Nos. 81-746 and 81-1172

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,

Respondents.

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., *et al.*,

Petitioners,

v.

CITY OF AKRON, *et al.*,

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On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

BRIEF *AMICI CURIAE* OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, THE AMERICAN MEDICAL ASSOCIATION, THE AMERICAN ACADEMY OF PEDIATRICS, AND THE NURSES ASSOCIATION OF THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., ET AL.

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INTEREST OF *AMICI CURIAE*

Amici curiae are four major organizations of health care professionals. Each *amicus* is dedicated to promoting the public welfare through the maintenance of high professional standards and the provision of quality health care.

Amicus American College of Obstetricians and Gynecologists ("ACOG") is a private, voluntary, nonprofit organization of physicians specializing in obstetric-gynecologic care. ACOG is the leading group of professionals providing health care to women; its 23,000 members represent approximately 90% of all obstetricians and gynecologists practicing in the United States.

Amicus American Medical Association ("AMA") is a private, voluntary, nonprofit organization of physicians. AMA was founded in 1846 to promote the science and art of medicine and the betterment of public health. Today, its membership exceeds 234,700.

Amicus American Academy of Pediatrics ("AAP") is a nonprofit Pan-American Association of approximately 24,000 physicians certified in the care of infants, children and adolescents. AAP's principal purpose is to ensure the attainment by all children of their full potential for physical, emotional and social health. Because of its commitment to the physical and mental wellbeing of our nation's youth, AAP has a particular interest in the parental consent issues discussed in Section II of this brief.

Amicus Nurses Association of The American College of Obstetricians and Gynecologists ("NAACOG") is a private, voluntary, nonprofit organization of 17,000 registered nurses and allied health workers specializing in obstetric-gynecologic nursing care. NAACOG's primary goal is to promote excellence in health care by furthering continuing education and setting standards for nursing practice.

Amici's interest arises from their devotion to the provision of the highest possible quality health care, their dedication to good medical practice, and their commitment to ensuring that patients can freely seek and obtain medical care and that physicians are in a position to discharge their responsibility to provide care and treatment according to their best clinical judgment and professional and ethical standards. *Amici*'s interest is not in debating the philosophical, ethical, moral or religious issues surround-

ing abortion; indeed, their members ascribe to widely divergent views on these issues. The organizations' members, however, share an interest in making certain that, once a patient has made a decision to seek medical care or treatment, such as an abortion, state laws do not unduly interfere with the physician's ability to exercise his best judgment in carrying out the patient's decision in the manner most suited to her particular health needs.[1]

The provisions of the Akron ordinance at issue in this case, like the statutory restrictions under review in other cases pending before the Court,[2] interfere with the free exercise of a woman's right to seek and obtain wanted medical care, prevent her physician from exercising his best professional judgment and providing patients with the best possible medical care, and present a serious obstacle to sound medical practice. Because the outcome of these cases will directly affect the professional services *amici* members provide and the patients whom they serve, *amici* wish to present their views as to the important medical issues raised by the statutory restrictions.[3]

SUMMARY OF ARGUMENT

Akron Ordinance Section 1870.06(B), which requires a physician to recite to his patient, before obtaining her consent to an abortion, seven paragraphs of supposed "facts" unrelated to the medical services being rendered—despite what may be his belief that many of the required statements are untrue, without scientific foundation or contraindicated by his patient's particular needs—unconstitutionally burdens the woman's right, in consultation with her physician and based on his professional opinion,

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[1] Such interest prompted ACOG to file briefs *amicus curiae* in *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973).

[2] *See, e.g., Planned Parenthood Ass'n of Kansas City v. Ashcroft* (No. 81-1255); *Ashcroft v. Planned Parenthood Ass'n of Kansas City* (No. 81-1623).

[3] The parties' written consents to the filing of this brief are being filed with the Clerk pursuant to Rule 36 of the Rules of this Court.

to decide whether to terminate her pregnancy and serves no legitimate state interest.

Akron Ordinance Section 1870.05(B), which makes punishable as a crime the performance of an abortion on a minor under fifteen years of age who has not produced the written consent of a parent or a court order, unconstitutionally inhibits the right to seek an abortion by vesting in a third party an absolute veto over the minor's decision even where she is mature enough fully to understand and intelligently to consent to an abortion and by denying a minor whose best interests militate against parental notice access to an independent judicial determination that she is sufficiently mature to consent or that an abortion would be in her best interests.

Akron Ordinance Section 1870.03, which requires that all abortions after the first trimester be performed in hospitals, unconstitutionally interferes with a woman's ability to obtain an abortion and her physician's ability to implement her decision in a manner best suited to her health needs, without providing any discernible safety benefit or serving any compelling health interest to which it is sufficiently narrowly tailored.

ARGUMENT

I. DETAILED SPECIFICATION OF THE INFORMATION THAT A PHYSICIAN MUST PROVIDE EACH ABORTION PATIENT UNCONSTITUTIONALLY BURDENS THE PATIENT'S RIGHT, IN CONSULTATION WITH HER PHYSICIAN, TO DECIDE WHETHER TO TERMINATE HER PREGNANCY.

Akron Ordinance Section 1870.06(B) requires an attending physician to recite to a patient seeking an abortion seven paragraphs of supposed "facts" before obtaining her "informed consent" to the procedure. No discretion or flexibility is permitted: on pain of criminal liability,[4] the physician must "make [the same specified]

[4] Akron, Ohio, Codified Ordinances ch. 1870, § 1870.18(A) ("Akron Ordinance"). The imposition of criminal sanctions for violation of the provisions of Akron Ordinance Chapter 1870 consti-

disclosures in all cases regardless of his own professional judgment as to the desirability of doing so" [5] and even though he may believe—as most physicians do—that many of the specified "facts" are untrue, unsupported by medical or scientific evidence, contrary to sound medical practice, irrelevant to any conceivable medical purpose, or contraindicated for certain patients. This requirement unduly restricts the exercise of medical judgment by the attending physician and unconstitutionally burdens the woman's right to decide, in consultation with her physician and in accordance with his best medical judgment, to terminate her pregnancy.[6]

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tutes "direct state interference with a protected activity" (*Maher v. Roe*, 432 U.S. 464, 475 (1977)), rather than the sort of "state encouragement of an alternative activity consonant with legislative policy" at issue in *Maher* and *Harris v. McRae*, 448 U.S. 297 (1980). Since "[c]onstitutional concerns are greatest" when, as here, "the State attempts to impose its will by force of law" (*Maher v. Roe*, 432 U.S. at 476) and since Akron's requirements directly "impinge[] upon a fundamental right . . . implicitly secured by the Constitution," they are "presumptively unconstitutional" (*Harris v. McRae*, 448 U.S. at 312, *quoting Mobile v. Bolden*, 446 U.S. 55, 76 (1980)), "may be justified only by compelling State interests, and must be narrowly drawn to express only those interests." *Carey v. Population Serv. Int'l*, 431 U.S. 678, 686 (1977).

