Nos. 81-185, 81-746 and 81-1172, 81-1255 and 81-1623

IN THE

Supreme Court of the United States

OCTOBER TERM, 1982

CHRIS SIMOPOULOS, M.D., FACOG,
Defendant-Appellant,

—v.—

COMMONWEALTH OF VIRGINIA,
State-Appellee.

CITY OF AKRON, et al.,
Defendants-Petitioners,

—v.—

AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Respondents.

(Caption continued on inside front cover)

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT AND THE UNITED STATES COURT OF APPEALS FOR THE EIGHTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE AND BRIEF AMICI CURIAE ON BEHALF OF NATIONAL ORGANIZATION FOR WOMEN; NATIONAL ABORTION RIGHTS ACTION LEAGUE; NORTHWEST WOMEN'S LAW CENTER; WOMEN AND HEALTH ROUNDTABLE AND WOMEN'S LAW PROJECT

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AKRON CENTER FOR REPRODUCTIVE HEALTH, INC., et al.,
Plaintiffs-Petitioners,

—v.—

CITY OF AKRON, et al.,
Defendants-Respondents.

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Petitioners,

—v.—

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Respondents.

JOHN L. ASHCROFT, ATTORNEY GENERAL OF THE STATE OF MISSOURI, et al.,
Defendants-Petitioners,

—v.—

PLANNED PARENTHOOD ASSOCIATION OF KANSAS CITY, MISSOURI, INC., et al.,
Plaintiffs-Respondents.

In the
SUPREME COURT OF THE UNITED STATES
October Term, 1982

No. 81-185

Chris Simopoulos, M.D., FACOG,
Appellant,
v.
Commonwealth of Virginia,
Appellee.

Nos. 81-746 and 81-1172
City of Akron, et al.,
Defendants-Petitioners,
v.
Akron Center for Reproductive
Health, Inc., et. al.,
Plaintiffs-Respondents.

Akron Center for Reproductive
Health, Inc., et al.,
Plaintiffs-Petitioners,
v.
City of Akron, et al.,
Defendants-Respondents.

Nos. 81-1225 and 81-1623

Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Petitioners,
v.
John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Respondents.

John L. Ashcroft, Attorney General
of the State of Missouri, et al.,
Defendants-Petitioners,
v.
Planned Parenthood Association of
Kansas City, Missouri, Inc., et al.,
Plaintiffs-Respondents.

ON APPEAL FROM THE SUPREME COURT OF VIRGINIA AND ON CERTIORARI TO THE UNITED STATES COURTS OF APPEALS FOR THE SIXTH AND EIGHTH CIRCUITS

MOTION FOR LEAVE TO FILE BRIEF AMICI CURIAE OF NATIONAL ORGANIZATION FOR WOMEN, NATIONAL ABORTION RIGHTS ACTION LEAGUE, NORTHWEST WOMEN'S LAW CENTER, WOMEN AND HEALTH ROUNDTABLE, AND WOMEN'S LAW PROJECT

The National Organization for Women, National Abortion Rights Action League, Northwest Women's Law Center, Women and Health Roundtable and Women's Law Project respectfully move, pursuant to Rule 36.3 of this Court's Rules, for leave to file the attached brief amici curiae. Counsel for Appellant Chris Simopoulos, Petitioner City of Akron, Respondent Akron Center for Reproductive Health, Petitioner Ashcroft and Respondent Planned Parenthood Association of Kansas City have consented to the filing of this brief and their letters of consent

have been filed with the Clerk. The Commonwealth of Virginia has refused consent.

The NATIONAL ORGANIZATION FOR WOMEN is a national membership organization of 170,000 women and men in over 750 chapters throughout the country. NOW has as one of its priorities, the preservation of the right to reproductive freedom, including abortion. NOW believes that every woman has a fundamental constitutional right to decide whether to terminate her pregnancy by abortion. NOW submits that the restrictions challenged herein impermissibly impinge upon this constitutionally protected right.

The NATIONAL ABORTION RIGHTS ACTION LEAGUE is dedicated to keeping abortion legal, safe and available. It has more than 150,000 national members plus af-

filiates with their own membership drawn from the pro-choice majority throughout the country.

The NORTHWEST WOMEN'S LAW CENTER is a non-profit public interest law organization dedicated to securing equal rights for women through law. Located in Seattle, the Law Center conducts community and continuing legal education programs throughout the Northwest on women's legal rights; offers information and referral, and advice and counseling services; and provides legal representation or assistance in selected cases that will impart the laws and legal rights of large numbers of women.

