Towards a Practical Implementation of the Abortion Decision: The Interests of the Physician, the Woman and the Fetus

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COMMENTS


The United States Supreme Court has considered the issue of a woman's right to an abortion,¹ and has resolved that such a right, guaranteed under the concept of individual privacy,² does exist. The Court did not, however, discuss the ramifications of an abortion resulting in a live birth, nor did the Court resolve the question of when life actually begins.³ Instead, the Court couched its decision in terms relating only to the fetus,⁴ stating that the fetus is not a person within the contemplation of the law.⁵ Many have disagreed with this conclusion, asserting that traditional Anglo-American law has always recognized the fetus as a person.⁶ However, a careful analysis of property, tort, wrongful death, social welfare and criminal law indicates that the fetus has never been accorded the rights and privileges of persons. Because the fetus is not a person under the law, it has no right to life and cannot in and of itself restrict the pregnant woman's decision to abort. That decision may be limited only by the state's legitimate interest in the potential of life in

². Id. at 153.
³. Id. at 159.
⁴. Id. at 159-68. The Court examined historical interests under the common law, state statutes, and the United States Constitution.
⁵. Id. at 158.

More than 100 bills have been introduced into the 93rd and 94th Congress in support of the movement to give the fetus rights of personhood. Letter from Lester S. Jayson, Director, Congressional Research Service, The Library of Congress, Washington, D.C., to Mary Sebek, Aug. 20, 1975. The most recent “Right-to-Life” legislative effort occurred on April 28, 1976, when Senator Jessie A. Helm (R-NC) attempted to bypass the Senate Judiciary Committee and introduce directly onto the Senate floor a constitutional amendment invalidating the Roe v. Wade decision. Discussion on the proposed amendment was tabled by a vote of 47-40. Chicago Sun-Times, Apr. 29, 1976, at 2, col. 1.
the fetus' at viability—the interim point at which the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid."7

In ruling on the question of a woman's right to abort a fetus, the Court unfortunately overlooked the situation in which the abortion results in a live birth. Live birth occurs when the fetus exhibits life signs8 after removal from the woman's body, whether or not the fetus is capable of meaningful survival.9 Because the Court apparently was not cognizant of the possibility of live birth after abortion, it focused only on the interests of the fetus prior to abortion and did not consider the legal

7. It is reasonable and appropriate for a State to decide that at some point in time another interest, that of... potential human life, becomes significantly involved. The woman's privacy is no longer sole and any right of privacy she possesses must be measured accordingly. 410 U.S. at 159.

8. Id. at 160. The Court placed the point of compelling state interest at viability, noting that "the fetus then presumably has the capability of meaningful life outside the mother's womb." Id. at 163 (emphasis added). Unfortunately, the Court did not choose to define "meaningful life." This raises the question of whether meaningful life is any life or only that life which will eventually be capable of independent self-sustenance. For a discussion of how increasingly sophisticated life-support systems may affect viability, see Comment, Viability and Abortion, 64 Ky. L.J. 146, 160-63 (1975).

At viability, the state may protect its interest in the potential of life in the fetus by limiting or even proscribing elective abortions. 410 U.S. at 163-64. However, under the Roe guidelines, a state need not exercise this right. Since a fetus is not a person, it has no right to demand such protection from the state; rather, it is entitled to only that degree of protection which the state determines to be within its own best interests.

An alternative to the state's exercise of its power would be its delegation of that power in the form of a statutory cause of action to specific third-parties. For example, the state could permit the putative father to enjoin the performance of a third trimester abortion, on the theory that the abortion would deprive him of a relational interest in the child the fetus would become. However, this method presents enforcement problems. Notifying all physicians who might perform such an abortion is impractical. Therefore, the pregnant woman might have to be imprisoned to prevent her from obtaining an abortion. For a discussion of the possibility of imprisoning a pregnant woman to prevent her from exercising her fundamental right to abortion, see Doe v. Doe, 314 N.E.2d 128, 133-34 (Mass. 1974) (Hennessy, J., dissenting).

The state might also give the putative father or heirs apparent a right to sue for damages. This method was attempted in 1973 by the Utah state legislature. See Utah Code Ann. §§76-7-307 to 76-7-308 (Supp. 1973). The statute was held unconstitutional in Doe v. Rampton, 366 F. Supp. 189 (D. Utah 1973), because it prohibited the free exercise of the guaranteed right to abortion prior to fetal viability. Had the state limited the remedy to compensation for the abortion of viable, third trimester fetuses, the statute might have been constitutional.

9. Life signs may include independent breathing, movement of the arms and legs, or a beating heart. The concept of live birth is discussed in notes 82-85 and accompanying text infra.

10. See note 8 supra.
ramifications of live birth. As a result, the legal responsibilities which the physician, the state, and the mother may owe to the aborted live-born are in doubt.

In addition, the Court failed to adequately identify and analyze the technical problems inherent in the determination of viability. Specifically, a physician cannot accurately predict the gestational age of a fetus; therefore, he cannot precisely delineate the point of viability. As a consequence, the physician who in good faith believes he is aborting a non-viable fetus may be subject to prosecution for wrongful abortion if the fetus is subsequently determined to have been viable. To avoid prosecution, many physicians have refused to perform abortions during the second trimester, thus directly affecting the pregnant woman's access to and exercise of her fundamental right to abort a non-viable fetus.

In order to alleviate these and other problems engendered by the Roe v. Wade decision, suggested guidelines for abortion will be proposed. The guidelines will seek to implement Roe v. Wade by defining and reconciling the woman's exercise of her fundamental right to abortion with the physician's right to practice his profession free from unwarranted prosecution and the state's legitimate interest in the potential of fetal life at viability. As a necessary prelude to the guidelines, and in order to correct the misconceptions concerning the status of the fetus, the author will first examine the legal precedent supporting the Court's holding that the fetus is not a person. Such an examination is essential to both an accurate appraisal of the scope and magnitude of the woman's right to abortion and a basic understanding of the suggested guidelines.

Fetal Interest Analysis

Property Law

The common law of property has been cited by many legal writers in support of the contention that the fetus is a person and, as such, is entitled to all of the rights and privileges accorded other persons under the law. However, this position ignores one of the basic tenets of property jurisprudence: any bequest to an unborn is a gift of a contingent interest in property. The interest becomes vested only upon the live

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11. See notes 74-77 and accompanying text infra.
13. See note 6 supra.
birth of the fetus. Thus the rights of the fetus are clearly distinguishable from those of persons. While a person may have either a vested or a contingent interest in property, the interest of a fetus is always contingent upon its live birth. The fetus itself may never have an estate, but merely the possibility of an estate, for it is not entitled to the use, possession or enjoyment of any property prior to birth. Likewise, if the fetus is a potential member of a class of beneficiaries, the class will not open and let it in until it has been born alive.

The courts have been less than clear in their treatment of fetal interests as contingencies. For example, some courts, in an attempt to protect property subject to a contingent fetal interest, have declared that "a child en ventre sa mère [in its mother’s womb] is ‘born’ and ‘alive’ for all purposes for his benefit.” From such statements, advocates of the fetal rights position have argued that since a fetus may inherit property as if it were a child already born, the law must consider it so for all purposes. However, protection of the contingent fetal inter-

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15. [L]egal relations with respect to property can exist only between persons in being. When we speak of a contingent remainder in unborn persons we mean that the law recognizes the possibility of a legal relationship arising in the future and that the recognition of this potential interest has present legal consequences . . . . (emphasis added)


16. MOYNIHAN, supra note 14, at 119-20. This method of distribution is consistent with the theory that, although unborn beneficiaries are entitled to take property equally with those beneficiaries living at the death of the testator, enjoyment in possession of the subject property is postponed until birth. Although courts often appoint a guardian ad litem for such unborns, the guardian's function is protection of the property, and not protection of the unborns.

17. In re Holthausen's Will, 175 Misc. 1022, 1024, 26 N.Y.S.2d 140, 143 (Sur. Ct. 1941); accord, Deal v. Sexton, 144 N.C. 157, 160, 56 S.E. 691, 692 (1907). This rule is not directed at the interests of the fetus, but rather at the interests of the person the fetus will become upon live birth.

18. Advocates of the fetal rights position assert that the fetus is a person from the moment of conception and as such is entitled to the rights and privileges accorded persons born alive, including the right to life.

19. Constitutional Conception of Life, supra note 6, at 999-1000, relying on Wallis v. Hodson, 26 Eng.Rep. 472 (Ch. 1740) (posthumous child entitled to an accounting of her
est is not protection for the benefit of the fetus. Rather, it is protection for the person the fetus may become.

The common law rules of intestate succession have been codified generally by state inheritance statutes. These statutes, like the common law, give the fetus no immediately cognizable interest in property. The fetus is precluded from taking as an intestate heir by virtue of the fact that an heir must survive the decedent. Only upon live birth does the fetus, as a child, fulfill the required condition of survival. Similarly, a fetus may take by intestate succession as a posthumous child of the decedent only if it is subsequently born. Finally, only a child may take as a pretermitted heir. If the fetus may not acquire property, it will obviously have nothing of which to dispose. For example, if property is devised to a fetus which is subsequently stillborn, the property does not pass through an "estate" of the fetus but rather through that of the grantor. On the other hand, if property is devised to a child who subsequently dies, the property passes through his estate for distribution to his heirs and not to those of the grantor. The distinction can effect a vastly different outcome in property distribution.