[5] *Akron Center for Reproductive Health, Inc. v. City of Akron*, 651 F.2d 1198, 1207 (6th Cir. 1981), *aff'g in part and rev'g in part* 479 F. Supp. 1172 (N.D. Ohio 1979) (*"Akron Center"*).

[6] *Amici* believe that three of the seven paragraphs of Section 1870.06(B)—subsections (3), (4) and (5)—are not properly before the Court because the City essentially conceded their unconstitutionality before the court of appeals. *See* Brief for City of Akron at 9, 35-36 (Feb. 28, 1980). We address Section 1870.06(B) as a whole, however, because the City has suggested to this Court that the section is constitutional in its entirety and because the individual subparts of Section 1870.06(B) are not severable. *See Akron Center*, 651 F.2d at 1207; 479 F. Supp. at 1202-03; *see also Sloan v. Lemon*, 413 U.S. 825, 834 (1973).

A. The Decision To Terminate Pregnancy Is a Decision To Be Made by the Patient in Consultation with Her Physician.

This Court held in *Roe v. Wade*, 410 U.S. 113 (1973), and *Doe v. Bolton*, 410 U.S. 179 (1973), that a woman has a constitutional right, in consultation with her physician and based on his professional opinion, to decide to terminate her pregnancy free from undue state interference. Those cases emphasized the central role of the physician-patient relationship in the abortion decision:

> The [*Roe*] decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is *inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.*[7]

Recognizing that the physician-patient relationship is the preferred forum for abortion decisionmaking, the Court has invalidated a number of state-imposed restrictions on access to abortion that impermissibly intrude on that relationship.[8] In *Doe*, for example, the Court struck down requirements that all abortions be performed in

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[7] *Roe v. Wade*, 410 U.S. at 165-66 (emphasis added). *See also Planned Parenthood v. Danforth*, 428 U.S. 52, 61 (1976) ("The participation by the attending physician in the abortion decision, and his responsibility in that decision, thus, were emphasized [in *Roe*]"); *Colautti v. Franklin*, 439 U.S. 379, 387 (1979) ("*Roe* stressed repeatedly the central role of the physician, both in consulting with the woman about whether or not to have an abortion, and in determining how any abortion was to be carried out. . . . *Roe*'s companion case, [*Doe*], underscored the importance of affording the physician adequate discretion in the exercise of his medical judgment").

[8] The Court has recognized the importance of "deference to the ["presumptively valid"] judgment exercised by a qualified professional" in other contexts as well. *See, e.g., Youngberg v. Romeo*, 50 U.S.L.W. 4681, 4684-85 (June 18, 1982).

accredited hospitals, that two other doctors concur in the attending physician's decision that an abortion would be in his patient's best interests, and that a "hospital committee" approve each abortion.[9] In *Planned Parenthood v. Danforth*, 428 U.S. 52, 82-83 (1976), the Court invalidated a provision requiring the attending physician to "preserve the life and health of the fetus" regardless of the stage of his patient's pregnancy. And in *Colautti v. Franklin*, 439 U.S. 379, 382 (1979), the Court found unconstitutionally vague a similar provision that imposed criminal liability on any physician who failed to determine whether there was "sufficient reason to believe that the fetus may be viable" and to employ the technique that "would provide the best opportunity for the fetus to be aborted alive . . . ." [10]

In contrast, the Court has upheld state regulations that recognize the importance of physician-patient consultation,[11] as well as regulations that neither "encumber[] the woman's exercise of [her] constitutionally protected right" because they place no "obstacles in the path of the doctor upon whom she [is] entitled to rely for advice in

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[9] 410 U.S. at 193-95, 198-200, 195-98. The committee requirement, the Court noted, "substantially limit[s]" the "woman's right to receive medical care in accordance with her licensed physician's best judgment and the physician's right to administer it." *Id.* at 197.

[10] The Court held that, by "condition[ing] potential criminal liability on confusing and ambiguous criteria," the statute had a "profound chilling effect" on physicians' willingness to perform certain abortions "in the manner indicated by their best medical judgment." 439 U.S. at 394, 396.

[11] *See, e.g., Connecticut v. Menillo*, 423 U.S. 9, 11 (1975); *cf. Doe v. Bolton*, 410 U.S. at 191-92 (statute requiring that physician's performance of abortion be "based upon his best clinical judgment that an abortion is necessary" read to permit physician to consider "all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient" so as to "allow[] the attending physician the room he needs to make his best medical judgment").

connection with her decision" [12] nor "confine the attending physician in an undesired and uncomfortable straitjacket in the practice of his profession." [13] Since *Roe*, the decisions of this Court have repeatedly emphasized that a woman has the right to choose her response to pregnancy upon consultation with a physician who is in a position properly to advise her and to determine, in light of medical ethics and professional standards of care, how best to effectuate her informed decision.

B. The Requirement That a Physician Recite a Standard Checklist of Information in All Cases, Regardless of the Circumstances, Significantly Interferes with the Physician-Patient Relationship and May Disserve the Patient's Best Interests.

The purpose of providing information to a patient about a contemplated medical procedure is to enable the patient to evaluate knowledgeably its risks and benefits and to decide intelligently whether or not to undergo the procedure.[14] Each patient, however, is unique and, consistent with the disclosure of facts necessary to obtain informed consent, a physician must be able to exercise discretion in determining the amount, nature and mode of presentation of the information that should be conveyed to a particular patient under the circumstances presented.[15] "In determining whether and how much he should disclose, the physician must consider the probable

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[12] *Whalen v. Roe*, 429 U.S. 589, 605 n.33 (1977).

[13] *Planned Parenthood v. Danforth*, 428 U.S. at 67 n.8 (upholding a statute that, rather than straitjacketing the physician, required only that the patient "certify in writing her consent to the [abortion] and 'that her consent is informed and freely given and is not the result of coercion' "; *id.* at 65).

[14] *See, e.g., Canterbury v. Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972); Waltz & Scheuneman, *Informed Consent to Therapy*, 64 Nw. U. L. Rev. 628, 630 (1970).

[15] *See, e.g., Salgo v. Leland Stanford Jr. Univ. Bd. of Trustees*, 154 Cal. App. 2d 560, 578, 317 P.2d 170, 181 (1957).

impact of disclosure on the patient, taking into account his peculiar knowledge of the patient's psychological, emotional and physical condition, and must evaluate the magnitude of the risk, the frequency of its occurrence and the viability of alternative therapeutic measures." *Woolley v. Henderson*, 418 A.2d 1123, 1130 (Me. 1980).[16]

In discharging his responsibility adequately to inform his patient about a contemplated abortion, as with his other professional responsibilities, the physician must be permitted "the room he needs to make his best medical judgment." *Doe v. Bolton*, 410 U.S. at 192.[17] Akron

