in the coercive stage. The hard core proponents of legalized abortion are now busy opposing abortion legislation that keeps abortion in the criminal code, or that seeks to regulate abortion other than through the medical practice act. Their aim is the psychological satisfaction of making abortion not only legal, but morally acceptable to all but the cranky Catholics. Part of the plan includes opposition of conscience clauses. Obviously this latter stance smacks of a betrayal of their promise that their wish was only freedom now, and thus they are somewhat at a disadvantage before the courts, at least as far as the conscience clause is concerned.

The initial campaign is aimed at the public hospital. In this they have been successful and the federal courts, as exemplified by *Nyberg v. City of Virginia*,<sup>1</sup> are requiring public hospitals to provide facilities and manpower for the performance of first and second trimester abortions. The *Nyberg* opinion clearly indicates that no individual can be compelled to perform abortions or participate; yet "we do hold that the hospital facilities must be made available for abortion services. . . ."<sup>2</sup>

The usual mistaken assumption is that *Roe v. Wade*<sup>3</sup> and *Doe v. Bolton*<sup>4</sup> have created a constitutional right to an abortion. The acts of a state or municipal hospital are acts of the state and their refusal to provide facilities thus violates the equal protection clause or the due process clause and can be rectified under 42 U.S.C. § 1983, goes the argument. This is a typical result of Supreme Court activity which, while claiming only to

---

\*Member, Illinois Bar. The author wishes to express his thanks to Dr. Joseph Stanton and Mrs. Carol McAvoy for their medical research.

<sup>1</sup> 495 F.2d 1342 (8th Cir. 1974) (petition for rehearing denied, June 3, 1974). See also *Doe v. Hale*, 369 F. Supp. 976 (D. Mass. 1974).

<sup>2</sup> 495 F.2d at 1347.

<sup>3</sup> 410 U.S. 113 (1973).

<sup>4</sup> 410 U.S. 179 (1973).

ignite a fire cracker, sets off an atom bomb. I refer, of course, to the pious statements expressed by several members of the Court that they were only dealing with a medical problem.

I said mistaken, and I meant mistaken. *Roe v. Wade* and *Doe v. Bolton* actually stand for the proposition that the "right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy,"<sup>5</sup> and even that "right is not unqualified . . ."<sup>6</sup> That means that the decision is one that can be freely made, and does not mean, as the federal courts are saying, that any hospital, even a public hospital, must take part in an affirmative action program to provide abortions.

I have a constitutional right of privacy to decide with my physician that I need a kidney transplant, but I have no right to the treatment unless I can afford it and can find a physician and hospital where the treatment can be provided.

In the hands of the lower courts, the woman's constitutional right to decide is translated into the public hospital's obligation to provide and perform, on the theory that a refusal constitutes state interference. This subtle shift in impact is rather typical of the abortion debate, and I really doubt my success in convincing any federal judge of this rationale. The Eighth Circuit in *Nyberg* avoided the impact of this argument by saying:

Appellant frames the issue to be whether the state has an affirmative duty under *Roe* and *Doe* to provide abortion facilities. This record does not present a situation where the hospital would be required to establish new or different facilities and staff in order to perform the operations. For reasons set out below, we find that the district court in this case was correct in ordering the Virginia Municipal Hospital to make its existing facilities available for the performing of abortions.<sup>7</sup>

The court thus limited its holding to only mandating the use of *existing facilities*.

The proponents of abortion have also been successful in convincing the courts that Medicaid must pay for abortions.<sup>8</sup> However, this fight may not be over, since there is a direct conflict for the conscientious administrator of these funds who is also compelled by the Social Security Act to provide aid for the unborn child. In *Alcala v. Burns*,<sup>9</sup> the Eighth Circuit, in holding that the word "child" in the Social Security Act,<sup>10</sup> includes the dependent unborn child, pointed out that although three district courts have ruled that an unborn child is not a dependent child, yet two circuits and twelve

<sup>5</sup> 410 U.S. 113, 153 (1973).

<sup>6</sup> *Id.* at 154.

<sup>7</sup> 495 F.2d at 1345.