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deceased father's estate); Industrial Trust Co. v. Wilson, 61 R.I. 169, 200 A. 467 (1938) (unborn child entitled to share in the income of the trust from the date of her father's death rather than upon the date of her subsequent birth). See also Trower v. Butts, 57 Eng.Rep. 72 (1823) (child in gestation at the testator's death may, at birth, take under will description bequeathing property to those "living at the [testator's] decease"). However, these results do not prove that the fetus is a person. In each case, the unborn child has an interest in property that will ripen upon birth. Should the fetus be stillborn, none of these rights or benefits accrues.


21. UNIFORM PROBATE CODE §2-108 (1969). See also ILL. REV. STAT. ch. 3, §2-3 (1975): "A posthumous child of a decedent shall receive the same share of his ancestor's intestate estate as if he had been born in his father's lifetime." (emphasis added)

22. These statutes apply only to children born or adopted after the execution of a will. See, e.g., UNIFORM PROBATE CODE §2-302 (1969); ILL. REV. STAT. ch. 3, §4-10 (1975).

23. This occurs when a devise contains alternative limitations, each subject to a condition precedent:

A, the grantor, devises Blackacre to C for life, then to the children of C, and if C has no children, then to D.

Assume that C has no children at the creation of the grant. Then D and the unborn children of C have mutually exclusive, alternate contingent remainders in Blackacre during the life of C. If C dies without children, then title to Blackacre will pass directly to D, in accordance with the will of A, the grantor. MOYNIHAN, supra note 14, at 124.

24. For example, assume the following devise in a will:

X devises Blackacre to A for life, then to the children of C who are born during A's lifetime.

At the creation of the grant, C is alive but has no children. Each of the following events may occur during the life of A:
In sum, an analysis of the interests of the fetus demonstrates that the law of property provides no basis for the contention that the fetus is a person under the law. Its rights are always dependent upon fulfillment of the condition precedent of live birth. Only when the fetus becomes a person at birth is it entitled to the rights and privileges accorded persons.

Tort Law

Under the common law of torts, as in the law of property, the fetus is without the independent rights of a person. All of its interests are contingent upon the condition precedent of live birth. That is, although a fetus may sustain injuries during the prenatal period, it has no action of its own for compensation. Only upon subsequent live birth does the cause of action for damages accrue to the child. Advocates of fetal rights ignore this born/unborn distinction and reason that because compensation may be recovered for fetal injuries, a cause of action accrues to the fetus. An analysis of fetal interest exposes the fallacy of this conclusion.

The primary purpose of tort recovery is to compensate a wronged party for damages he has sustained. The action was originally limited to recovery for injuries inflicted upon a person then in existence. Prena-
tal injuries were specifically excluded under the theory that the unborn child was part of the mother at the time of the injury. As a result, only damage to the fetus which physically affected the mother was recoverable by her. No separate action for injuries to the fetus was allowed.\textsuperscript{28} However, in the landmark case of \textit{Bonbrest v. Kotz},\textsuperscript{29} the common law cause of action was expanded to include recovery for injuries sustained during the process of live birth.\textsuperscript{30} More recently, courts have allowed recovery to a child for injuries suffered during gestation.\textsuperscript{31} Significantly, these cases discuss recovery only in terms of the interests of the liveborn child; they are silent as to any rights of the unborn.

\textit{Bonbrest} and the related cases have done nothing to create rights of personhood in the fetus. They merely make the fetus's position under the common law of torts consistent with its position under the law of property.\textsuperscript{32} The fetus itself is given no new cause of action. Rather, the person the fetus is to become is permitted a personal right of recovery contingent upon live birth. If the fetus is stillborn, no action will lie.\textsuperscript{33}

\begin{itemize}
  \item \textsuperscript{28} Dietrich v. Northampton, 138 Mass. 14 (1884) (unborn child which died as a result of injuries to mother could not sue under common law tort). \textit{Accord}, Norman v. Murphy, 124 Cal.App.2d 95, 268 P.2d 178 (1954).
  \item \textsuperscript{29} 65 F. Supp. 138 (D.D.C. 1946).
  \item \textsuperscript{30} \textit{Id. at 140}. The decision implies that a liveborn who is capable of survival, whether or not he survives, has a common law action for damages sustained at any time during gestation. For a somewhat different interpretation of \textit{Bonbrest}, see Rice, \textit{supra} note 6, at 1072.
  \item Keyes distinguished \textit{Dietrich}, discussed in note 28 \textit{supra}, by noting that in \textit{Dietrich} the fetus was not born alive. By limiting the \textit{Dietrich} holding to cases involving similar facts, the Keyes court in effect limited recovery for prenatal injuries to liveborn infants. Courts following \textit{Bonbrest} and Keyes have permitted recovery for prenatal injuries. However, recovery has been limited to injuries sustained during fetal viability, fixed at approximately the third trimester of gestation, when the fetus is capable of independent life. Kelly v. Gregory, 282 App.Div. 542, 125 N.Y.S.2d 696 (1963). That theory has undergone some erosion in Sinkler v. Kneale, 401 Pa. 267, 164 A.2d 93 (1960), which allowed a liveborn infant a right of action for injuries sustained at one month gestation. Illinois has also rejected the viability distinction. \textit{See Daley v. Meier, 33 Ill.App.2d 218, 178 N.E.2d 691 (1st Dist. 1961) (one month).}
  \item Because recovery is contingent upon live birth, it is illogical to further condition recovery upon viability. If the child must carry the effects of prenatal injuries, it makes little difference whether those injuries were sustained at one month gestation or at viability. For a full discussion of viability, \textit{see} notes 71-77 and accompanying text \textit{infra}.
  \item \textsuperscript{32} For a discussion of fetal interests in property, \textit{see} notes 13-24 and accompanying text \textit{supra}.
  \item \textsuperscript{33} Actions at common law did not survive the death of the plaintiff. Current survival
The legal rationale for the distinction is clear. A fetus born after having sustained injuries requires compensation during life as does a person first born and then injured. A fetus which is never born alive needs no compensation. Thus, the law of torts clearly distinguishes between the fetus and a person, permitting only the person to recover.

Wrongful Death

Wrongful death statutes have been enacted by each state to create a cause of action in favor of the survivors of a decedent whose death proximately resulted from injuries inflicted by a third-party tortfeasor. The action does not accrue to the decedent, rather, it accrues to and for the sole benefit of the survivors after the death of the decedent. Originally, recovery was limited to actual pecuniary loss sustained by the survivors. However, in the majority of jurisdictions the statute has been expanded by judicial interpretation to permit parental recovery.

Statutes create a right in the personal representative of the decedent to continue the action as if the decedent had survived. See, e.g., ILL. REV. STAT. ch. 3, §339 (1975). However, survival actions have never been brought on behalf of a fetus.


Most modern statutes are patterned after Lord Campbell’s Act and create a new cause of action for the death of the decedent in favor of the decedent’s personal representative for the exclusive benefit of certain designated persons. W. PROSSER & J. WADE, CASES AND MATERIALS ON TORTS 1088 (5th ed. 1971). Because wrongful death recovery is a creature of statute, it falls within the jurisdiction of the legislature to grant, to withhold or to restrict as it sees fit. Norman v. Murphy, 124 Cal.App.2d 95, 99, 268 P.2d 178, 180 (3d Dist. 1954).

35. It is believed that Lord Campbell’s Act, The Fatal Accidents Act of 1846, 9 & 10 Vict., c. 93, limited damages to pecuniary loss sustained, because American statutes patterned after the act have adopted this limitation. C. MCCORMICK, HANDBOOK ON THE LAW OF DAMAGES §93 (1935). In the case of wrongful death recovery for a deceased child, courts have found an implied pecuniary loss in the form of services the child would have rendered to the family unit. But see Baird v. Chicago, B. & Q. R.R., 11 Ill.App.3d 264, 296 N.E.2d 365 (4th Dist. 1973) (recovery limited to provable pecuniary damages).

for the loss of an expected relational interest in the child the fetus would have become. Because the death of a fetus may give rise to a cause of action under the wrongful death statute, some authors have suggested that the fetus is a person. This characterization of the fetus is inaccurate, for the true parties in interest under the statute are not the fetus, but the survivors of the fetus. It is only to allow compensation to these survivors for their loss that judicial interpretation has expanded the definition of "deceased person" to include the stillborn fetus.