The WOMEN AND HEALTH ROUNDTABLE, a project of the Federation of Organizations for Professional Women, is an association of organizations and indi-

viduals concerned with women's health issues and policy. Through a series of publications and forums during its five year history, the Roundtable has monitored public health policy and analyzed its implications for women. The Roundtable is concerned that policies such as those before this Court, would infringe on a woman's constitutionally protected right to choose to terminate her pregnancy.

The WOMEN's LAW PROJECT is a non-profit public interest law firm working since 1973 to challenge sex discrimination in the law and in legal and social institutions.

Amici are womens' rights organizations whose constituencies and interests are seriously affected by the decisions in these cases. At issue is the consti-

tutionality of governmentally created obstacles to the exercise of a woman's constitutionally protected right to decide whether to terminate a pregnancy. Amici request leave to file this brief because of the extraordinary importance of these cases to the lives of women and children. Amici believe that their brief will elaborate for the Court the grave impact on individuals of the government restrictions challenged herein.

Respectfully submitted,

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INTEREST OF AMICI

The interest of amici appears in the foregoing motion.

INTRODUCTORY STATEMENT AND SUMMARY

These three cases involve attempts by state and local governments to restrict the opportunity of a woman to exercise her constitutionally protected decision to terminate her pregnancy. In Simopoulos v. Commonwealth of Virginia, No. 81-

185, the constitutionality of a Virginia statute that requires, inter alia, that all post-first trimester abortions be performed in hospitals is being challenged by a physician convicted of violating this law. He is appealing from the Virginia Supreme Court's affirmance of his conviction. 221 Va. 1059; 277 S.E.2d 194 (1981).[1] A Missouri statute similarly requiring that all abortions after the first trimester of a pregnancy be performed in hospitals is at issue in Ashcroft v. Planned Parenthood Association of Kansas City, Nos. 81-1225 and

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[1] Other issues raised by Dr. Simopoulos on appeal include whether the burden of proof imposed on him was improper and whether the prosecution failed to produce evidence necessary for conviction. These issues of due process and fairness in criminal proceedings, although important, are outside the specific interests of amici and are not addressed herein.

81-1623. The Eighth Circuit upheld the constitutionality of this provision, 655 F.2d 848 (8th Cir. 1981).[2]

City of Akron v. Akron Center for Reproductive Health, Nos. 81-746 and 81-1172, involves a challenge to the constitutionality of an Akron, Ohio ordinance that imposes an in-hospital requirement similar to those in the Virginia and Missouri laws. In addition, the Akron ordinance requires that a woman seeking an abortion be counseled by the attending physician; that she be

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[2] Also presented for review are requirements that: minors obtain judicial authorization or parental consent for an abortion; a pathology report be submitted for every abortion; two physicians be present at all second trimester abortions. All but the first of these provisions were struck down by the Eighth Circuit. Although amici believe that all three of these provisions are invalid, they will not address them further herein.

told specified information before she consents to an abortion; and that she wait 24 hours after she consents before obtaining an abortion. The Sixth Circuit upheld the in-hospital requirement, but declared the counseling, consent and waiting period provisions unconstitutional, 651 F.2d 1198 (6th Cir. 1981).[3]

These statutory schemes all have the effect of burdening the procreative decisions of women. Amici believe that individuals have the constitutionally protected right to make such decisions

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[3] Other provisions of the Akron ordinance presented for review in this Court are requirements that all minors seeking abortions notify at least one parent and, if the minor is under 15 years of age, obtain the consent of at least one parent; and that the fetus be disposed of in a "humane" manner. These provisions were struck down by the Sixth Circuit. Amici believe that the Sixth Circuit's decision should be affirmed, but will not address these issues further herein.

free from government interference. In this brief, amici demonstrate the serious restrictive impact of certain of the legislative enactments at issue in these cases. Although some of these provisions were upheld and some struck down by the lower courts, amici argue that none of these restrictions can survive the strict judicial scrutiny mandated by this Court's precedents, and all should be invalidated.

ARGUMENT

I.

THE CHALLENGED REGULATIONS SERIOUSLY RESTRICT — AND IN SOME INSTANCES EFFECTIVELY ELIMINATE — THE FUNDAMENTAL RIGHT OF A WOMAN TO DECIDE WHETHER OR NOT TO TERMINATE HER PREGNANCY

The right of every individual to be free from governmental interference in the exercise of personal procreative decisions has long been recognized as a fundamental liberty protected by the United States Constitution. See, e.g., Carey v. Population Services International, 431 U.S. 678 (1977); Eisenstadt v. Baird, 405 U.S. 438 (1972); Griswold v. Connecticut, 381 U.S. 479 (1965). This Court has made clear that the constitutional right to privacy is "broad

enough to encompass a woman's decision whether or not to terminate her pregnancy." Roe v. Wade, 410 U.S. 113, 153 (1973). This right to reproductive choice "protects the woman from unduly burdensome interference with her freedom to decide to terminate her pregnancy." Maher v. Roe, 432 U.S. 464, 473-74 (1977).