<sup>8</sup> *Klein v. Nassau County Medical Center*, 347 F. Supp. 496 (E.D.N.Y. 1972); *In re City of New York v. Wyman*, 30 N.Y.2d 537, 281 N.E.2d 180, 330 N.Y.S.2d 385 (1972).

<sup>9</sup> 494 F.2d 743 (8th Cir. 1974).

<sup>10</sup> 42 U.S.C. § 606(a) (1970).

district courts have decided that an unborn child is a dependent child. This, of course, represents a conflict on the part of the person administering the same funds since he must provide the funds to destroy the child, and he must provide the funds for the child's benefit. That conflict has now been raised in the three-judge case that is pending in South Dakota. This conflict has been raised in a case now pending in the Eighth Circuit.

The conscience clause is also the target of litigation. The twist here is an attempt through the courts to limit the conscience clause only to individuals, and exclude any entity or institution. In the three-judge court case now pending in Minnesota the plaintiffs have argued the unconstitutionality of the corporate conscience clause in both the Minnesota statute<sup>11</sup> and the "Church Amendment."<sup>12</sup>

They attempt to find state action under receipt of Hill-Burton grants, state licensure and regulation.<sup>13</sup> The argument is then made:

Hospital corporations, however, are unlikely candidates for the exercise of such First Amendment rights of conscience as envisioned by free exercise of religion. A corporation cannot pray, or experience guilt and fear of damnation. Nor can a corporation participate in religious services. It is an entity with many rights and privileges, but the free exercise of religion by a hospital corporation is difficult to comprehend. More importantly, however, the conscience clauses at issue here do not limit themselves to strictly private denominational hospitals, but go beyond even to cover fully public hospitals. This broad sweep, in itself, is plainly inconsistent with *Nyberg*, and the principles announced in many other cases.<sup>14</sup>

Plaintiffs in *Hodgson v. Anderson* filed a class action seeking to have the court include all hospitals as a class of defendants. The ultimate aim, of course, is to require all hospitals, public, private or denominational, to provide facilities for abortions. As far as I am aware, they have not sought to compel the individuals to participate. But I am sure you can expect to see attempts to declare immunity from civil liability for refusal to participate or perform eliminated from the law. Such an attempt will not be made even by the hard core pro-abortionist who is willing to let well enough alone, but may occur through an otherwise innocuous personal injury action; and I can envision the facts of a pregnant woman brought to a hospital seeking an abortion, being refused admission and being sent to some other hospital 50 miles away, dying en route. Then a personal injury action is filed testing the viability of the conscience clause.

I want to shift my focus now, and approach this subject from a slightly

---

<sup>11</sup> MINN. STAT. ANN. § 145.42 (Supp. 1974).

<sup>12</sup> Act of June 18, 1973, Pub. L. No. 93-45, tit. IV, § 401(b)(2)(A), 87 Stat. 91.

<sup>13</sup> See Note, *Implications of the Abortion Decisions: Post Roe and Doe Litigation and Legislation*, 74 COLUM. L. REV. 237, 254-63 (1974).

<sup>14</sup> Brief for Plaintiff at 8, *Hodgson v. Anderson*, 378 F. Supp. 1008 (D. Minn. 1974).

different point of view, but I will be returning to my subject matter en route.

I have on other occasions and in other papers outlined what I consider to be a reasonable analysis for planning the road back to sanity in the abortion debate. I should state at the outset that I consider a sane solution to this problem one that includes legal protection for the unborn child.

I have divided the areas of responsibility into four, three of which I will outline in brief form only. The fourth area I will discuss at greater length, both in terms of future application and current activity, mainly because it involves all of us as lawyers.

First and foremost, stemming the abortion tide is an educational job, albeit a massive one. Just what exactly is the nature of the phenomenon that is gripping the world as is evidenced in the abortion debate, I do not know. Why mankind should be bent on the massive destruction of its unborn is a phenomenon I do not understand, and which I do not think is explained by mere references to secular humanism or the population problem. My opinion is that the malaise is much deeper, and is not one we will understand until someone can explain Dachau, Treblinka or Buchenwald.