Unfortunately, the issue of parental recovery for the death of a fetus has been clouded by uneven judicial application of the term "deceased person." In those jurisdictions where wrongful death recovery is permitted, compensation is almost universally conditioned upon the viability of the fetus at the time of the injury. The use of a fetal viability

37. Under the relational interest theory, the parents of a child have a vested interest in the relationship that they may expect to enjoy with that child throughout his life. See Note, Abortion: The Father's Rights, 42 U.CIN.L.REv. 441 (1973). The theory has been urged in opposition to wrongful death statutes which require live birth as a precondition to recovery for subsequent death. Advocates maintain that unless the law says that fetal life is without value, the incident of birth should be irrelevant to the issue of compensation for the parents. Id. at 448-49.


39. The Illinois Wrongful Death Statute is exemplary:

Every such action shall be brought by and in the names of the personal representatives of such deceased person, and except as otherwise hereinafter provided, the amount recovered in every such action shall be for the exclusive benefit of the surviving spouse . . . .

ILL. REV. STAT. ch. 70, §2 (1975). The statute has been interpreted to permit recovery for the death of an unborn child under the theory that the survivors have sustained as great a loss as if the child had first been born and then died. Chrisafogeorgis v. Brandenberg, 55 Ill.2d 368, 304 N.E.2d 88 (1973).


41. Those jurisdictions which permit recovery for the death of a viable fetus are: Alabama: Eich v. Town of Gulf Shores, 300 So.2d 354 (Ala. 1974) (the purpose of the

Nevada is the only state thus far which has allowed recovery for a pre-viable fetus. White v. Yup, 458 F.2d 617 (Nev. 1969). One reason given for limiting wrongful death recovery to survivors of viable fetuses is the difficulty in proving that the dead fetus was alive at the time of the injury. Since the fetus is never born alive, plaintiff must supply expert medical testimony from which the existence of fetal life and normal development may be inferred. In addition, plaintiff must prove that the fetus was killed by the injury alleged and not as a result of natural causes. Because of the necessarily speculative nature of the opinion testimony presented, proof of proximate cause is often impossible. However, the difficulty of proof alone should not absolutely foreclose the assertion of legal rights. Nor should the risk of some spurious suits work an embargo or nullification of all claims. Moen v. Hansen, 537 P.2d 266, 268 (Wash. 1975).

The absurdity of conditioning recovery on the gestational age of the fetus may be seen in the following examples. If a pre-viable fetus is injured and subsequently stillborn, there is usually no action under wrongful death. However, if the fetus is injured and is subsequently born alive, to live for only a few minutes and then die, there is recovery for injury to the person under tort. In both cases the loss to the parents is equal, yet only in the latter instance may they recover for that loss. Sée Mone v. Greyhound Lines, Inc., 331 N.E.2d 916, 920 (Mass. 1975) (Brauchut, J., dissenting) (if viability was not a requirement where the fetus survived its prenatal injury and was born alive, then viability should not limit or condition the remedy in stillbirth cases).
statutes are not intended to protect the fetus; rather, they seek to protect the survivors' interests in the fetus. The fiction that the stillborn fetus is a "deceased person" is necessary only to achieve the statutory purpose of compensating the survivors.

Aid to Families with Dependent Children

The Aid to Families with Dependent Children Program (AFDC) established under Title IV of the Social Security Act, has as its purpose the distribution of funds for the care of needy dependent children within the family unit. The program is administered by the states under standardized eligibility rules promulgated by the Department of Health, Education and Welfare. Under federal rules, a state must pay benefits to all persons who qualify as eligible aid recipients. Some states provide AFDC benefits to pregnant women without living children, while other states deny such benefits on the theory that the unborn are not yet dependent children.

As a result of the disparity, pregnant women in non-benefit states


43. The program permits needy children to stay in the home with a non-working mother or other eligible relative(s). See President Roosevelt's Message to Congress recommending passage of the legislation, H.R. Doc. No. 81, 74th Cong., 1st Sess. 29-30 (1935), and Committee Reports in both Houses: S. Rep. No. 628, 74th Cong., 1st Sess. 16-17 (1935); H.R. Rep. No. 615, 74th Cong., 1st Sess. 10 (1935).

44. See 45 C.F.R. §233.90 (1975).


brought class actions seeking to compel AFDC payments during pregnancy. The lower courts split on whether such payments were required. In *Burns v. Alcala* the Supreme Court resolved the issue. Limiting its opinion to an interpretation of Title IV of the Social Security Act, the Court found that Congress had used the word "child" in its ordinary context to refer to an individual already born. Thus, the legislative definition of "dependent children" could not support the inclusion of the unborn. Because the fetus was not eligible for aid as a dependent child, the Court concluded that no state could be required to provide AFDC benefits to pregnant women.

The fact that AFDC benefits may be denied prior to live birth of the fetus is consistent with the legislative purpose of providing aid to the dependent child. As interpreted in *Alcala*, the AFDC program gives the fetus no rights. The program, like the law of property and torts, conditions all rights and privileges upon live birth.

**Criminal Law**

The criminal law has never viewed the intentional killing of a fetus as homicide unless the fetus was first born alive and then died. While

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48. This split resulted from varying judicial interpretations of Congress's intent in its use of the term "dependent children." Those courts which held that the unborn child is entitled to AFDC benefits relied upon: 1) a presumption of eligibility in the absence of specific exclusion, and 2) the consistency of inclusion with the stated purposes of AFDC. See Carver v. Hooker, 369 F. Supp. 204, aff'd, 501 F.2d 1244 (1st Cir. 1974), vacated, 420 U.S. 1000 (1975); Wilson v. Weaver, 358 F. Supp. 1147, aff'd, 499 F.2d 155 (7th Cir. 1974); Stuart v. Canary, 367 F. Supp. 1343 (N.D. Ohio 1973). See note 47, supra.


50. *Id.* at 580-81.

51. When used in this part—

(a) The term "dependent child" means a needy child (1) who has been deprived of parental support or care by reason of the death, continued absence from the home, or physical or mental incapacity of a parent, and who is living with his father, mother, . . . in a place of residence maintained by one or more of such relatives as his or their home, and (2) who is (A) under the age of eighteen, or (B) under the age of twenty-one and . . . a student regularly attending school, college or university, or . . . a course of vocational or technical training . . .


52. The finding that the unborn child was not an eligible recipient within the definition of "dependent child" effectively permits each state to determine whether it will offer AFDC benefits to pregnant women. See note 46 supra.

53. See, e.g., *Keeler v. Superior Court of Amador County*, 2 Cal.3d 619, 470 P.2d 617, 87 Cal.Rptr. 481 (1970), in which the court refused to find the defendant guilty of murder,
it is true that some feticides were punishable under both common law and statute, the penalties were, without exception, less than those imposed for the killing of a person. For example, at common law, killing a fetus before it had quickened was without consequence; killing it after quickening was sometimes a misdemeanor, at most a felony, but never murder. Thus, the criminal law has neither regarded nor protected the fetus as a person. This legal distinction is also apparent in the even where the evidence was clear that his actions had caused the death of the fetus. It stated that the legislature had never intended to change the common law rule that required a live birth to evoke the protection of the homicide statute. See also Clarke v. State, 117 Ala. 1, 23 So. 671 (1897); Passley v. State, 194 Ga. 327, 21 S.E.2d 230 (1942); State v. Dickinson, 23 Ohio App. 259, 263 N.E.2d 253 (1970).


If there be anyone who strikes a pregnant woman or gives her a poison whereby he causes an abortion, if the foetus be already formed or animated, and especially if it be animated, he commits homicide. However, no reported cases support Bracton's view, absent the occurrence of live birth and subsequent death. The Law and the Unborn Child, supra note 6, at 362.

Part of the reason for the live birth requirement under the common law was the problem of proof. Only if the infant were first born alive was it possible to determine whether death resulted from a criminal as distinct from a natural cause. Rex v. Sims, 75 Eng. Rep. 1075 (K.B. 1601); R. Perkins, Criminal Law 29-30 (2d ed. 1969).

54. A quick child is "[o]ne that has developed so that it moves within the mother's womb." Black's Law Dictionary 1415 (4th ed. rev. 1968).

55. If the killing of the fetus occurred during an abortion with the mother's consent, there was no crime. If the killing occurred without her consent, the resulting offense was assault and battery. W. Clark & W. Marshall, A Treatise on the Law of Crimes §292, at 394 (5th ed. 1952). See also Smith v. Gaffard, 31 Ala. 45 (1857); Abrams v. Foshee, 3 Iowa 273 (1856); Smith v. State, 33 Me. 48 (1851); Commonwealth v. Parker, 50 Mass. 263 (1845); State v. Cooper, 22 N.J.L. 52 (1849).

56. Under English statutes, any person who provided the means to produce an abortion would be guilty of only a misdemeanor. Quay, Justifiable Abortion — Medical and Legal Foundations, 49 Geo. L.J. 395, 432, 436 (1961) [hereinafter cited as Quay].