Consistent with these principles, the Court has invalidated government imposed restrictions that run afoul of this constitutional standard. In Doe v. Bolton, 410 U.S. 179 (1973), for example, a state law requiring that all abortions be approved in advance by a hospital abortion committee was held unconstitutional because the limitation

was "unduly restrictive of the patient's rights and needs." 410 U.S. at 198. In Planned Parenthood v. Danforth, 428 U.S. 52 (1976), spousal and parental consent requirements could not pass constitutional muster because the state did not have the 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." 428 U.S. at 74. See also Bellotti v. Baird, 443 U.S. 662 (1979).

The limitations on abortions imposed by the challenged restrictions in the trilogy of cases now before the Court similarly attempt to circumscribe a woman's behavior and significantly im-

pair the exercise of her fundamental right to decide whether to bear a child. These restrictions cannot be dismissed as "not burdensome or chilling." Planned Parenthood v. Danforth, 428 U.S. at 66, citing 392 F. Supp. at 1374. Nor can they be characterized as merely "state encouragement of . . . childbirth," Maher v. Roe, 432 U.S. at 475, or described as placing "no obstacles in the pregnant woman's path to an abortion." 432 U.S. at 474. See also Harris v. McRae, 448 U.S. 297 (1981). The statutory schemes enacted by Missouri, Virginia and Akron, Ohio forcefully inject government into a constitutionally protected decision-making process, riding roughshod over individuals' most

private decisions. They are aimed at coercing a woman not to terminate her pregnancy by placing obstacles directly in her path.

A. For Many Women, The Challenged Regulatory Schemes Effectively Eliminate The Right To Decide To Terminate A Pregnancy

Although benign sounding on its face, the requirement that a second trimester abortion be performed in a hospital effectively eliminates, for many women, the ability to exercise their fundamental right to reproductive choice. In Missouri, Virginia and Akron, Ohio, as in many areas of this country, there are few, if any, hospitals that perform second trimester abortions. Regulations requiring that all second trimester abortions be performed in hospitals

effectively eliminate the right to decide to terminate a pregnancy when there are no hospitals to provide such medical care.

For example, unrebutted testimony in the Akron case revealed that there were only two hospitals in Akron performing second trimester abortions, and during 1977, only nine second trimester abortions were performed in these two hospitals. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (6th Cir. 1981). Many Akron women seeking second trimester abortions were referred to clinics in Cleveland, Ohio and in the state of Michigan. 651 F.2d at 1209. In Planned Parenthood Association v. Ashcroft, No. 79-4142, slip op.

at 10 (W.D. Mo. Oct. 2, 1981), aff'd, 664 F.2d 687 (8th Cir. 1981), the district court concluded that the effect of Missouri's in-hospital requirement was to render unavailable a common method of second trimester abortions in the state.[4] Similarly, testimony in Simopoulos v. Commonwealth of Virginia, 221 Va. 1059, 277 S.E.2d 194 (Sup. Ct. 1981), demonstrated that only two hospitals in Northern Virginia performed second trimester abortions.

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[4] On remand from the Eighth Circuit Court of Appeals in Planned Parenthood Ass'n v. Ashcroft, 655 F.2d 848 (8th Cir. 1981), the district court found that the in-hospital requirement in Missouri did in fact result in the performance of fewer second trimester abortions. Planned Parenthood Ass'n v. Ashcroft, No. 79-4142, slip op. at 9. The district court there had the benefit of reviewing expert testimony comparing the incidence of abortions in Missouri in two recent consecutive years, one without and one with the in-hospital requirement. Id. at 9 n.14 & 15 and text.

Nor is this picture unique to Missouri, Virginia or Akron, Ohio. In Louisiana, for example, no hospitals perform abortions after the first trimester. Margaret S. v. Edwards, 488 F. Supp. 181, 192 (E.D. La. 1980). A recent national survey indicated that less than one-third of all hospitals in the United States perform abortions after the first trimester.[5] Henshaw, Forrest, Sullivan, Tietze, "Abortion Services in the United States, 1979 and 1980," 14 FAM. PLAN. PERSP. Jan.-Feb. 1982, at 5 (1982) [hereinafter cited as "Henshaw"].