Nor do I think that pejorative references to technology can supply the magic of a ready answer. Certainly technology can and has supplied the tools for the massive killings that modern man has come to accept as natural to his state, but nonetheless all the technologists are human, and no machine is operated unless by a person.

I do not mean by education a mission in the sense in which the Church uses that word, that is to say, a job the end of which is never in sight. True, educating the world to the humanity and civil rights of the unborn is a difficult and lengthy job, but it is not one the end of which is never in sight.

No. I mean educational in a much narrower sense: the transmission of information about the nature of unborn life, and the transmission of persuasive argumentation on why, for the sake of mankind, the life of the unborn should be protected by law. Obviously, when I express it thus I am not talking about persuading our confessional brethren, as necessary as that may seem to some, but rather persuading our nonconfessional brethren in a pluralistic and very secular society.

Thus, we should create educational institutions utilizing the available exemptions under the tax statutes to disseminate the information and educate the people. Some already exist, but they are uncoordinated in their efforts and somewhat ineffective in their results.

Obviously, the Catholic school is an excellent tool for this purpose, and pro-life educational courses should be included in the curriculum. Such a course should be scientifically sound and should equip the student with the full arsenal of legal, medical and moral tools. It is not enough to merely condemn abortion as a moral wrong in a society which accepts it as a social good. The burden of this job must be accepted by the school system itself.

Secondly, we should support the political efforts to obtain a constitutional amendment which may be the only way this problem can be solved. In my opinion, this would be best achieved by the creation of a national organization acting in concert with the various state organizations. The national organization should probably be a 501(c)(4) organization with a self-contained 501(c)(3) educational and legal defense fund, and with ad hoc political action committees created as necessary at state levels.<sup>15</sup>

The state organizations should be mirror organizations of the national, that is to say, each state should consist of a single statewide 501(c)(4) organization, with political action committees created on local levels as deemed necessary. Members of the state organization would also be members of the national. There should be no more than one or two 501(c)(3) educational organizations per state.

No one enjoys over-structured organizations less than I, and anyone who has suffered through one understands what I am talking about. Nonetheless, the abortion problem, in my opinion, will not be solved unless the will of the people is moved to solve it. This means organizational expertise is necessary in every state, and necessary now. We cannot wait to create strong state organizations until the amendment is out of Congress. Seven years is a long time, and momentum is very important and must not be lost. Waiting to create a strong state organization until the amendment is through Congress would cause a terrific loss of momentum. Also, strong state organizations will be effective in getting the amendment through Congress since a strong state organization can lobby at home where lobbying is most respected.

Thirdly, we should support alternatives to abortion. This means supporting Birth Rights and any other organization or hospital that brings aid to the problem pregnancy. We should create a uniform package of legislation that can be introduced in every state and the Federal government to bring help to the problem pregnancy. The benefit of and necessity for this are self-evident.

Fourth and last, we should create a national Legal Defense Fund, similar to the NAACP Legal Defense Fund, the ultimate purpose of which will be the reversal of the judge-made law of *Roe v. Wade* and *Doe v. Bolton*. For those of you who have attempted and realized all the difficulties in drafting a Human Life Amendment, think how simple it would be for a Justice of the United States Supreme Court to write out those magic words, "We hereby reverse . . ." There are few, if any, conceptual problems that can deter the federal judicial will from a fiat solution to a pesky problem.

None of these areas is distinct from the other, except conceptually and organizationally. The Iowan who lobbies his legislator in Des Moines must

---

<sup>15</sup> See INT. REV. CODE OF 1954, § 501(c)(3), (4).

educate, persuade, point out viable alternatives, and show legal reasons why the unborn should be protected by law. In that sense all the activities overlap, but as we plan them we allocate our talents and our money according to our plans, and in that sense they are very distinct.

I want to take a closer look at what we can achieve through the courts. There are two approaches here: negative and positive.

By the negative approach I refer merely to a holding action, to defensive actions protecting a right *not* to be involved. This, of course, involves the conscience clause.

As we move into the coercive era of abortion, passing conscience clauses has become a little more difficult than previously. Opponents in state legislatures are becoming somewhat bolder in their attempts to defeat or minimize the effect of the clause.