57. Id. at 432. The willful killing of an unborn child by any injury to the mother, which would be murder if it resulted in the mother's death, is manslaughter. It seems clear that the penalty is conditioned on the prospect or occurrence of an injury to the mother. See, e.g., Ark. Stat. Ann. §41-2223 (1964); Fla. Stat. Ann. §782.09 (1965); Mo. Ann. Stat. §559.090 (1953). See also F. Wharton, Criminal Law §517 (12th ed. 1932) (killing the mother during an abortion was either murder in the second degree or manslaughter, while killing the fetus was merely considered the perpetration of a criminal abortion).
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subsequently-enacted abortion statutes. In no case was the penalty for wrongful abortion equivalent to that for murder.

Despite the fact that the abortion statutes treated the fetus as something less than a person, some authors assert that these statutes were, in any event, primarily intended to protect the fetus. However, an examination of the operation of these statutes indicates that the true purpose was to protect the life and health of the mother from the unskilled abortionist. Protection of the fetus was merely incidental. This conclusion follows from the fact that, although some statutes provided for prosecution of the pregnant woman if she either procured or performed her own abortion, there is no record of any such prosecution. If the purpose of the statutes was protection of the fetus, logic would demand prosecution of any person, including the mother, who was responsible for its death. But if, on the other hand, the purpose of the statutes was the protection of the pregnant woman, then the state's failure to prosecute her is consistent with the statutory intent. Moreover, third-parties who procured or performed abortions were prosecuted, whether or not the woman was pregnant. This fact further

58. For a complete history of English and American abortion statutes, see generally Quay, supra note 56.

59. See, e.g., N.Y. Penal Law §§125.27, 125.45 (McKinney 1975) (murder in the first degree is a class A-1 felony, punishable by death; criminal abortion in the first degree is a class D felony, punishable by not more than seven years' imprisonment); Law of July 28, 1961, ch. 38, §23-1 [1961] Ill. Laws 1983 (repealed 1973) (murder is a separate offense punishable by death; criminal abortion is punishable by one to ten years' imprisonment).

60. The Law and the Unborn Child, supra note 6, at 364; Constitutional Conception of Life, supra note 6, at 1002.


62. See, e.g., Cal. Penal Code §275 (West 1972); N.Y. Penal Law §§125.50, 125.55 (McKinney 1975); Utah Code Ann. §76-2-2 (1973). But see Destro, supra note 6, at 1256 n.30 (1975), citing In re Vince, 2 N.J. 443, 451, 67 A.2d 141, 145 (1949): "The rule proscribing prosecution [of the woman aborted] was . . . based upon evidentiary considerations: the courts needed the woman's testimony to bring the abortionist before the bar." While this rationale may in part account for the absence of prosecution of the patient, it cannot explain the states' failure to prosecute a woman whose abortion is self-induced.


(a) A person commits abortion when he uses any instrument, medicine, drug or other substance whatever, with the intent to procure a miscarriage of any woman. It shall not be necessary in order to commit abortion that such woman be pregnant or, if pregnant, that a miscarriage be in fact accomplished. (emphasis added)
demonstrates that the real purpose of the statutes was protection of the woman.  

More modern abortion statutes, although now obsolete, offer additional indications of the law's regard for the fetus. They permitted termination of pregnancy under the following circumstances: 1) whenever the pregnant woman's physical or mental health was endangered; 2) whenever the fetus might be born with grave physical or mental defects; or 3) whenever pregnancy resulted from felonious intercourse. Clearly, none of these provisions protected the fetus, especially the last, under which a fetus could be aborted solely because the circumstances of its conception were socially disapproved. In other words, the fetus in and of itself had no interest in or right to life unless the state, the mother and the physician were first in agreement. If at times the criminal law appears to offer its protection, it does so only incidentally to the protection of persons. The criminal law, like the law of property, torts, wrongful death and social welfare, gives the fetus neither rights nor protection prior to live birth.

The analysis of the legal precedent in these five sections supports the

64. State v. Murphy, 27 N.J.L. 112 (1858), in which an abortionist who advised a pregnant woman to swallow a substance was convicted of procuring a miscarriage, although it could not be proved that the woman actually ingested the substance. Because the statute was for the protection of the woman, it was unnecessary for the state to prove that the substance was in fact taken.

65. See, e.g., Model Penal Code §230.3(2) (Proposed Official Draft 1962), which provides in relevant part:

(2) Justifiable Abortion. A licensed physician is justified in terminating a pregnancy if he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or that the pregnancy resulted from rape, incest, or other felonious intercourse.

66. See Roe v. Wade, 410 U.S. 113 (1973); Doe v. Bolton, 410 U.S. 179 (1973). These cases effectively nullified all penal abortion statutes which limited or proscribed abortion prior to the point of fetal viability (at approximately the twenty-eighth week of pregnancy).


70. It is clearly not in the best interests of the fetus to be aborted. Nor is there in this case any countervailing danger to the pregnant woman in a continued pregnancy. Rather, the fetus is aborted purely because of the public policy consideration of the state, and the social and moral stigma attached to the woman who delivers a child resulting from rape, incest or other felonious intercourse.
Court's decision that the fetus is not a person. Just as this analysis is essential to an acceptance of the proposed guidelines, so too is an understanding of the meaning of viability and the problems associated with its determination.

**VIABILITY AND LIVE BIRTH**

The Supreme Court's choice of viability as the point at which the state may intervene in the woman's exercise of her fundamental right to abort was serious error. Although the Court set the upper limit of viability at the beginning of the third trimester of pregnancy, after approximately twenty-eight weeks, it failed to define the lower limit of viability. Thus, *Roe v. Wade* allows the state to intervene and prescribe elective abortions during the second trimester of pregnancy.

71. The Court, citing L. HELLMAN & J. Pritchard, Williams Obstetrics (14th ed. 1971) [hereinafter cited as HELLMAN & Pritchard], stated:

Interpretations of the word "viability" have 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 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 medical care, furthermore, has permitted survival of increasingly small infants.

410 U.S. at 160 n.60.

The twenty-eight week point of viability is medically accepted because it marks the period at which substantial fetal weight gain coincides with functionally complete development. While a smaller fetus has some chance of survival, its actual viability is limited to whether or not its lungs are fully mature and operational, usually at twenty-six to twenty-eight weeks. Some physicians consider only those fetuses with functioning lungs to be liveborn because fetuses without independent respiration capabilities cannot be given respiratory support and so cannot take on oxygen; they die, often within hours of birth. Cf. S. Clayton, D. Fraser & T. Lewis, Obstetrics 645 (12th ed. 1972) [hereinafter cited as Clayton, Fraser & Lewis]. A suggested alternative to respiratory sustenance for pre-twenty-six week liveborns is direct oxygenation of the bloodstream, but no such method has yet been devised. Interview with Ervin E. Nichols, M.D., Director-Practice Activities, The American College of Obstetricians and Gynecologists, Chicago, Illinois, on Mar. 4, 1976 [hereinafter cited as Nichols]. For a discussion of attempted methods of direct oxygenation of premature liveborns, see "Fetuses, Pregnant Women, and In Vitro Fertilization" in Part III: Dep't of H.E.W., Protection of Human Subjects, 40 Fed. Reg. 33525, 33534 (1975).

whenever there is evidence that the fetus is at least potentially viable. This requires the physician to make two highly speculative determinations. Not only must he attempt to determine the age of the fetus, he must also decide whether or not it is viable.

A physician can rarely determine the exact gestational age of a fetus, even during the third trimester of pregnancy, because his access to fetal information is extremely limited and unreliable. His bases of inquiry determination of viability, without regard to the trimester of gestation, is not invalid although it may prevent abortions within the second trimester of pregnancy). But see Hodgson v. Anderson, 378 F. Supp. 1008 (D. Minn. 1974), appeal dismissed for want of jurisdiction sub nom. Spannaus v. Hodgson, 420 U.S. 903 (1975) (state statute which places viability at twenty weeks in order to restrict abortion during the second trimester of pregnancy is invalid; the period of viability is presumed to be no sooner than twenty-four weeks unless individualized data indicate otherwise).

Realistically, current medical evidence would prevent the state's setting viability at a point prior to the twentieth week. See note 73 infra.

73. Unfortunately, it is almost impossible to determine fetal age and weight before the fetus is removed from the uterus. In addition, fetal weight is very seldom closely correlative of fetal age because of the variations in rates of fetal weight gain and development. Nichols, supra note 71. For example, while Hellman & Pritchard, supra note 71, at 1027, place 400 gram fetal weight at approximately twenty weeks of gestation, the University of Illinois at the Medical Center reports a spontaneously aborted fetus of twenty-eight weeks weighing only 300 grams. Interview with Marcia Mauer, Ass't. Prof. of Nursing, University of Illinois at the Medical Center, Chicago, Illinois, on Mar. 5, 1976.