[16] Just as some patients wish to be informed about every conceivable complication, no matter how remote, that may result from a surgical procedure, others find such information frightening and prefer to be spared the details. *See, e.g.*, Laufman, *Surgical Judgment*, in Christopher's Textbook of Surgery 1459 (L. Davis 9th ed. 1968); Nemiah, *Psychological Aspects of Surgical Practice*, in Surgery: A Concise Guide to Clinical Practice 9 (G. Nardi & G. Zuidema 3d ed. 1972). Indeed, in certain cases there may be valid medical reasons for nondisclosure. *See, e.g., Canterbury v. Spence*, 464 F.2d at 789; *Sard v. Hardy*, 281 Md. 432, 443, 379 A.2d 1014, 1022 (1977); 40 Pa. Stat. Ann. § 1301.103 (Purdon 1982-83 Supp.). For example, when excessive disclosure would result in anxiety, fear, emotional distress or even increased physical pain, a doctor may decide in the exercise of his best professional judgment to tell his patient no more than she wishes to hear. *See, e.g., Roberts v. Wood*, 206 F. Supp. 579, 583 (S.D. Ala. 1962) (disclosure of risks of "a technical nature beyond the patient's understanding" may cause "anxiety, apprehension, and fear . . . [with] a very detrimental effect on some patients"); *Woolley v. Henderson*, 418 A.2d at 1130 (the doctor must decide "whether disclosure of possible risks may have such an adverse effect on the patient as to jeopardize success of the proposed therapy"; "full disclosure under some circumstances could constitute bad medical practice"); *Cobbs v. Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972) (*en banc*) (a patient has a right to decline to be informed about the risks of a proposed medical procedure). *Cf.* Ohio Admin. Code § 3701-47-06 (B) (1975) (pre-abortion counseling "shall not be forced upon the woman").

[17] Indeed, it is the patient's *right* to obtain her doctor's independent judgment about such matters. *See, e.g., Word v. Poelker*, 495 F.2d 1349, 1352 (8th Cir. 1974).

Ordinance Section 1870.06(B) allows a physician none of this room. By spelling out the information that each patient must receive, regardless of her unique needs and the physician's professional judgment as to what is in that patient's best interests, it imposes on the physician exactly the sort of "undesired and uncomfortable strait-jacket" the Court cautioned against in *Danforth*.[18]

C. The Requirement That a Physician Provide Information He Believes To Be Untrue, Without Medical Foundation, or Not in His Patient's Best Interests Serves No Legitimate State Interest.

By denying a patient the independent judgment of her physician and depriving the physician, on pain of criminal prosecution, of the opportunity to administer to the individual needs of his patients, Section 1870.06(B) would be constitutionally objectionable even if the information required to be conveyed were accurate and pertinent. But the required information is not all accurate and pertinent; Section 1870.06(B) thus suffers from infirmities far more serious than merely confining the physician to a prepared speech.

First, Section 1870.06(B) requires the attending physician to convey to his patients information that he—like most physicians—may believe to be demonstrably false.[19] For example, the doctor is required to inform his patient that the fetus may be viable at a gestational age of only 22 weeks,[20] even though there is no scientific or medical

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[18] 428 U.S. at 67 n.8. *Compare* Akron Ordinance § 1870.06(C), which requires only that the physician inform his patient "of the particular risks associated with her own pregnancy and the abortion technique to be employed," including instructions for post-operative care, and provide her "with such other information [as] in his own medical judgment is relevant to her decision."

[19] This raises serious questions under the first amendment. *See Wooley v. Maynard*, 430 U.S. 705 (1977); *West Va. State Bd. of Educ. v. Barnette*, 319 U.S. 624 (1943).

[20] Akron Ordinance § 1870.06(B)(4).

evidence to support this statement and the experience of the profession confirms its inaccuracy.[21]

The doctor also is required to tell his patient that abortion is a "major surgical procedure," [22] despite the fact that most physicians regard abortion, particularly if performed during the first 18 weeks of pregnancy, as a relatively minor surgical procedure.[23] In addition, the doctor is required to tell his patient that abortion can result in "serious complications, including hemorrhage, . . . sterility and miscarriage and prematurity in subsequent pregnancies" and that it may leave unaffected or worsen existing psychological problems or result in "severe emotional disturbances," [24] notwithstanding that there is little or no evidence that a properly performed abortion increases the risk of any such complications.[25] And, in any event, the required recitation of possible complications is grossly misleading in the absence of information as to the frequency with which these complications occur.[26]

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[21] "[O]n an empirical basis the current limits of viability are clear: there is no unambiguous documentation that an infant born weighing less than 601 grams at a gestational age of 24 weeks or less has ever survived." Nat'l Comm'n for the Protection of Human Subjects of Biomedical and Behavioral Research, *Research on the Fetus* 55 (U.S. Dep't of HEW 1975). *See also* Grimes & Cates, *Complications from Legally-Induced Abortion: A Review*, 34 Obstet. & Gynecol. Survey 177, 182 (1979) ("Grimes & Cates").

[22] Akron Ordinance § 1870.06(B)(5).

[23] The district court so found based on the evidence presented at trial. *Akron Center*, 479 F. Supp. at 1203. *See also* nn. 47-55 & nn. 63-65 and accompanying text *infra*.

[24] Akron Ordinance § 1870.06(B)(5).

[25] *See* ACOG, *Important Medical Facts About Abortion* 10 (Patient Information Booklet 1978).

[26] An explanation of remote risks, absent information as to the unlikelihood of their occurrence, "may well result in alarming a patient who is already unduly apprehensive and who may as a result refuse" treatment or may increase "the risks by reason of the physiological results of the apprehension itself." *Salgo v. Leland*

Second, Section 1870.06(B) requires the attending physician to convey, as if it were an established fact, information for which there is no medical foundation. For example, it requires the physician to inform his patient of the "unborn child's" sensitivity to pain, notwithstanding the medical profession's complete ignorance on that subject.[27]

Third, Section 1870.06(B) requires the attending physician prior to performing an abortion to supply information that bears no relevance to the contemplated procedure or to related medical concerns. For example, the section requires the physician to inform his patient that the embryo or fetus is "a human life from the moment of conception" and to describe "in detail the anatomical and physiological characteristics of the particular unborn child at the gestational point of development at which time the abortion is to be performed," including "appearance, mobility, tactile sensitivity, including pain, percep-

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Stanford Jr. Univ. Bd. of Trustees, 154 Cal. App. 2d at 578, 317 P.2d at 181; *see also* n.16, *supra*. Accordingly, courts have traditionally recognized that "[t]he physician need not deliver a 'lengthy polysyllabic discourse on all possible complications'" and that the physician is under no duty "to discuss the relatively remote risks inherent in common procedures." *Sard v. Hardy*, 281 Md. at 444, 445, 379 A.2d at 1022.

Indeed, by its omission, Akron Ordinance Section 1870.06 (B) (5) leaves the erroneous impression that the patient can avoid "serious complications" by forgoing abortion and electing childbirth, an option that actually may pose a greater risk to her health. *See* nn. 49-55 and accompanying text *infra*.