The conscience clause generally exempts individuals and hospitals from participating in or providing facilities for abortions, and exempts them from civil liability for having refused. With the exception of purely public hospitals, the conscience clauses have proved immune from suit,<sup>16</sup> and I am confident that that will remain the case.

The Second Circuit held that the activities of a 501(c)(3) organization are infected with state action and subject to suit under 42 U.S.C. § 1983 of the Civil Rights Act.<sup>17</sup> The disastrous impact of this case, if it remains the law, is apparent, and what effect it would have on conscience clauses remains to be seen.

However, I am constrained to say no conscience clause has yet saved a baby, nor do I think that one ever will. On the contrary, the conscience clause tends to be the enemy of the unborn, that is to say, where it polarizes it neutralizes. I do not wish confrontation or suffering on anyone, but the uninvolved denominational hospital hiding behind its conscience clause is no friend of the unborn. For that matter, of course, neither is the uninvolved lawyer.

Now let's take a look at the positive or affirmative possibilities of the litigation route. In this respect state statutes and litigation work hand in hand; possible proposed state legislation concerning abortion should be drafted with an eye towards the possibilities of what can be achieved in court.

I am not a believer in legislation that is an outright disavowal of the court, as we witnessed in the Rhode Island case. I am a believer in attempting to achieve the maximum possible with legislation, *e.g.*, even if the statute complies with *Roe v. Wade* and *Doe v. Bolton* there is no reason it cannot contain a preamble which states that the unborn child is a human

---

<sup>16</sup> See, *e.g.*, *Doe v. Bellin*, 479 F.2d 756 (7th Cir. 1973); *Doe v. Hale Hosp.*, 369 F. Supp. 970 (D. Mass. 1974); *Watkins v. Mercy Medical Center*, 364 F. Supp. 799 (D. Idaho 1973).

<sup>17</sup> *Jackson v. Statler Foundation*, 496 F.2d 623 (2d Cir. 1974).

person from conception, that the statute is passed of necessity, allowing abortions only because of those cases, but that in all other areas of the law the unborn child shall be treated as a person.

In other words, just because *Roe v. Wade* and *Doe v. Bolton* create a fourteenth amendment right of privacy protecting the abortion decision does not mean that the statute passed in conformity has to wipe out the child's existence, which unfortunately has happened. (Some of the statutes that have been passed in conformity with those two decisions have gone much further by making abortion on demand the law of that particular state.) Quite the contrary, as long as the statute does not interfere with the mother's rights except as permitted, it can create all and any rights you want in the child.

Think of the educational impact such a statute can have. Think how important it would be in the area of litigation, if each time the court looked at the statute it saw and read such language. You must realize that thinking of it in these terms is thinking of the road back in terms of 25, 50, or 75 years and that means creating precedent whereby, ultimately, a court can reach down and find the reason that it wants if it wants to reverse those two cases.

The preamble or some other sections of the statute can also indicate that in the event *Roe v. Wade* and *Doe v. Bolton* are reversed, or a Human Life Amendment adopted, then that part of the statute allowing abortions becomes null and void except in conformity with the Amendment. This vitiates the problem of what happens 15 years from now if an amendment comes out of the Congress and you have what is, in effect, an abortion on demand statute.

The really affirmative counterattack comes, of course, when statutes and causes find some way of limiting the currently available liberal access to abortion. In other words, what do we do now to start the process going the other direction? What area can we find under those cases that will give us room to protect the unborn? One of the current ways being employed is by limiting the performance of abortion in some manner after viability.

There are two ways of considering the meaning of viability: (1) as meaning simply to live, or (2) in the sense that a neonatologist uses it—able to survive the neonatal period, or 28 days. For example, when a neonatologist says that a child of such and such an age is capable of surviving, he means that it will live beyond the 28 days. Now we should consider it in both senses, but in the statistics that I am about to quote, you should remember that it is used in only the latter sense, that is, able to survive for 28 days after birth.