Hellman & Pritchard provides the following approximate fetal survival rates based on single-birth weights:

<table>
<thead>
<tr>
<th>Birth Weight in Grams</th>
<th>Percent of Survival</th>
</tr>
</thead>
<tbody>
<tr>
<td>401 [20 wks] - 1000 [28 wks]</td>
<td>4.1</td>
</tr>
<tr>
<td>1000 - 1500</td>
<td>52.2</td>
</tr>
<tr>
<td>1501 - 2000</td>
<td>81.6</td>
</tr>
<tr>
<td>2001 - 2500</td>
<td>96.2</td>
</tr>
<tr>
<td>2500+</td>
<td>99.5</td>
</tr>
</tbody>
</table>

74. Tests for calculating fetal age have been largely developed to aid physicians during the last trimester of pregnancy in determining the best time to deliver by Cesarean section. Nichols, supra note 71. These tests are therefore not geared to distinguish between twenty-four and twenty-eight week second trimester fetuses, but rather to find gestational age with accuracy at or after thirty-two to thirty-four weeks, when there is the best chance of delivering a viable liveborn.
are largely confined to maternal history and estimated uterus size.\textsuperscript{75} With regard to maternal history, the physician is entirely dependent upon the mother's recollection of the date of conception, for he is usually without independent knowledge.\textsuperscript{76} If the mother is either unable or unwilling to provide this information, the physician must rely on a subjective evaluation of the size of the uterus in order to estimate fetal size and thus weight. However, uterus size, even in combination with a complete maternal history, only permits the physician to calculate gestational age to within an accuracy of four to six weeks.\textsuperscript{77}

Some of the newer tests have greatly improved the accuracy of age determination in the third trimester, especially when used in combination. For example, with amniocentesis, an analysis of the cytologic and biochemical characteristics of the amniotic fluid, a physician can predict fetal age by measuring the extent of certain chemical agents present. After thirty-four weeks, creatin levels rise, indicating muscle maturity; after thirty-eight weeks, increased lipid levels indicate liver development. Another useful tool is x-ray, which can sometimes determine age as early as twenty-six weeks, although accuracy is generally not recognized prior to thirty-eight weeks. \textit{Greenhill \& Friedman, supra note 73, at 171-76.}

One of the newest and most significant testing methods is ultrasonography, which uses sound waves bounced across the bi-parietal diameter of the fetus's head to measure growth changes and so determine gestational age. Here, again, accuracy occurs only during the third trimester, at about the thirty-second week. Prior to that time, measurement of the fetal head is difficult due to unpredictable twisting and turning. As with many new age determinant methods, sonography remains a research tool, limited in availability to only tertiary hospitals (large research or university-affiliated centers). Secondary (largely metropolitan, suburban or medium central-city hospitals) and primary (rural, routine and emergency facilities) centers have no practical access to such techniques.

\textsuperscript{75} Nichols, \textit{supra} note 71.

\textsuperscript{76} The physician will usually have independent knowledge of maternal history only if he has been treating the patient for infertility with hormones or if the patient has been artificially inseminated. In either case, medical records narrow the possibilities of conception dates. \textit{Id.} Even when the pregnancy has been “planned,” the mother is often unable to pinpoint the exact \textit{month} of conception. For example, the pregnant woman may menstruate after conception and so believe herself to be one month less pregnant than she really is. Or the woman may be so irregular in her menstrual cycle that any determination is at best speculative. This is most often true in cases of very young patients who have only recently begun, or have not yet in fact begun, menstruating.

In addition to being unable to provide accurate information, the woman may be unwilling to do so. If she believes that she is beyond the time limit for a legal abortion in the second trimester, she may lie to obtain the abortion. Clark, Gosnell \& Cook, \textit{A New Doctors' Dilemma, Newsweek, Mar. 3, 1975, at 25 [hereinafter cited as Clark, Gosnell \& Cook].}

\textsuperscript{77} Nichols, \textit{supra} note 71. Intrauterine growth charts indicate generally wide weight ranges for the normal-weight fetus. Small or large-for-age fetuses may vary even more widely. \textit{See note 73 supra.} Thus, a uterus which feels like it contains a 500 gram, twenty-two week non-viable fetus may actually contain a viable fetus of twenty-eight to thirty-two weeks.
Despite the difficulties and inherent imprecision in determining fetal age, the physician who errs and aborts a potentially viable second trimester fetus may be liable for an illegal abortion and subject to criminal prosecution. At least two states have already brought criminal charges under just such circumstances. These actions have prompted some

78. See, e.g., I11. REV. STAT. ch. 38, §81-17 (1975) (an abortion performed in violation of this section is a Class 2 felony).

79. The most publicized criminal prosecution of a physician relating to abortion is the case of Commonwealth v. Edelin, No. 81823 (Suffolk Cty. Super. Ct.), appeal docketed, No. AC75-604 (Mass. Intermediate App. Ct. 1975). Dr. Edelin was indicted and subsequently convicted of manslaughter for the killing of an unborn viable fetus in the womb of its mother during a hysteroscopy abortion. For a full discussion of abortion procedures, see note 11 infra. The prosecution alleged that the fetus was twenty-four to twenty-eight weeks of age, had exhibited life signs within the mother and was ultimately smothered inside the mother by Dr. Edelin. The defense elicited testimony from Edelin's medical associates which placed the age of the fetus variously at twenty to twenty-two weeks, twenty-four weeks, and twenty-five to twenty-seven weeks. After removal, the fetus weighed between 600 and 700 grams. Wecht, A Comparison of Two Abortion-Related Legal Inquiries, 3 J. LEGAL MED. 36, 37-40 (1975) [hereinafter cited as Wecht].

The Edelin case might have presented a good setting in which to determine the liability of a physician who in good faith fails to determine accurately second trimester fetal age or viability, who aborts a viable fetus which is subsequently liveborn, and who either fails to sustain the liveborn's life or takes affirmative action to kill the liveborn after delivery. Unfortunately, none of these issues was reached because Edelin was not prosecuted for a wrongful abortion, but rather for the killing of a person. The prosecution did not charge Edelin with wrongful abortion because at the time of the act, the Massachusetts statute was inoperative as a result of the Roe v. Wade decision. See MASS. GEN. LAWS ch. 272, §19 (1970). Therefore, the prosecution charged that Edelin had killed a person, alive inside the body of the mother, and was guilty of the crime of manslaughter. Such a charge can have no legal basis unless the fetus is first born alive outside the body of the mother and then killed. Prior to expulsion, the fetus is not a person under either the common or statutory law. See text accompanying notes 13-70 supra. See also note 82 infra. The trial judge recognized this as law and instructed the jury that

A fetus is not a person, and not the subject of an indictment for manslaughter. In order for a person to exist he or she must be born . . . . Birth is the process which causes the emergence of a new individual from the body of its mother. Once outside the body of its mother, the child has been born within the commonly accepted meaning of that word . . . . In order for the defendant to be found guilty in this case, you must be satisfied beyond a reasonable doubt, . . . that the defendant caused the death of a person who had been born alive outside the body of his or her mother.


The jury found Edelin guilty of manslaughter. It apparently disregarded the judge's instructions requiring that the fetus be liveborn to convict Edelin of manslaughter, and instead accepted the prosecution's theory that a fetus which exhibits life signs inside the
ABORTION DECISION

physicians and hospitals to refuse to perform non-therapeutic abortions beyond the twentieth week of pregnancy, even though the possibility of viability is highly unlikely until at least the twenty-sixth week. If fear of criminal prosecution induces a significantly greater number of doctors and hospitals to adopt such twenty week abortion policies, the availability of late second trimester abortions will be seriously restricted, and the right of a pregnant woman to abort after twenty weeks will be effectively precluded. Under such blanket policies, whether or not a fetus is viable after the twentieth week will be irrelevant, for no individual determination will be made. Instead, the fiction of twenty week fetal viability will be an irrebuttable presumption used to deprive the pregnant woman of her fundamental right to abort a fetus which, in all probability, is not viable.

Determining viability is not the sole problem facing the physician. In addition, he must deal with the reality of live birth following abortion. Live birth occurs when any fetus, regardless of age, is removed from its mother's womb and exhibits independent breathing, with movement of the mother before expulsion is a person. Under these circumstances, it was clearly the obligation of the trial court to set aside the jury's verdict; this he refused to do. The verdict is now on appeal.

For a similar case with a markedly different result, see In re: Formal Open Inquest into the Death of Baby Girl Doe, Coroner's Hearing, Allegheny County, Pa. (1974), discussed in Wecht, supra, at 40-42.

80. See American Civil Liberties Union Foundation, Abortion Clinic Directory (Oct. 1975). The Los Angeles Planned Parenthood office reported a ten percent increase in the number of women coming in because doctors and hospitals had refused to abort them after the sixteenth or seventeenth week of pregnancy. Alpern, supra note 12, at 24. In the entire midwestern area of the United States there are reportedly only four Chicago hospitals which continue to perform non-therapeutic second trimester abortions, and these only at a combined rate of approximately fifteen per week. Interview with Faculty, Dep't of Maternal-Child Nursing, University of Illinois at the Medical Center, Chicago, Illinois, on Mar. 5, 1976 [hereinafter cited as Nursing Faculty]. Thus, abortion, at least after the first trimester, is practically unavailable in the midwest.

81. The majority of late-term abortions are performed on single, young, poor and minority women. As stated by Dr. James Waters, Jr., a plaintiff in the 1973 Roe v. Wade case, the fact that a patient gets to eighteen weeks means she has difficulty making up her mind, she has economic problems, she's not smart enough to know she's pregnant, and she's scared to death to tell her family.