[27] 479 F. Supp. at 1203. The section also requires the physician to inform the patient that she "is" pregnant and of the number of weeks that have elapsed since conception. The effect of these requirements is to prohibit the performance of menstrual extractions to terminate a pregnancy, a procedure performed soon after the first missed menstrual period, since at that time the physician cannot determine conclusively—as Section 1870.06(B) requires him to do—that the patient "is" pregnant. *See Planned Parenthood Ass'n of Kansas City v. Ashcroft*, 483 F. Supp. 679, 697-98 (W.D. Mo. 1980), *aff'd in part and rev'd in part*, 655 F.2d 848, 868-69, *supplemented*, 664 F.2d 687 (8th Cir. 1981), *cert. granted*, 50 U.S.L.W. 3934 (May 24, 1982).

tion and response, brain and heart function, the presence of internal organs and the presence of external members." [28] Both Akron's "theory of life" [29] and the anatomical and physiological description of the embryo or fetus are plainly "irrelevant and extraneous to the medical services being rendered" and contribute in no way to the patient's understanding of the nature of the proposed procedure or to her weighing of the risks and benefits thereof.[30]

There can be no doubt that the intended purpose, and presumably the effect, of Section 1870.06(B) is to discourage patients from obtaining abortions. But the City of Akron has no legitimate interest, compelling or otherwise, in requiring a physician to provide his patient with inaccurate, baseless or irrelevant information that might intimidate and deter her from effectuating her decision to terminate her pregnancy. Section 1870.06(B) thus impermissibly burdens the patient's exercise of her constitutional right, in consultation with her physician, to decide whether and how to terminate her pregnancy and gratuitously encroaches on the physician's exercise of his professional judgment as to the nature and extent of the information his patient needs or desires to make an informed decision. While a narrowly drawn requirement that the patient certify that her decision to have an abortion has been made without coercion may be permissible,[31]

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[28] Akron Ordinance § 1870.06(B)(3).

[29] *Roe v. Wade*, 410 U.S. at 162.

[30] *Freiman v. Ashcroft*, 584 F.2d 247, 251 (8th Cir. 1978), *aff'd mem.*, 440 U.S. 941 (1979). *See Planned Parenthood League of Mass. v. Bellotti*, 641 F.2d 1006, 1021 (1st Cir. 1981) (striking down a statute requiring the disclosure of information "not directly material to any medically relevant fact, and [that] does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement"). Similarly irrelevant and thus equally objectionable are Sections 1870.06(B)(6) and (7) of the Akron ordinance.

[31] *See Planned Parenthood v. Danforth*, 428 U.S. at 65-67. In a footnote in *H.L. v. Matheson*, 450 U.S. 398, 400 n.1 (1981), the Court

Section 1870.06(B) goes too far in requiring the physician to read a lengthy statement, major portions of which are untrue, without foundation or irrelevant, and even when to do so might be "unwelcome, and medically contraindicated." [32]

II. THE REQUIREMENT THAT ALL MINORS OBTAIN PARENTAL CONSENT OR COURT AUTHORIZATION FOR AN ABORTION IS UNCONSTITUTIONAL.

Akron Ordinance Section 1870.05(B) makes punishable as a crime the performance of an abortion on a minor under fifteen years of age who has not produced the written consent of a parent or a court order. Authorization may be withheld even from a minor who has demonstrated that she "has attained sufficient maturity to make a fully informed decision" regarding termination of her pregnancy. *Bellotti v. Baird*, 443 U.S. 622, 650

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in dictum referred to a Utah informed consent statute. The constitutionality of that statute, however, was not before the Court. Moreover, the Utah statute, which referred in general terms to fetal development and "abortion procedures" and provided for the disclosure of additional information that the physician considered relevant, was substantially less intrusive than Akron Ordinance Section 1870.06(B).

[32] *Planned Parenthood League v. Bellotti*, 641 F.2d at 1022. Significantly, every federal court that has considered similar, detailed recitations that leave the physician no discretion to tailor the information to the particular needs of his patients has held such requirements to be an unwarranted intrusion into the physician-patient relationship and an unconstitutional burden on the exercise of a patient's constitutionally protected right to obtain an abortion on consultation with a physician who is free to exercise his best judgment. *See, e.g., Planned Parenthood Ass'n of Kansas City v. Ashcroft*, 655 F.2d at 866-68 (no review sought); *Planned Parenthood League v. Bellotti*, 641 F.2d at 1018-22; *Charles v. Carey*, 627 F.2d 772 (7th Cir. 1980); *Leigh v. Olson*, 497 F. Supp. 1340 (D.N.D. 1980); *Margaret S. v. Edwards*, 488 F. Supp. 181 (E.D. La. 1980).

(1979).[33] The decisions of this Court in *Planned Parenthood v. Danforth* and *Bellotti v. Baird* leave no doubt that such a regulation, which permits an absolute third party veto, parental or judicial, of a minor's decision to terminate her pregnancy, even where she is mature enough fully to understand and intelligently to make such a decision and to consent to an abortion, is unconstitutional.[34]

Section 1870.05(B) is also constitutionally infirm because, as a practical matter, it requires parental notice of every abortion sought by a minor.[35] Such compulsory

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[33] *See Scheinberg v. Smith*, 659 F.2d 476, 480-81 (5th Cir. 1981) (statute that "does not provide an exception to [best interests] inquiry when the court determines that the minor in question is adequately mature to make the abortion decision herself" vests a court "with constitutionally impermissible discretion to ignore a minor's maturity in determining whether to authorize her abortion").

[34] In *Danforth*, 428 U.S. at 74, the Court held that "the State does not have the constitutional authority to give a third party an absolute, and possibly arbitrary, veto over the decision of the physician and his patient to terminate the patient's pregnancy"; in *Bellotti*, 443 U.S. at 647, a plurality of the Court held that "every minor must have the opportunity—if she so desires—to go directly to a court without first consulting or notifying her parents." In *H.L. v. Matheson*, 450 U.S. at 413, the Court upheld a parental notice provision challenged by an unemancipated minor who lived at home and depended on her parents for support, but left open the question whether a parental notice requirement would be constitutional as applied to mature or "best interests" minors. *See id.* at 420 (Powell, J., concurring) ("a State may not validly require notice to parents in all cases, without providing an independent decisionmaker to whom a pregnant minor can have recourse if she believes that she is mature enough to make the abortion decision independently or that notification otherwise would not be in her best interests").

[35] Ohio law, which governs proceedings under the ordinance (Brief for Petitioner City of Akron at 4 n.2, 26), requires that all complaints filed in juvenile court be served on the minor's parents. Ohio Rev. Code Ann. § 2151.28 (Page 1976).

parental notice in all cases denies mature and best interests minors access to judicial proceedings that "will be completed with anonymity and sufficient expedition," [36] and cannot be reconciled with *Bellotti*'s pronouncement that "the constitutional right to seek an abortion may not be unduly burdened by state-imposed conditions upon initial access to court." [37] A mature minor or a minor whose best interests militate against parental notification must be permitted, without parental notification or consultation, to seek an independent judicial determination that she is mature enough to consent or that an abortion would be in her best interests.[38]

Amici recognize the interest in fostering parental consultation and advice "in important decisions by minors." *Bellotti v. Baird*, 443 U.S. at 637. But the physician's primary duty is to his patients, and many minors are sufficiently mature to make reasonable and responsible decisions about their medical needs. Where the reasonably expected parental reaction to such a minor's interest in terminating her pregnancy would be verbal or physical abuse, expulsion from the home or a similar extreme reaction, the minor is entitled to receive medical care without attempting to surmount the obstacle of parental consultation. Indeed, the specter of parental notice in such circumstances may deny the minor medical care and consultation altogether, cause extreme anxiety and mental distress, or result in a delay in seek-

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[36] *Bellotti v. Baird*, 443 U.S. at 644.