Among the states which have limited use of abortion after viability, Georgia forbids abortion "after the second trimester" unless it is necessary to preserve the life or health of the woman.<sup>18</sup> Idaho forbids abortion unless

---

<sup>18</sup> GA. CODE ANN. § 26-1202 (Supp. 1974).



necessary to preserve the life of the woman during the "third trimester" and requires that the abortion be done in a "manner consistent with preservation of any reasonable potential for survival of a viable fetus."<sup>19</sup> Under Illinois statutes, a "third trimester" abortion shall be done only to preserve the life or mental health of a woman;<sup>20</sup> an abortion "after a gestation period of twenty completed weeks" requires registration under the Utah Records Act. Indiana prohibits abortion "after viability" except to preserve the life of the mother or prevent grave permanent injury to her health; the physician must determine if the fetus is viable in accordance with acceptable medical standards. Under Nebraska laws, viability means the ability to live outside the womb "by natural or life-supporting systems;"<sup>21</sup> abortion cannot be done after viability except to preserve the life or health of the woman. In Nevada an abortion cannot be done "after the 24th week of pregnancy" unless necessary to preserve life or health.<sup>22</sup> Tennessee does not define viability, but limits abortion "[d]uring viability of the fetus."

The Minnesota statute, as do the proposed Massachusetts and Pennsylvania statutes, requires the physician to certify that the child is viable and in his best medical judgment take steps to bring about the live birth and survival of the child.

True, the best that can be done is some difference in kind after the twentieth to the twenty-fourth week. Twenty weeks seems to be the lower end and at present the lowest point that can reasonably be substantiated, although it remains to be seen whether the courts will agree. Certainly 22 to 24 weeks seems safe.

Although only 1.2% of all abortions take place after 20 weeks, yet the concern and litigation over viability can be an important educational tool. The Supreme Courts of Illinois and Oregon have since January 22, 1973, created in their respective states wrongful death actions for the unborn viable child. The Oregon court even indicated that the word "person" in its constitution included the viable unborn child.<sup>23</sup>

Such events cannot escape public notice and are bound to have impact someday. So, too, the cases in the Fourth, Fifth and Eighth circuits and the 12 district court cases granting aid to unborn children under Social Security legislation as children in their own right, are bound to have impact someday.

For the present, our counterattack will probably settle into legislative and judicial determinations of viability for whatever little aid and comfort that can give us. Consequently, I want to look in depth at viability.

---

<sup>19</sup> IDAHO CODE § 18-608(3) (Supp. 1974).

<sup>20</sup> ILL. ANN. STAT. §§ 81-11 to -19 (Supp. 1974).

<sup>21</sup> NEB. REV. STAT. § 28-4, 144 (Supp. 1972).

<sup>22</sup> NEV. REV. STAT. § 442.250(1)(c) (1973).

<sup>23</sup> See *Libbee v. Permanente Clinic*, 518 P.2d 636 (Ore. 1974); *Chrisafogeorgis v. Brandenburg*, 55 Ill. 2d 368, 304 N.E.2d 88 (1973).

## VIABILITY

There are several references to viability in the *Roe v. Wade* decision.<sup>24</sup> I quote in full the following for the reason that many people have misread the case thinking that the pregnancy has been divided into neat categories of trimesters, and that consequently some significant point of legal demarcation has been made at the end of the second trimester:

- (a) For the stage prior to approximately the end of the *first* trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.
- (b) For the stage subsequent to approximately the end of the *first* trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.
- (c) *For the stage subsequent to viability*, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.<sup>25</sup>

Nowhere in the opinion did the Court say that the child has a protectable interest in and of itself. The Court avoided that question and looked at the issue from the point of view only of the state's right or compelling interest to invade the area of the decision protected by the fourteenth amendment. At viability the *state* has a compelling interest in potential life which is somewhat limited, in fact, if it has any meaning at all, since even after viability abortion is permissible for amorphous health reasons.

It is clear that the Court has *not* indicated when viability occurs, but only that something important does occur at viability in terms of the state's right and interest in protecting fetal life.