82. Complete expulsion from the mother's body has usually been a legal requisite of live birth. See Jackson v. Commonwealth, 265 Ky. 295, 96 S.W.2d 1014 (1936); People v. Hayner, 300 N.Y. 171, 90 N.E.2d 23 (1949); Cordes v. State, 54 Tex. Crim. 204, 112 S.W. 943 (1904). See also Atkinson, Life, Birth and Live Birth, 20 L.Q. Rev. 134, 139-46 (1904). But see People v. Chavez, 77 Cal.App.2d 621, 176 P.2d 92 (4th Dist. 1947) (a fetus fatally wounded during the birth process which died after total expulsion is a person for purposes of the homicide statute).
of the arms and legs, a beating heart, or pulsation of the umbilical cord, denoting heart action.\textsuperscript{3} Live birth may occur as early as twenty weeks, when the fetus has less than a .001 percent chance of survival due to the immaturity of its respiratory system.\textsuperscript{4} Thus, live birth is not indicative of fetal viability; it may ante-date viability and actual capability of survival by as much as eight weeks.\textsuperscript{5} However, the fact of live birth, no matter how fleeting the life signs, is of significance in that it marks the beginning of independent legal personality.\textsuperscript{6} For the duration of life, the liveborn is entitled to the rights and privileges enjoyed by other persons under the law. For example, upon live birth the fetus's contingent right to take property becomes vested\textsuperscript{6} and he may have an action brought in his own name to recover for tortious injuries sustained during gestation.\textsuperscript{7} In the event of his subsequent death, the liveborn infant is treated as a deceased person in all respects. Therefore, if death results from tortious injuries, the personal representative of the liveborn may bring a survival action for the benefit of the liveborn's estate.\textsuperscript{8} If death results from a criminal act or omission, the state may prosecute for the killing of a human being under homicide statutes.\textsuperscript{9} 

83. WILLSON, BEECHAM & CARRINGTON, supra note 73, at 8. However, "[h]earbeats are to be distinguished from several transient cardiac contractions; respirations are to be distinguished from fleeting respiratory efforts or gasps . . . ." HUGHES, supra note 73, at 454.

To many hospitals, doctors and nurses, live birth means that the fetus has exhibited any one of the indicated life signs, for example, a fetal heart tone, whether or not the fetus has an actual capability to survive. Nursing Faculty, supra note 80. The capability to survive requires at the minimum that the fetus have a functional respiratory system so that it can be attached to a respirator for life support if necessary. See note 71 supra. Clearly, a fetus can exhibit life signs although it is physically incapable of survival; that is, it can be liveborn but not viable. Because a fetus cannot survive absent respiratory capability, some physicians refuse to recognize live birth without fetal respiration. Nichols, supra note 71. Such characterization of live birth indicates that some physicians do not distinguish between live birth and viability, while others view them as two very separate concepts.

84. See notes 71, 73 supra.

85. Viability requires functional lungs, which usually do not develop in the fetus until twenty-six to twenty-eight weeks into gestation. Therefore, the fetus born alive between twenty and twenty-six weeks is almost never viable. Nichols, supra note 71.

86. See text accompanying notes 13-70 supra.

87. See notes 14-15 and accompanying text supra.

88. See notes 30-31 and accompanying text supra.

89. See note 33 and accompanying text supra.

90. In a prosecution for homicide, the state must prove not only that the fetus was completely expelled, but also that it was independent and separate in existence from the mother when it was killed. See Montgomery v. State, 202 Ga. 678, 44 S.E.2d 242 (1947); State v. O'Neall, 79 S.C. 571, 60 S.E. 1121 (1907); Morgan v. State, 148 Tenn. 417, 256 S.W. 433 (1923). But see Commonwealth v. Edelin, No. 81823 (Suffolk Cty. Super. Ct. 1975), discussed in note 79 supra.
The viability/live birth distinction is of immense significance in the issue of state regulation of abortion, for it permits the state to treat the physician's good faith act of aborting what he reasonably believes to be a non-viable second trimester fetus in vastly different ways. The Roe decision itself gives the state the limited power to regulate and punish only for the abortion of viable fetuses. However, state statutes supplement that power by providing a sanction for killing any fetus first born alive. Thus, whether the product of an abortion is a stillborn fetus or a liveborn infant has serious criminal implications. Assuming that the physician has made a good faith determination of the gestational age of the fetus and reasonably believes it to be non-viable, his act of aborting that fetus may produce three legally inconsistent results. If the fetus is non-viable and dies during the abortion prior to expulsion from the mother's womb, then there has been a legal abortion and no crime. If, despite the physician's good faith determination to the contrary, the fetus is viable and it dies prior to expulsion, then the state may prosecute for a wrongfully performed abortion. On the other hand, if a fetus is aborted and subsequently born alive, then viability is legally irrelevant. If the physician fails to take affirmative action to preserve the life of the liveborn or if he acts to cause its premature death, the state may

91. 410 U.S. at 164-65. See note 7 and accompanying text supra.
92. See generally notes 53-70 and accompanying text supra.
93. See note 78 supra.
94. Whether or not a physician should take affirmative action to preserve a liveborn aborted fetus is the subject of both ethical and moral debate. The Executive Board of The American College of Obstetricians and Gynecologists, in a recent policy statement of ethical considerations relating to abortion, affirmed its official position that the physician does not have an adversary relationship with the fetus and

does not view the destruction of the fetus as an end in itself. The College consequently recognizes a continuing obligation on the part of the physician towards the survival of a fetus born alive following a procedure for abortion, and where this can be achieved without additional hazard to the health of the mother.


Eighteen states, by statute, now require physicians to use extraordinary measures to preserve the life of the liveborn. A Review of State Abortion Laws Enacted Since January 1973, 4 Fam. PLAN./POPI. RPR. 108, 113 (1975). What affirmative action, if any, is appropriate when an aborted fetus is born alive is largely dependent upon the age, weight and physical development of the liveborn. For example, a fetus so small and immature as to be without the capability of respiration cannot survive. See notes 71, 73, 83 supra. In such a case, affirmative action merely requires that the liveborn be made comfortable in a warm incubator until its lungs begin to function or it eventually expires from lack of oxygen. On the other hand the live birth of a viable fetus with functional lungs requires
prosecute him for the intentional or negligent criminal killing of a person. 95

The three disparate results which stem from the same fact situation are absurd. In each case, the physician has made a good faith determination regarding viability and has performed the abortion upon that premise. However, the law disregards the physician's good faith and instead considers only the condition of the fetus after expulsion from the mother. It then imposes liability on the physician as if he knew or could have known the condition of the fetus when it was in the womb. 96

Clearly, the parameters established by the United States Supreme Court in *Roe v. Wade* have created substantial problems for the pregnant woman and her physician. In order to minimize these problems and to implement satisfactorily the *Roe* decision, new guidelines incorporating both medical and legal realities are suggested in the following section.

**SUGGESTED GUIDELINES**

The proposed guidelines seek to secure the woman's fundamental

more sophisticated assistance, including intravenous feeding and a respirator, if necessary.

Equipment and resources are often limited. Many times only one or two respirators are available for all prematurely born infants. Under these circumstances, which liveborn receives what treatment becomes a matter of physician discretion. This is sometimes known as the "triage" theory. Those who cannot survive are made as comfortable as possible and left to die; those who will survive regardless of treatment receive minimal care; only those whose survival depends upon treatment receive extraordinary aid. Nichols, supra note 71. To allow non-viable liveborns to die may seem inhumane; however, to permit viable liveborns to perish because necessary equipment is being used to temporarily prolong the life of an aborted fetus which cannot be viable is absurd.

Incident to the live birth of a fetus is the question of who is to assume the financial responsibility of its care and custody. Thus far six states have enacted legislation which makes an aborted fetus born alive a ward of the state, on the theory that it is a dependent or neglected child. 4 FAM. PLAN./POP. RPTR., supra, at 113.

95. The liveborn, regardless of age or condition, is a person, the unexcused killing of whom is a criminal offense. See note 90 and accompanying text supra.

96. In order to combat the inequity of divergent legal results for the killing of a non-viable fetus, one author has suggested that the physician could avoid criminal liability by administering a toxic substance to the fetus during the abortion. He states that while such a recommendation "may be morally and theologically reprehensible to many physicians, nevertheless [it] would appear to be prophylactically sound from a legal standpoint, based upon the Laufe and Edelin cases." Wecht, supra note 79, at 44. As recognized by Dr. Wecht, the difference in legal liability for the killing of a non-viable fetus either inside or outside the womb is grounded in a mere cosmetic distinction. In both cases the fetus is killed. However, in the former, fetal death is silent, unobtrusive and sanctioned. In the latter, it is highly visible, emotionally and morally unsettling, and clearly criminal.
right to abort a non-viable fetus by protecting the physician from unwarranted prosecution. First, they provide notice to the physician of what constitutes good faith in performing an abortion and when he can be held liable for error. In addition, they recognize that the medical definition of abortion does not require the purposeful destruction of the fetus, but only its expulsion or extraction from the body of the pregnant woman. Moreover, they acknowledge the practical difficulties inherent in assessing gestational age and viability prior to the thirty-second week of pregnancy. Finally, the proposed guidelines recognize the state's interest in both the liveborn aborted fetus and the potential of life in the viable fetus. They permit the state the greatest possible leeway in safeguarding its interests, while still preserving the woman's right to an abortion.