[37] *Id.* at 648.

[38] Missouri requires written parental consent or court authorization of an abortion for all minors under eighteen who are not "emancipated." Mo. Ann. Stat. § 188.028 (Vernon Supp. 1982), at issue in *Planned Parenthood Ass'n of Kansas City v. Ashcroft* (No. 81-1255). The Missouri requirement is unconstitutional for the same reasons that Akron Ordinance Section 1870.05(B) is unconstitutional.

ing an abortion that itself may lead to increased health risks or the birth of an unwanted child.[39] For these reasons, *amicus* ACOG has taken the position that professionals working with adolescents should "encourage family involvement whenever feasible," but that "the adolescent should *not* be denied care and services by reason of such considerations."[40] ACOG's view, based upon the experience of its members, is that regulations and "[p]olicies which prevent confidentiality deter adolescents from seeking care, and should be avoided in the interest of health."[41]

III. THE REQUIREMENT THAT ALL SECOND TRIMESTER ABORTIONS BE PERFORMED IN HOSPITALS IS UNCONSTITUTIONALLY OVERBROAD.

In *Roe v. Wade*, the Court held that, notwithstanding a woman's constitutional right to decide, in consultation with her physician, "whether or not to terminate her pregnancy," abortion implicates certain state interests, including the protection of maternal health, which grow "as a woman approaches term." 410 U.S. at 153, 162-63. Once those interests become " 'compelling,' " the state may regulate the abortion decision in ways reasonably related to its interest. *Id.* at 163.

On the basis of "present medical knowledge" at that time—specifically, the "established medical fact" that "until the end of the first trimester mortality in abor-

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[39] "[T]he abortion decision is one that simply cannot be postponed, or it will be made by default with far-reaching consequences." *Bellotti v. Baird*, 443 U.S. at 643.

[40] ACOG, *Statement of Policy: Adolescent Reproductive Health Care* (1979) (emphasis added).

[41] *Id.* As explained to the United States Department of Health and Human Services on April 15, 1982, the position of *amicus* AMA regarding the provision of health care to adolescents and confidentiality policies is virtually identical to ACOG's position. *See also* AAP, Committee on Adolescence, *Pediatrics* 71-73 (1979).

tion may be less than mortality in normal childbirth"—the Court in *Roe* held that the state could regulate the abortion decision to promote its interest in maternal health "[f]or the stage subsequent to approximately the end of the first trimester . . . ." [42] As the Court stated, except when in light of "present medical knowledge," it would be "equally dangerous" for a woman to forgo abortion, "any interest of the State in protecting the woman from an inherently hazardous procedure . . . has largely disappeared." 410 U.S. at 149.

The Court has recognized that "present medical knowledge" changes, and that flexibility in defining the critical points at which state interests become compelling in order to accommodate advances in medical science is essential. With respect to the state's interest in the potential life of the fetus, for instance, the Court has declined to permit the states to establish a specific point of presumptive viability and has instead deliberately "left the [compelling] point flexible for anticipated advancements in medical skill." [43]

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[42] *Id.* at 163-64. *See also Doe v. Bolton*, 410 U.S. 179.

[43] *Colautti v. Franklin*, 439 U.S. at 387. *See also Roe v. Wade*, 410 U.S. at 159-61; *Planned Parenthood v. Danforth*, 428 U.S. at 61, 64.

Despite its conclusions that decisions of other courts finding that the state's maternal health interest does not automatically become compelling at the end of the first trimester are "persuasive" and that the evidence "in the present case was more detailed than that produced" in *Gary-Northwest Indiana Women's Serv. v. Bowen*, 496 F. Supp. 894 (N.D. Ind. 1980), *aff'd mem. sub nom. Gary-Northwest Indiana Women's Serv. v. Orr*, 451 U.S. 934 (1981), the court of appeals in this case held, on the basis of the summary affirmance of *Gary-Northwest*, that no such flexibility exists and that the beginning of the second trimester is a "bright line" point at which the state's interest in maternal health automatically becomes compelling. 651 F.2d at 1210. The court erroneously overlooked the fact that, as one of its bases for affirmance, the state in *Gary-Northwest* relied upon the district court's finding that "Plaintiff's [legal] theory, even if accurate, lacked sufficient evidence to support it" (Appellee's Motion to Affirm at 4), so that the issue of whether

In the nine years since *Roe* was decided, medical knowledge has progressed dramatically and, now, "more is known about the morbidity and mortality of induced abortion than any other surgical procedure." [44] Measured as it must be "in the light of present medical knowledge," [45] Akron Ordinance Section 1870.03, requiring that all abortions after the first trimester be performed in hospitals, cannot stand.[46]

A. Abortion Today, When Performed Prior to the Late Second Trimester, May Be Performed as Safely in a Properly Licensed Nonhospital Facility as in a Hospital.

Abortion today, while perhaps politically controversial, is a remarkably safe medical procedure. A patient undergoing an abortion faces about the same risk of death as does a patient receiving an intra-muscular injection of penicillin for gonorrhea.[47] A tonsillectomy is twice as risky, and an appendectomy is nearly a hundred times as risky, as a legal abortion.[48]

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the beginning of the second trimester forms a "bright line" was "by no means adequately presented to and necessarily decided by this Court." *Illinois State Bd. of Elections v. Socialist Workers Party*, 440 U.S. 173, 183 (1979).

[44] Grimes & Cates at 177.

[45] *Roe v. Wade*, 410 U.S. at 163; *Planned Parenthood v. Danforth*, 428 U.S. at 61.

[46] The same is true of Missouri statute § 188.025 under consideration in *Ashcroft v. Planned Parenthood Ass'n of Kansas City* (No. 81-1623). Mo. Ann. Stat. § 188.025 (Vernon Supp. 1982).

[47] Grimes, *Abortion and Health: Past, Present and Future* 5 (Mar. 7, 1981) (Paper prepared for Health Care Commission, American College of Obstetricians and Gynecologists). From 1972 through 1978, the death-to-case rate for legal abortions was 2.2 deaths per 100,000 procedures; the rate for penicillin injections administered to gonorrhea patients was 2 deaths per 100,000 injections. *Id.*

[48] *Id. See also* Wennberg, *The Need for Assessing the Outcome of Common Medical Practices*, 1 Ann. Rev. Pub. Health 277 (1980).