Medical texts usually refer to the length of pregnancy as 40 weeks and use 20 weeks as the midpoint. For example, in the text used by Justice Blackmun<sup>26</sup> there appears this statement: "Twenty weeks, of course, marks the midpoint of the normal duration of human pregnancy, counting from the last menstrual period."<sup>27</sup>

The factual question as to when the child *en ventre sa mere* becomes viable is unanswered in either *Roe v. Wade* or *Doe v. Bolton*, as well it should be since the record in those cases contained no evidence on that point. Justice Blackmun, in dicta, did refer to viability as "usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks."<sup>28</sup> The difficulty, of course, is to get the lower federal courts to look

---

<sup>24</sup> See *Roe v. Wade*, 410 U.S. 113, 160-62, 164-65 (1973).

<sup>25</sup> *Id.* at 164-65 (emphasis added).

<sup>26</sup> *Id.* at 160 n.59.

<sup>27</sup> L. HELLMAN & J. PRITCHARD, *WILLIAMS OBSTETRICS* 1027 (14th ed. 1971) [hereinafter cited as *WILLIAMS*].

<sup>28</sup> *Roe v. Wade*, 410 U.S. 113, 160 (1973) (footnote omitted).

at the texts and see the context from which that statement came. He supported this statement by reference to a medical text.<sup>29</sup> He also referred to Dorland's Medical Dictionary.<sup>30</sup> Dorland's does not refer to age and the exact quotation from the medical text indicates that *the passage was selectively ready* by Justice Blackmun, since the medical text places the lower end of the viability scale at 20 weeks, not 24 weeks based on a single case, as Justice Blackmun stated. The text reads:

Abortion is the termination of a pregnancy at any time before the fetus has attained a stage of viability. *Interpretations of the word "viability" has varied between fetal weights of 400 g (about 20 weeks of gestation) and 1,000 g (about 28 weeks of gestation).* Since an infant reported by Monro that was said to weigh only 397 g survived, on the basis of this single precedent an infant weighing 400 g or more may be regarded as capable of living. Although our smallest surviving infant weighed 540 g at birth, survival even at 700 or 800 g is unusual. Attainment of a weight of 1,000 g is therefore widely used as the criterion of viability. Infants below this weight have little chance of survival, whereas those over 1,000 g have a substantial chance, which increases greatly with each 100 g increment. *Expert neonatal care, furthermore, has permitted survival of increasingly small infants.*<sup>31</sup>

Another standard medical dictionary defines viability as usually "cannot[ing] a fetus that has reached 500 grams in weight or 20 gestational weeks."<sup>32</sup>

We should remember that Justice Blackmun defined viability to include the *use of artificial aids* to keep the child alive.<sup>33</sup>

The text cited by Justice Blackmun states:

This lower limit might logically be set at 400 g, because no fetus weighing less at birth has ever been known to survive. One fetus weighing 397 g on the second day of life, but doubtless slightly more than 400 g at birth, has survived, however, as reported by Monro. As shown in Figure 1, a fetus weighing approximately 400 g has a gestational age of about 20 weeks. Convenience is another reason for adopting this figure, since nearly all state departments of vital statistics require the reporting of all births in which the period of gestation is in excess of 20 weeks. *Twenty weeks, of course, marks the midpoint of the normal duration of human pregnancy, counting from the last menstrual period.* A premature infant might therefore be defined as weighing between 400 and 2,500 g at birth. The round figure of 500 g, however, has certain advantages as the definition of the limit between abortion and prematurity and is so employed elsewhere in this text.<sup>34</sup>

<sup>29</sup> *Id.* at 160 n.60.

<sup>30</sup> *Id.* at 160 n.59.

<sup>31</sup> WILLIAMS, *supra* note 27, at 493 (emphasis added).

<sup>32</sup> STEDMAN'S MEDICAL DICTIONARY (22d ed.).

<sup>33</sup> *Roe v. Wade*, 410 U.S. 113, 160 (1973).

<sup>34</sup> WILLIAMS, *supra* note 27.