1. Good Faith

1.1 The good faith professional judgment of a physician shall be an absolute defense to any action, either criminal or civil, brought with respect to any matter pertaining to abortion.

Comment: This provision confronts the problem inherent in the concept of fetal viability: the inevitable margin of physician error. It recognizes that abortion involves medical decisions which can best be made by a physician, and that these decisions are not appropriate subjects for adversary legal proceedings which occur after the fact. The defense is intended to protect the physician who makes any good faith decision, including one which concerns age or condition of the fetus, medical condition of the mother, or choice of an abortion procedure. For example, a physician's good faith determination that a fetus is non-viable will be an absolute defense to any criminal or civil proceeding, even if the aborted fetus is subsequently determined to have been viable. The physician has acted in good faith if he has utilized the information and

97. Hughes, supra note 73, at 452; accord, Greenhill & Friedman, supra note 73, at 185. See also note 94 supra. Many physicians, however, believe that the decision to terminate a pregnancy by abortion must realistically be viewed as a decision to sacrifice the fetus, because removal from the womb prior to the third trimester will almost certainly produce a fetus which is either stillborn or incapable of survival. Nichols, supra note 71.

98. See note 74 supra.

99. See notes 71, 73, 83 supra.

100. These guidelines will ultimately suggest that the Court refrain from attempting to second-guess a physician's good faith determination of gestational age and fetal viability for purposes of abortion, and that it instead defer to the expertise of the medical profession. Cf. H. Hart & A. Sacks, Preface to the Legal Process: Basic Problems in the Making and Application of Law at iii (tent. ed. 1958).
techniques commonly available to and in use by the medical community.\textsuperscript{101}

1.2 The good faith defense (1.1) shall not be available to a physician who aborts a fetus which he knows, or in the exercise of good faith professional judgment should have known, was viable at the time of the abortion.

\textit{Comment:} This provision denies the good faith defense to a physician who either negligently or intentionally fails to comply with accepted medical practices.

1.3 A physician who aborts a fetus which he knows, or in the exercise of good faith professional judgment should have known, was viable at the time of the abortion may be subject to such civil or criminal liabilities as the state may prescribe.

\textit{Provided,} the physician shall not be liable for the killing of a person if the abortion did not produce a liveborn infant.

\textit{Comment:} This provision will allow the state a remedy against the physician who negligently or knowingly and intentionally aborts a viable fetus in contravention of professional guidelines and state law. However, this provision does not permit the state to ignore the United States Supreme Court ruling that the fetus is not a person.\textsuperscript{102} That is, while the state may prosecute the physician for wrongful abortion of a viable fetus, it may not prosecute for the killing of a person unless the aborted fetus was first born alive and then killed.\textsuperscript{103}

2. \textbf{Phase I — First Twenty Weeks}

2.1 During the first twenty weeks inclusive of pregnancy, the fetus is conclusively presumed to be non-viable.

\textit{Comment:} This phase encompasses the first trimester of pregnancy and the first half of the second trimester. These two periods were com-

\textsuperscript{101} The American College of Obstetricians and Gynecologists has already established some policy guidelines relating to first trimester abortions which, if complied with, would evidence good faith professional standards. For example,

1. Verification of the diagnosis and duration of pregnancy.

3. Recorded pre-operative [abortion] history and physical examination, particularly directed to identification of pre-existing or concurrent illnesses or drug sensitivities that may have a bearing on the operative procedures . . . .

\textit{Statement on Abortion,} The American College of Obstetricians and Gynecologists, as amended June 20, 1974, on file at The American College of Obstetricians and Gynecologists, Chicago, Illinois.

\textsuperscript{102} Roe v. Wade, 410 U.S. at 157, 158, 161, 162.

\textsuperscript{103} See note 53 supra.
bined for practicality and convenience because the interests of the mother (2.2) and the state (2.3) are uniform throughout.\textsuperscript{104} The non-viability of the fetus is conclusively presumed based upon medical evidence that no fetus below this age has ever survived outside the mother's womb.\textsuperscript{105}

2.2 The pregnant woman, in consultation with her physician, has an unrestricted right to abort a fetus during this phase.

Comment: This provision recognizes the \textit{Roe v. Wade} determination that a state has no interest in the potential of life in a fetus prior to viability, and so may not limit the woman's choice to abort.\textsuperscript{106}

2.3 The state may regulate the medical abortion procedure and abortion facilities to the extent necessary to protect the health and well-being of the pregnant woman.

Comment: The state has an interest in the health and well-being of all of its citizens. Therefore, it may regulate abortion to the extent procedurally necessary to protect the pregnant woman, but not so as to limit her decision or choice to abort. Regulation of abortion must be similar to state health regulation of other medical procedures, practices and facilities.

3. Phase II — Twenty-One to Twenty-Eight Weeks

3.1 From the twenty-first week through the twenty-eighth week of pregnancy, the conclusive presumption of fetal non-viability continues.

Comment: This provision is designed to minimize speculation about fetal viability during the last half of the second trimester of pregnancy.\textsuperscript{107}

\textsuperscript{104} The Supreme Court in \textit{Roe v. Wade} held that a woman has a fundamental right to abort which may be limited by a compelling state interest only at the point of fetal viability. The Court delineated its trimester guidelines as follows:

First trimester (up to and including the twelfth week of pregnancy): The state may not restrict the woman's right to abort. The decision to abort is made by the woman in consultation with her physician.

Second trimester (from the thirteenth through approximately the twenty-eighth week of pregnancy): The state may not restrict the woman's right to abort a non-viable fetus; however, it may regulate hospital facilities to the extent necessary to protect the health and well-being of the woman. The decision to abort is still solely within the province of the woman and her physician.

Third trimester (from approximately the twenty-ninth week of pregnancy until full term): The state's interest in the potential life of the viable fetus becomes compelling, and it may therefore limit or proscribe all non-therapeutic abortions. The woman's right to abort is secondary to the interest of the state. 410 U.S. at 164-65.

\textsuperscript{105} See notes 71, 73 supra.

\textsuperscript{106} See note 104 supra.
While the fetus may be viable toward the end of this phase, the medically documented incidence of survival is almost negligible. The presumption reflects the fact that the medical profession generally does not recognize viability prior to the end of the twenty-eighth week of gestation.

3.2 The pregnant woman, in consultation with her physician, retains the unrestricted right to an abortion during this phase.

Comment: Because of the continued presumption of non-viability, the state may not intervene in the decision made by the pregnant woman and her physician. See Comment to 2.2.

3.3 The state may continue to regulate the medical abortion procedure and abortion facilities to the extent necessary to protect the health and well-being of the pregnant woman.

Comment: This provision reaffirms the continuing interest of the state in the health and well-being of its citizens. Again, however, the state medical regulation may not infringe upon the pregnant woman's choice or decision to abort.

3.4 The state may regulate the methods by which an abortion may be performed, including the prescription of certain medically recognized methods which in and of themselves do little or no harm to the fetus.

Provided, the prescribed method(s) has been adequately tested, is recognized as both safe and effective by the medical profession, and is readily available to the profession at large, and

Further provided, the method(s) poses no greater risk to the health and well-being of the pregnant woman than other methods generally in use.

107. See notes 71, 73, 83 supra.

108. A fetus which weighs 1000 grams (at approximately twenty-eight weeks) or less has only a 4.1 percent rate of survival outside the womb. Hellman & Pritchard, supra note 71, at 680. See notes 71, 73 supra.

By conclusively presuming fetal non-viability prior to the end of the twenty-eighth week, the guidelines seek to eliminate the absurdity of requiring a physician to speculate upon an already speculative determination. That is, if a physician in good faith places the approximate age of a fetus at twenty-six weeks, he should not then be required to speculate further as to whether or not that particular fetus may be viable. While the Supreme Court ideal may be individualized viability determinations for purposes of late second trimester abortions, the practicalities of ascertaining gestational age permit a knowledgeable approximation at best. See notes 71, 73 supra. To hold the medical profession to a higher standard is irrational.

Comment: This provision recognizes the state's interest in the health and well-being of all of its citizens, including the liveborn aborted fetus who becomes a ward of the state. See Comment to 3.5. Therefore, the state may prescribe abortion methods which are most likely to produce healthy liveborns.

110. Eight states, including Illinois, automatically make the aborted liveborn a public ward. However, most states permit exceptions for abortions performed to save the life or health of the mother and for parents who agree in advance of the abortion, or shortly thereafter, to assume responsibility for the liveborn. 4 Fam. Plan./Pop. Rptr., supra note 94, at 112. This legitimate state interest in the health and well-being of the liveborn was also recognized by the United States Supreme Court in Burns v. Alcala, 420 U.S. 575 (1975). See notes 48 & 52 and accompanying text supra.