Legal abortion is also safer than childbirth. While the mortality rates for both childbirth and abortion are quite low and on the decline, the mortality rate for abortion is declining at a faster pace.[49] As a result, the risk of death from childbearing, which was five times the risk of death from legal abortion between 1972 and 1975,[50] grew to ten times the risk of death from legal abortion between 1976 and 1978.[51] And while childbirth was the more frequent response to pregnancy, it is still significant that, on average, approximately three times as many women died from childbearing each year between 1972 and 1978 than the total number of women who died from legal abortions in all those years combined.[52]

The mortality rate for second trimester abortions has also fallen dramatically since *Roe v. Wade* was decided.[53]

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[49] LeBolt, Grimes & Cates, *Mortality From Abortion and Childbirth: Are the Populations Comparable?*, 248 J. A.M.A. 188, 189-90 (1982) ("LeBolt, Grimes & Cates"). *See also* Cates, Rochat, Grimes & Tyler, *Legalized Abortion: Effect on National Trends of Maternal and Abortion-Related Mortality (1940 through 1976)*, 132 Am. J. Obstet. & Gynecol. 211 (1978).

[50] Cates, Smith, Rochat & Grimes, *Mortality From Abortion and Childbirth: Are the Statistics Biased?*, 248 J. A.M.A. 192 (1982) ("Cates, Smith"); Cates & Tietze, *Standardized Mortality Rates Associated with Legal Abortion: United States, 1972-1975*, 10 Fam. Plan. Persp. 109 (1978); Cates, Grimes, Smith & Tyler, *Legal Abortion Mortality in the United States: Epidemiologic Surveillance, 1972-1974*, 237 J. A.M.A. 452 (1977).

[51] LeBolt, Grimes & Cates at 190.

[52] *Id.* at 189. In 1972 alone, for instance, nearly 500 women died from childbearing whereas only 138 women died from legal abortions in the seven-year period between 1972 and 1978. *Id.*

Moreover, recent studies show that the mortality rate for childbirth, unlike that for legal abortions, may be underestimated by 25-50%. Cates, Smith at 193-95; Rubin, McCarthy, Shelton, Rochat & Terry, *The Risk of Childbearing Re-Evaluated*, 71 Am. J. Pub. Health 712 (1981).

[53] It is important to note that current medical knowledge and practice regarding abortion demonstrate that the risk of abortion increases only linearly, and not exponentially, as gestational age increases. *See* Grimes & Cates at 177.

Between 1972 and 1975, the death-to-case rate for second trimester abortions ranged between 17.6 and 11.4 per 100,000 procedures; by 1977, it had fallen to 6.5.[54] In contrast, the death-to-case rate for childbirth, which hovered between 15.2 and 10.4 per 100,000 live births between 1972 and 1975, had fallen to 9.3 by 1977.[55]

A principal reason for the increased safety of abortions after the first trimester has been the widespread adoption of dilatation and evacuation ("D&E") as an accepted technique for second trimester abortion.[56] In essence, D&E is a modified application of first trimester curettage techniques (dilatation and curettage and suction curettage) to second trimester abortions,[57] and differs significantly from instillation methods [58] which, until 1978, were the most common technique for performing second trimester abortions.[59]

D&E offers two distinct advantages over instillation as a procedure for second trimester abortions. First, it is

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[54] Benditt, *Second-Trimester Abortion in the United States*, 11 Fam. Plan. Persp. 358 (1979) ("Benditt").

[55] Cates, Smith at 195.

[56] *See* Benditt at 358; Tyler, Cates, Schulz, Selik & Smith, *Second-Trimester Induced Abortion in the United States*, in Second Trimester Abortion 13, 18-20 (1981) ("Tyler, Cates").

[57] *See generally* J. Pritchard & P. MacDonald, Williams Obstetrics 603-07 (16th ed. 1980) ("Pritchard & MacDonald"); Benditt at 359.

[58] Instillation methods, also known as amniotic infusion, involve the artificial induction of labor through transabdominal, intraamniotic injection of an abortifacient solution, such as saline or prostaglandin, and delivery of the aborted fetus, usually within 12 to 36 hours of the injection. *See* Dep't of Med. & Pub. Affairs, Geo. Washington Univ. Med. Center, *Pregnancy Termination in Midtrimester—Review of Major Methods*, Population Rep., Series F, No. 5 pp. F-65, F-66-67 (Sept. 1976); Pritchard & MacDonald at 608-11; Grimes, Schulz, Cates & Tyler, *Methods of Midtrimester Abortion: Which Is Safest?*, 15 Int'l J. Gynaecol. Obstet. 184, 186 (1977) ("Grimes, Schulz").

[59] Cates & Grimes, *Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities*, 58 Obstet. & Gynecol. 401 (1981) ("Cates & Grimes").

safer,[60] in large part due to its unique efficacy for early second trimester abortions performed between 13 and 16 gestational weeks.[61] Second, D&E is more acceptable to

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[60] D&E carries a significantly lower risk of mortality and complications than instillation procedures. *See, e.g.*, Cates & Grimes at 404; Cadesky, Ravinsky & Lyons, *Dilation and Evacuation: A Preferred Method of Midtrimester Abortion*, 139 Am. J. Obstet. & Gynecol. 329 (1981); Hubacker, *Dilatation and Extraction for Late Second-Trimester Abortion*, 15 Advances in Planned Parenthood 119, 122 (1981); Grimes, Hulka & McCutchen, *Midtrimester Abortion by Dilatation and Evacuation Versus Intra-amniotic Instillation of Prostaglandin F_{2x}: A Randomized Clinical Trial*, 137 Am. J. Obstet. & Gynecol. 785 (1980) ("Grimes, Hulka & McCutchen"); Grimes & Cates at 188; Cates, *D&E After 12 Weeks: Safe or Hazardous?*, 13 Contemp. Ob/Gyn 23 (1979) ("Cates"); Grimes, Schulz at 187; Grimes, Schulz, Cates & Tyler, *Mid-Trimester Abortion by Dilatation and Evacuation*, 296 New Eng. J. Med. 1141 (1977).

[61] Cates, Schulz, Grimes & Tyler, *The Effect of Delay and Method Choice on the Risk of Abortion Morbidity*, 9 Fam. Plan. Persp. 266, 268 (1977) ("Cates, Schulz").

Because of the small size of the amniotic sac, instillation procedures generally cannot be performed until the sixteenth or seventeenth week. Cates, Schulz at 268; H. Holtrop & R. Waife, *Uterine Aspiration Techniques in Family Planning* 18 (1976); Burnett, King, Burkman & Atienza, *An Evaluation of Abortion: Techniques and Protocols*, 10 Hosp. Prac. 97, 101 (1975). By enabling physicians to perform earlier abortions that, using instillation methods, would have had to have been postponed until the sixteenth week, D&E has provided the means to reduce the risk of abortion.