And finally its definitions of abortuses, immature, premature and mature infants as applied to the *human* product of conception is as follows:

Consistent with the convention of using weight groups of 500 g, an immature infant is defined as weighing between 500 and 999 g. The following definitions thus emerge:

1. Abortuses. Fetuses of birth weight under 500 g. No chance of survival.
2. Immature Infants. Fetuses of birth weight from 500 to 999 g. Poor chance of survival.
3. Premature Infants. Fetuses of birth weight from 1,000 to 2,499 g. Chances of survival range from poor to good according to weight.
4. Mature Infants. Fetuses of 2,500 g or more. Optimal chances of survival.<sup>35</sup>

Another standard reference is the study by Schlesinger and Alloway of 436,254 live births in the New York Department records.<sup>36</sup> They had 622 births *between 20 and 23 weeks gestation*:

436,254 Live Births in N.Y.  
Surviving Neonatal Period, 28 days

Length of  
Gestation

20-23 weeks, 8.2% of these (622 babies) survived the neonatal period  
24-27 weeks, 29.1% of these (1403 babies) survived the neonatal period  
28-31 weeks, 58.8% of these (2953 babies) survived the neonatal period  
32-35 weeks, 86.7% of these (7365 babies) survived the neonatal period  
35 weeks  
or older, 99.2% of these (423,991 babies) survived the neonatal period

This report of significant survival of tiny birthweight babies is *not unusual*.

Another book on the subject indicates in the preface that it "is dedicated to those who work toward the achievement of the initial right of man to be born without handicap and the privilege of women to bear without injury."<sup>37</sup> The authors go on to state that:

At this age the normal fetus weighs approximately 500 grams, has a crown-to-rump (CR) length of 16.5 cm., and, at least occasionally, is capable of extrauterine survival—it is then said to be "viable." Viability, though, is a changing concept. Medical advances in the treatment of the premature make it possible to anticipate that even these very small abortuses of 20 weeks' gestation may soon have a greater chance of survival and one surely does not then wish to describe a surviving fetus as an abortus.<sup>38</sup>

The following table provides an analysis of fetal growth:

<sup>35</sup> *Id.* at 1028.

<sup>36</sup> Schlesinger & Alloway, 18 J. PEDIATRICS (1955).

<sup>37</sup> REID, RYAN & BEHIRSCKE, *Preface to PRINCIPLES AND MANAGEMENT OF HUMAN REPRODUCTION* (1972).

<sup>38</sup> *Id.* at 255.

Appraisal of the fetus and neonate:  
growth, development, nutrition

TABLE 5-2.<sup>39</sup> Fetal dimensions at the most significant periods of fetal development.\*

Gestational age (Weeks) Classification	Less than 20 Nonviable	21 to 23 Immature	24 to 36 Premature	37 to 40 or more Full Term
Length (cm)				
Crown-rump	16	16-24	24-31	31-35
Crown-heel	25	25-37	37-47	47-50
Weight (gm)	500	500-999	1000-2499	2500 or more
Biparietal head diameter (cm)	4.5	4.5-6.8	6.8-8.8	8.8-9.7
Length of extremity (cm)				
Upper	8.7	8.7-13.6	13.6-17.8	17.8-19.7
Lower	9.1	9.1-14.4	14.4-18.9	18.9-20.9
Foot	3.0	3.0-5.0	5.0-6.6	6.6-7.4

\* The figures are not applicable for "small-for-dates" babies.

You will note that it lists the child of less than 20 weeks gestation as nonviable, and the child at 21 to 23 weeks as "immature." It should be pointed out that the word "viability" implies some inherent capability on the part of the child, but it equally applies to the present state of the medical art of keeping little babies alive. Immature and premature babies, *if cared for*, do better than ever before in history. For example, in their study, Lubchenco, et al., show that more and more children under 500 grams are being admitted to neonatal and perinatal hospital centers for the purpose of life-giving treatment.<sup>40</sup>

An additional important reference to viability comes from Greenhill's *Obstetrics*:<sup>41</sup>

Immature and premature infants are those born so early in the course of gestation that their organs have not fully developed. Their chances of survival are not as good as those of full-term infants.

<sup>39</sup> This table is found in SYMPOSIUM ON THE FUNCTIONAL PHYSIOPATHOLOGY OF THE FETUS AND NEONATE 73 (H. Abramson, M.D., ed. 1971).