111. During the second trimester of pregnancy, three abortion methods are prevalent. In the hypertonic saline amnio-infusion method (saline), amniotic fluid is partially removed from the amniotic cavity, and 200 ml [milliliters] of twenty percent sodium chloride is injected into the amniotic sac. Within several hours, significant physiological changes occur within the body of the pregnant woman, usually culminating in active labor and abortion in approximately thirty-six to forty hours. The fetus and placenta then deliver spontaneously. Unfortunately, serious complications may result in a significant number of cases, often requiring active intervention by the physician to save the life of the pregnant woman. In the event of failed labor, a second or even third injection may be necessary. ACOG [The American College of Obstetricians and Gynecologists] Technical Bulletin, No. 37—Feb. 1976, on file at The American College of Obstetricians and Gynecologists, Chicago, Illinois.

If repeated saline injections fail, resort to hysterotomy may be advisable. Since the morbidity associated with hysterotomy is higher than that for other methods of abortion, this procedure is usually employed only when other methods are inappropriate, Willson, Beecham & Carrington, supra note 73, at 200, or when sterilization by tubal ligation is to be performed simultaneously, Greenhill & Friedman, supra note 73, at 388. The hysterotomy procedure is similar to a Cesarean delivery in that the physician makes an incision in the uterus, detaches the placenta from the uterine wall and removes the fetus. Clark, Gosnell & Cook, supra note 76, at 24.

The newest, safest and most effective second trimester abortion method involves the use of Prostaglandin F\(_{1\alpha}\) administered (like the saline solution) by the intra-amniotic route. With Prostaglandin, the period of labor is reduced from approximately thirty-six hours to less than twenty-four hours, and destructive physical changes which occur in the pregnant woman with saline are bypassed. Anderson, Prostaglandin vs Saline for Midtrimester Abortion, 4 Contemp. Ob/Gyn 91 (1974) [hereinafter cited as Anderson]. The only currently recognized disadvantage of Prostaglandin is a higher incidence of minor gastrointestinal side effects, such as vomiting and diarrhea. ACOG Technical Bulletin, No. 27—Apr. 1974, on file at The American College of Obstetricians and Gynecologists, Chicago, Illinois. Failed abortion, although rare, should be completed by other means, e.g., a hysterotomy. Id. For extended discussion and evaluation of clinical results obtained with the use of Prostaglandin F\(_{1\alpha}\), see Corson & Bolognese, Intra-Amniotic Prostaglandin F\(_{1\alpha}\) as a Midterm Abortifacient: Effect of Oxytocin and Laminaria, 14 J. Reprod. Med. (No. 2) 47 (1975); Corson, Bolognese & Merola, Intra-Amniotic Prostaglandin F\(_{1\alpha}\) to Induce Midtrimester Abortion, 117 Am. J. Ob/Gyn 27 (1973).

Of the three methods discussed, the saline method is least likely to produce a liveborn
However, the state's power to prescribe abortion methods is strictly limited to those methods which are acceptable to the medical community at large and which are also readily available to members of that community. If a state were permitted to prescribe outside these narrow restrictions, it might effectively restrain the pregnant woman's access to a safe and effective abortion. This provision is not intended to prohibit or discourage the development of safer and more effective abortion techniques.

The final proviso recognizes that a given drug or procedure, while safe and effective for the majority of pregnant women, may pose a threat to the life or health of a particular woman. In that case, her physician may elect to use an alternate procedure, despite the propensity of that procedure to produce a stillborn or badly damaged liveborn infant. Because it upsets the physiology of the fetus during the process of abortion. The incidence of survival among saline-aborted fetuses weighing between 600 and 700 grams is approximately 1.4 per 100,000. ACOG Technical Bulletin, No. 37—Feb. 1976, on file at The American College of Obstetricians and Gynecologists, Chicago, Illinois. With hystero¬my, the number of live births increases, but because of the high maternal morbidity rate, this method is not favored for routine, second trimester abortions. Prostaglandin is the only method which is likely to produce an aborted liveborn without damage, aside from that normally sustained during delivery, because it does not in and of itself upset the physiology of the fetus. The fact that Prostaglandin also does not upset the physiology of the mother makes this method the overwhelming choice of physicians who have access to the drug for second trimester abortions. Nichols, supra note 71.

Both saline and hysterotomy are widely acknowledged and accepted procedures. Prostaglandin has been only recently developed and tested. Anderson, supra note 111, at 91. Prostaglandin is currently available only in limited quantities and only in tertiary facilities. See note 74 supra.

Were a state at the present time to prescribe the exclusive use of Prostaglandin for abortions without regard to its limited availability, the state would be unreasonably restricting the pregnant woman's access to abortion. A similar attempt by the Commonwealth of Kentucky to limit access to abortion by proscribing the saline method, without an accepted alternate method of second trimester pregnancy termination, was held unconstitutional in Wolfe v. Schroering, 388 F. Supp. 631 (W.D. Ky. 1974). See also Planned Parenthood v. Danforth, 392 F. Supp. 1362 (E.D. Mo.), application for stay of enforcement of Missouri House Bill No. 1211 pending appeal granted, 420 U.S. 918 (1975). However, it would seem that the state could, consistent with these guidelines, prefer Prostaglandin for abortion where it is available.

Any abortion method is unsafe for some pregnant women because of a particular body condition, chemical balance or previous abortion experience. For example, the saline method is not recommended for use in women in whom labor should not be induced, or in women who cannot handle a forty gram salt load. ACOG Technical Bulletin, No. 37—Feb. 1976, on file at The American College of Obstetricians and Gynecologists, Chicago, Illinois. Prostaglandin is contraindicated in the presence of acute pelvic inflammatory disease or when hypersensitivity to the drug itself exists. Warning Insert, The Upjohn Company, Kalamazoo, Michigan (Oct. 1973). Hysterotomy is contraindicated whenever...
election is made in good faith, the physician will have a defense to all actions brought against him. (1.1)

3.5 The state may regulate medical procedure concerning the live-born aborted fetus, and take all steps it deems necessary to sustain the health and well-being of the liveborn. Provided, the state shall assume sole financial responsibility for the care of the liveborn and shall not shift the burden of financial responsibility to the woman who has chosen to abort the liveborn.

Comment: This provision acknowledges the common law rule that a liveborn infant is a person for all purposes under the law. Thus, the state may regulate medical procedure to the extent necessary to preserve the health and well-being of the liveborn.115 If the state chooses to exercise its power to regulate, it must assume the financial burden incident to such regulation, because the aborted liveborn has realistically become a ward of the state.116

4. Phase III — Twenty-Nine Weeks to Term
4.1 After the twenty-eighth week of pregnancy, the fetus is conclusively presumed to be viable.

Comment: This phase encompasses the entire third trimester of pregnancy, during which viability is most likely.117

4.2 The pregnant woman's access to elective abortions may be restricted or even totally proscribed by the state during this phase. Provided, a state may neither restrict nor proscribe abortion when the life or health of the pregnant woman may be threatened by a continued pregnancy.

Comment: This provision recognizes the state's compelling interest in the potential of life in the viable fetus. If the state so chooses, it may further that interest by proscribing all non-therapeutic abortions.118 However, when the life or health of the mother is threatened by continued pregnancy, the state's interest in potential life may not supersede its duty to protect the life and health of the pregnant woman. This limitation on state proscription of abortion is consistent with the common law concept that a fetus is not entitled to the rights, privileges and protections accorded living persons. It is also consistent with many pre-

other less dangerous methods are appropriate and available. Willson, Beecham & Carrington, supra note 73, at 200.
115. See note 94 supra.
116. See note 110 supra.
117. See note 71 supra.
118. See note 8 supra.
Roe criminal statutes which permitted abortion when continued pregnancy threatened the life or health of the pregnant woman.119

CONCLUSION

A woman's exercise of her fundamental right to abortion prior to fetal viability is dependent upon her access to a physician who is willing to perform the abortion. If significant numbers of physicians refuse to perform second trimester abortions because they fear unwarranted state prosecution, the pregnant woman is effectively precluded from exercising her fundamental right. The suggested guidelines have been proposed as a solution to this and other problems surrounding exercise of the abortion right. It is hoped that the states will act expeditiously to implement legislation incorporating these guidelines. However, should the states fail to act, the Supreme Court must take the initiative to provide appropriate guidance in order to preserve and protect the woman's fundamental right to abortion.

Mary Sebek

119. See, e.g., Ga. Code §26-1202(a) (1972) (affirmative defense to criminal abortion that a licensed physician performed the abortion to preserve the life or health of the pregnant woman); Law of July 28, 1961, ch. 38, §23-1, [1961] Ill. Laws 1983 (repealed 1973) (affirmative defense to criminal abortion that a licensed physician performed the abortion to preserve the life of the pregnant woman).