Experience during the 1970s reflects this advance. Between 1973 and 1978, the percentage of second trimester abortions performed between weeks 13 and 15 increased significantly while the percentage performed after week 15 fell. *See* U.S. Dep't of Health & Human Services, Center for Disease Control, *Abortion Surveillance—Annual Summary 1978* iv (1980); Henshaw, Forrest, Sullivan & Tietze, *Abortion in the United States, 1978-1979*, 13 Fam. Plan. Persp. 6, 17 (1981) ("Henshaw, Forrest 1978-79"); Tyler, Cates at 18. During this same period, the percentage of second trimester abortions performed by D&E increased while the percentage performed by instillation declined and, by 1977, D&E surpassed saline instillation as the most frequently used second trimester procedure. Grimes & Cates, *Dilatation and Evacuation*, in Second Trimester Abortion 119, 120 ("Dilatation and Evacuation").

second trimester abortion patients than instillation procedures because it is quicker, less expensive, less painful and less emotionally traumatic.[62] And because D&E eliminates the prolonged labor associated with instillation procedures, it typically can be performed safely on an outpatient basis at either a hospital or a clinic.[63]

Recognition of the fact that most second trimester abortions are as safe as or safer than childbirth has led to a change in the views of many physicians regarding the advisability of hospitalization for all second trimester abortions. There is now sufficient evidence and experience with the D&E technique in particular to demonstrate that, up to at least 16 weeks, abortions performed by physicians in nonhospital facilities are at least as safe as those performed in hospitals.[64] Moreover, based on the experience of its members, *amicus* ACOG recommends in its *Standards for Obstetric-Gynecologic Services* that "[i]n a hospital-based or in a free-standing ambulatory surgical facility, or in an outpatient clinic meeting the criteria required for a free-standing surgical facility,

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[62] ACOG, *Methods of Midtrimester Abortion*, Tech. Bull. No. 56 (Dec. 1979); Rooks & Cates, *Emotional Impact of D&E vs. Instillation*, 9 Fam. Plan. Persp. 276-77 (1977); Grimes, Hulka & McCutchen at 789.

[63] *See, e.g.*, Cates at 28; Pritchard & MacDonald at 603; Dilatation & Evacuation at 121.

[64] Grimes, Cates & Selik, *Abortion Facilities and the Risk of Death*, 13 Fam. Plan. Persp. 30-32 (1981); Cates & Grimes at 406-07; Grimes, Cates & Tyler, *Comparative Risk of Death from Legally Induced Abortion in Hospitals and Nonhospital Facilities*, 51 Obstet. & Gynecol. 323 (1978). *See also* Cates, Schulz, Grimes, Horowitz, Lyon, Kravitz & Frisch, *Dilatation and Evacuation Procedures and Second-Trimester Abortions*, 248 J. A.M.A. 559 (1982).

Indeed, nonhospital facilities actually enjoy a lower death-to-case rate than hospitals. Cates & Grimes at 404, 406. When adjusted for confounding factors such as the greater tendency of hospital abortion patients to have preexisting conditions and to undergo concurrent sterilization, however, the death-to-case rate for hospital abortions is equivalent to that for nonhospital abortions. *Id.*

abortions should be limited generally to 18 weeks from the last menstrual period." [65]

The decision where an abortion is to be performed—like the decision as to the procedure to be used—should be made in accordance with the patient's desires and the physician's medical judgment.[66] There are a number of reasons why a patient might choose, and a physician might recommend, that an abortion be performed in a nonhospital facility. Hospitalization, for instance, often entails "emotional and financial stresses." [67] In addition, nonhospital facilities frequently provide more extensive counselling services for the abortion patient and more specialized staff. Because most second trimester abortions can be performed as safely in a properly equipped and staffed nonhospital facility as in a hospital, a nonhospital abortion thus will often be in the patient's best interest. Requiring all second trimester abortions to be performed in hospitals therefore interferes with the physician's exercise of his best medical judgment in carrying out his patient's abortion decision in a manner best suited to her individual health and personal needs without offering any discernible safety benefit.

Moreover, a woman in the second trimester of pregnancy who wishes to have an abortion may also have

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[65] ACOG, *Standards for Obstetric-Gynecologic Services* 54 (5th ed. 1982) ("*ACOG Standards*"). ACOG's standards for "free-standing surgical facilities" recommend that they "be licensed to conform to requirements of state or federal legislation" and "maintain the same surgical, anesthetic, and personnel standards as recommended for hospitals." *Id.* at 52. "Surgical procedures may be performed in those facilities under general or regional block anesthesia when it is expected that the postoperative recovery will permit discharge on the same day. There should be a written policy requiring the medical staff to provide for prompt emergency treatment or hospitalization in the event of an unanticipated complication." *Id.*

[66] *See* n. 77, *infra.*

[67] *ACOG Standards* at vii.

difficulty implementing her decision in the face of a hospitalization requirement.[68] Akron Ordinance Section 1870.03, for example, has the practical effect of severely limiting a woman's ability to obtain a second trimester abortion in that city.[69] As a result, a woman seeking a second trimester abortion in Akron is likely to face the choice of carrying to term, traveling elsewhere for her abortion, or undergoing an illegal abortion. Each such option poses a greater risk to a woman's health than undergoing an abortion at a properly equipped and staffed nonhospital abortion facility in Akron.[70]

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[68] Less than 30% of all short-term general non-Catholic hospitals in the United States provide abortion services, and the percentage continues to decline. Henshaw, Forrest 1978-79 at 14; Henshaw, Forrest, Sullivan & Tietze, *Abortion Services in the United States, 1979 and 1980*, 14 Fam. Plan. Persp. 5, 12 (1982) ("Henshaw, Forrest 1979-80"). *See also* Nathanson & Becker, *Obstetricians' Attitudes and Hospital Abortion Services*, 12 Fam. Plan. Persp. 26 (1980). Moreover, nearly two-thirds of those hospitals providing abortion services do not provide second trimester abortions. Henshaw, Forrest 1979-80 at 14.

[69] As the court of appeals found, the "unrebutted testimony" showed that "there were only two hospitals in Akron in which second trimester abortions were being performed." *Akron Center*, 651 F.2d at 1209. "During the year preceding trial, only nine such abortions were performed in these two hospitals" while "approximately 10% of the 6000 women who sought abortions at the Akron clinics during the same period were in their second trimester of pregnancy." *Id.*

[70] The ability of freestanding clinics to provide "safe abortions in a supportive setting" has been clearly established. Am. Pub. Health Ass'n, *APHA Recommended Program Guide for Abortion Services (Revised 1979)*, 70 Am. J. Pub. Health 652, 654 (1980). *See also* n. 64, *supra*. Moreover, such facilities have become the major abortion provider, performing nearly 80% of all abortions. Henshaw, Forrest 1979-80 at 5. While freestanding abortion facilities also perform 33% of second trimester abortions (Henshaw, Forrest 1978-79 at 7), a considerably higher percentage of such abortions could be performed safely in those facilities but for the existence of hospitalization requirements such as Section 1870.03. *See Planned Parenthood Ass'n of Kansas City v. Ashcroft*, 664 F.2d

B. Akron Has No Cognizable Interest in Requiring That All Second Trimester Abortions Be Performed in Hospitals.

Medical science has made many advances since the late 1960s and early 1970s, and it is no longer an "established medical fact" that mortality in abortion is less than mortality in normal childbirth only "until the end of the first trimester." *Roe v. Wade*, 410 U.S. at 163. Because it would be "equally dangerous" for a woman to forgo an abortion even well into the second trimester of her pregnancy, any interest the state might have in protecting the woman from an inherently dangerous procedure "has largely disappeared." *Id.* at 149. As the Court has made clear, up until that point, "the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician." *Id.* at 166.