<sup>40</sup> Lubchenco, et al., *Neonatal Mortality Rate: Relations to Birth Weight and Gestational Age*, 81 J. PEDIATRICS 814-22 (1972).

<sup>41</sup> J. P. GREENHILL, OBSTETRICS.

The weight of immature and premature babies, at least for purposes of classification, is usually taken as the main index of their gestational age. There is general agreement that a weight of 2500 gm. (5.5 lbs.) should mark the upper boundary of prematurity; that is, the borderline between a premature and mature infant. The weight of a premature baby is taken as the basis of age.<sup>42</sup>

I also refer you to the study of Pakter, et al.,<sup>43</sup> showing live births after abortions in 27 cases, 14 of which were between 17 to 20 weeks of gestation, 6 were between 21 to 24 weeks of gestation, and the remaining were older. These children were born alive after abortions and died later as a result of the abortion. I further refer you to an article which describes a case of a fetus born at a gestational age of 21 weeks *which survived and is still living*, and another of 22 weeks.<sup>44</sup> The literature contains numerous other reports of children born alive during the second half of the gestation period who have survived and are living today.<sup>45</sup> In their study of Perinatal Mortality at the Chicago Lying-In Hospital, 1931-1966, Potter and Davis, using a weight of 400 grams ("this figure was selected because it appeared to be the average weight attained by a fetus at 20 weeks") as the low end of the viability spectrum, said:

Born alive were 101,398 over 2,500 grams with a survival of 99.5 percent, 6,617-1,000 to 2,500 grams with a survival of 86.3 percent and 463-400 to 1,000 grams with a survival of 6.4 percent, a total of 98.4 percent survival of all live-born infants over 400 grams.<sup>46</sup>

On April 15, 1974, William J. Curran, Professor of Legal Medicine at Harvard University, indicated that the U.S. Supreme Court may be mistaken in assuming that viability can be precisely defined "as a scientifically and philosophically accepted point of demarcation in fetal development."<sup>47</sup>

It is apparent from a review of this material that the medical literature accepts 20 weeks, or at almost exactly mid-term in the pregnancy, as the lower end of the viability spectrum, speaking conservatively.

Further, it is also apparent that research in the area of neonatal intensive care will push viability further and further back in the years to come. The whole area of perinatal medicine is only 10 years old. Research on the artificial placenta is in its embryonic state, and research into the chronic

---

<sup>42</sup> *Id.*

<sup>43</sup> Pakter et al., 14 CLINICAL OB. GYN. 290 (1971).

<sup>44</sup> *Morbidity and Mortality of Infants Weighing Less Than 1,000 Grams in an Intensive Care Nursery*, 50 J. PEDIATRICS 46 (1972).

<sup>45</sup> See, e.g., Schlesinger, *Neonatal Intensive Care, Planning for Services and Outcomes Following Care*, 82 MED. PROGRESS 916-20.

<sup>46</sup> Potter & Davis, *Study of Perinatal Mortality at the Chicago Lying-In Hospital* 339 (1931-66).

<sup>47</sup> Washington Post, April 15, 1974.

killer of the premature (underdevelopment of the lung structure) has had significant results in recent years. We can expect that development of the artificial placenta will radically change our notions of the meaning of viability. Medical research on the unborn has only just begun.

When I say that it remains to be seen how the Court will handle this issue, I did not mean to imply that our opponents were taking 20-week viability lying down. As a matter of fact they are vitally concerned and are attempting to do everything possible to push viability as far forward as possible, even to 28-32 weeks. For example, in the Minnesota case Dr. Louis Hellman filed an affidavit explaining away as anecdotal the *Canadian Medical Journal* case on which he had relied when he published his book. Although he admitted to personal knowledge of one 530 gram fetus that survived, he, as did others, urged the court to consider 28 weeks as the point of viability. In actuality they consider viability as a socializing or definitional term which should be limited to a point where all fetuses are actually viable and not, they would say, be based on medical oddities that have survived in the range of 20-23 weeks.

Establishment of viability at 20 weeks may seem insignificant if one considers that only 1.2% of all abortions occur after this time, but nonetheless I consider it an important step on the road back to sanity, and one well worth the effort on behalf of the unborn.