In light of the safety of legal abortions, as demonstrated over the past decade, a state's interest in protecting maternal health is adequately served by physician licensing requirements such as are used by states to regulate other medical procedures far more complex and hazardous than abortion.[71] Regulations like Akron's hospitalization requirement that limit access to second trimester abortions, even though such abortions, if performed prior to the sixteenth gestational week, are safer than childbirth, pose a substantial risk of hampering

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at 689 (during the period in which Missouri's statutory hospitalization requirement was "removed" by district court order, nearly half of second trimester abortions in Missouri were performed in non-hospital facilities).

The high percentage of abortions performed in freestanding clinics is part of a larger, general trend in obstetrics and gynecology toward ambulatory health care and out-patient minor surgery. *See, e.g., ACOG Standards* at 51-53; Foster, *Ambulatory Gynecologic Surgery*, in Ambulatory Care in Obstetrics and Gynecology 399 (G. Ryan ed. 1980).

[71] *See* nn. 47-49, *supra*, & n. 77, *infra*.

patients' chances of obtaining abortions at precisely the point in their pregnancies at which it may be in their health interests to do so and deprive patients of the independent judgment of their physicians as to the best choice between equally safe facilities for the performance of abortions best suited to their individual needs.

C. Even If Akron Has a Cognizable Interest in Protecting Maternal Health Throughout the Second Trimester of Pregnancy, the Requirement That All Second Trimester Abortions Be Performed in Hospitals Is Not Reasonably Related to That Interest.

Even if the Court should conclude that, present medical knowledge notwithstanding, a state's interest in maternal health automatically becomes compelling at the beginning of the second trimester, Akron's hospitalization requirement is not reasonably related to that interest or sufficiently "narrowly drawn to express only the legitimate state interests at stake." [72] Instead, it is an overbroad restriction of a woman's right to decide, in consultation with her physician, whether to terminate her pregnancy.

In *Roe*, the Court suggested in dictum that a state may regulate the facilities in which second trimester abortions are performed.[73] In *Doe*, however, the Court made clear that, even with respect to hospitalization requirements, it is the state's burden to prove "that only the full resources of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy [its] health interests." [74] Indeed, the Court in *Doe* held that a statutory

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[72] *Roe v. Wade*, 410 U.S. at 155.

[73] *Id.* at 163.

[74] 410 U.S. at 195. In *Doe*, the Court struck down a hospital requirement that "fail[ed] to exclude the first trimester." *Id.* This determination stemmed not from any finding that second trimester hospitalization requirements were, as a matter of law, reasonably related to maternal health, but rather from the dearth of evidence concerning the relative safety of post-first trimester abortions that existed at that time.

The Court has found other second trimester regulations similarly not reasonably related to maternal health. In *Planned Parenthood*

requirement that all abortions be performed in JCAH-accredited hospitals was unconstitutional even as applied to post-first trimester abortions because it was not reasonably related to maternal health.[75]

Akron's blanket hospitalization requirement likewise must fall. The City has not demonstrated that "only the full resources of a licensed hospital" would satisfy its health interests. ACOG's 1974 recommendation that second trimester abortions be performed in hospitals—a standard on which the City relied at trial—has been revised to reflect the current view of the medical profession that many second trimester abortions can be performed as safely in appropriate nonhospital facilities as in hospitals.[76] The Akron ordinance is not reasonably related to maternal health because it lacks foundation in light of current medical practice and knowledge, because it locks physicians into outmoded standards of care, and because no evidence exists that it provides any incremental safety benefit beyond that already provided by state physician licensing requirements.[77]

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v. Danforth, 428 U.S. at 77-79, it held that a statute proscribing second trimester abortion by saline amniocentesis was unconstitutional because the state failed to show that other, safer second trimester abortion procedures were available.

[75] 410 U.S. at 193-94. On this basis alone, Akron's hospitalization requirement is constitutionally infirm since Section 1870.01(B) defines "hospital" to include only those hospitals accredited by JCAH or by the American Osteopathic Association. *Akron Center*, 479 F. Supp. at 1208.

[76] *See* pp. 23-24, *supra*. The revision was occasioned by "[n]ew information on the expanded role of ambulatory health care in obstetrics and gynecology, in addition to ongoing changes necessitated by numerous societal and scientific advances since publication of the last edition in 1974 . . . ." *ACOG Standards* at vii.

[77] It also should be noted that hospitalization requirements for abortion lack rationality when considered in light of the manner in which states and municipalities generally treat other medical procedures, including those of comparable risk and those of far greater risk than abortion. Akron, for instance, does not require by law that any other procedure—whether childbirth, setting a

The Akron ordinance interferes significantly with a woman's ability to exercise her constitutional right to decide whether or not to terminate her pregnancy. First, as the record in this case demonstrates, it has the practical effect of severely limiting a woman's ability to obtain a second trimester abortion in Akron. Since abortion at that point is as safe as or safer than childbirth, the ordinance thus forces a woman to choose between alternatives—either childbirth, an illegal abortion, or traveling to a place where a legal abortion may be obtained—that are in many cases "more dangerous to her health than the method outlawed." [78] And, second, it interferes with a woman's right to consult with her physician by denying the physician "the room he needs to make his best medical judgment," [79] including making the determination that a properly equipped nonhospital facility is preferable for a particular patient's overall health and wellbeing.[80]

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fractured limb, or delicate brain surgery—be performed in a hospital.

Whether hospitalization is required in any given case is a judgment that a physician "is called upon to make routinely whenever surgery is considered." *United States v. Vuitch*, 402 U.S. 62, 72 (1971). Any suggestion that physicians will exercise poor judgment in deciding when an abortion patient should be hospitalized is "degrading to the conscientious physician, particularly the obstetrician, whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients." *Doe v. Bolton*, 410 U.S. at 196-97. "He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so-called 'error,' and needs." *Id.* Absent evidence that physicians are peculiarly likely to exercise poor judgment in deciding whether to hospitalize abortion patients, there is no "constitutionally justifiable pertinence" in hospitalization requirements. *Id.* at 197.

[78] *Planned Parenthood v. Danforth*, 428 U.S. at 79.

[79] *Doe v. Bolton*, 410 U.S. at 192. *See also Colautti v. Franklin*, 439 U.S. at 397.

[80] It thereby places an "obstacle[] in the path of the doctor upon whom she [is] entitled to rely for advice in connection with her [abortion] decision." *Whalen v. Roe*, 429 U.S. at 605 n. 33.

Rather than serving as "a reasonable regulation for the protection of maternal health," [81] Akron's blanket hospitalization requirement is "an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority of abortions after the first 12 weeks." [82]

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals striking down the required informed consent recitation (Section 1870.06(B)) and the parental or judicial consent requirement (Section 1870.05(B)) should be affirmed and the judgment upholding the second trimester hospitalization requirement (Section 1870.03) should be reversed.

Respectfully submitted,

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[81] *Planned Parenthood v. Danforth*, 428 U.S. at 79.

[82] *Id.*