Where hospitals are unavailable to perform a second trimester abortion, a

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[5] Even where hospital facilities are available, the increased financial cost may put the abortion beyond the reach of many women. See discussion infra.

government imposed hospitalization requirement essentially acts as a governmental veto of a woman's decision to seek an abortion.[6] It operates as the kind of unauthorized, arbitrary governmental usurpation of a woman's constitutionally guaranteed right to decide to

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[6] Despite this dramatic unavailability of hospital facilities, twenty-one states have acted to require hospitalization for second trimester abortions. Conn. Agencies Regs.§ 19-13-D54 (1973); Ga. Code Ann. § 26-1202(b) (1973); Hawaii Rev. Stat. § 453-16(a)(2) (1970); Idaho Code Ann. 18-608.2 (1973); Abortion Law of 1975, Sec. 18-24, Ill. Rev. Stat. ch. 111 1/2, § 84 and Rules 12.6 and 12.61 (1977); Ind. Code 35.1-58.5(b)(2) (1974); Ky. Rev. Stat. § 311.760(2) (1974); La. Rev. Stat. Ann. § 1299.35.3 (West 1981); Mass. Gen. Laws Ann. ch. 112, § 12N(2)(West 1974); Mich. Admin. Code R.325.3851 (1979); Mo. Ann. Stat. § 188.025 (Vernon 1978); Mont. Code Ann. § 94-5-618 (1974); Nev. Rev. Stat. 442.250.2 (1981); N.J. Admin. Code, tit. 13 § 13, § 35-7.2 (1978); N.Y. Pub. Health Law § 4164 (1974); N.D. Cent. Code ch. 14-02:1-04.2 (1981); Okla. Stat. tit. 63 § 1-731.B (1978); Tenn. Code Ann. § 39-301(e) (1981); Utah Code Ann. § 76-7-302(2) (1974); Va. Code § 18.2-73 (1975); Wis. Admin. Code, § Chap. Med. 11.05 (1978).

terminate her pregnancy, consistently condemned by this Court. Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Bellotti v. Baird, 443 U.S. 622 (1979).

B. Where The Challenged Restrictions Do Not Totally Eliminate The Right of a Woman To Decide To Terminate a Pregnancy, They Unduly Burden Her Exercise of This Constitutionally Protected Right

Those challenged provisions that do not operate to totally eliminate the ability of a woman to decide to terminate her pregnancy nonetheless erect significant obstacles to the exercise of her right by imposing a mandatory waiting period, requiring attending physician counseling and establishing controlled consent procedures. This is also the consequence of the hospitaliza-

tion requirement in those areas where hospital facilities exist but are totally inadequate. These restrictions cause unnecessary delays in the performance of abortions; jeopardize the health of women who decide to terminate a pregnancy; and subtantially increase the financial costs of abortion, thereby limiting the ability of many women to undergo a safe, legal abortion procedure. They represent deliberate governmental intrusion into the constitutionally protected realm of personal decision-making.

1. The mandatory waiting period and the hospitalization requirements operate to cause unnecessary and health endangering delays in the performance of abortions.

Although advanced as a benevolent "cooling off" period, the mandatory

waiting period required by the Akron ordinance injects the government directly into the personal decision-making process reserved to the woman and her physician. The decision to seek an abortion is made after extensive consultation and consideration. See Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. 542, 551 (D. Me. 1979). It is not made precipitously or irresponsibly as the language of the challenged legislation might have one think. Yet, once the decision has been reached, the mandatory waiting period temporarily forecloses the availability of an abortion. It is "direct state interference" with a woman's abortion decision. Maher v. Roe, 432 U.S. at 473-75, quoted in

Planned Parenthood League v. Bellotti, 641 F.2d 1006, 1014 (1st Cir. 1981).

Although the Akron restriction challenged herein explicitly imposes a 24-hour delay between the time a woman signs the consent form and undergoes the abortion, in reality the delay it causes will be far greater. The evidence in Akron showed that no city clinic performed abortions more than three times a week. Thus, a 24-hour waiting period may actually mean a minimum delay of two to four days. 651 F.2d at 1201. See also Planned Parenthood League v. Bellotti, 641 F.2d at 1014; Charles v. Carey, 627 F.2d 772, 785 (7th Cir. 1980). Especially for women who must travel to the abortion facility, this

extended delay can be a severe hardship. Such a scheme necessarily imposes

> burdens in terms of time, money, travel and work schedules; for many women, particularly the poor, the rural, and those with pressing obligations, these burdens will be substantial.

Planned Parenthood League v. Bellotti, 641 F.2d at 1015.

In addition, the second trimester hospitalization requirement, where not an insuperable barrier, similarly causes for many women a significant delay in obtaining medical care. As discussed at Point I, supra, hospital facilities are unavailable in many places, and where available, at best are inadequate. As a result, even where a facility can be found, travel time and the time it takes

to make appropriate arrangements (e.g., locating the hospital; scheduling hospital space availability; accommodating the woman's family and employment responsibilities) frequently result in delaying performance of the abortion. Donovan, "Analysis: Courts Rejecting 'Maternal Health' Rationale for Hospitalization for All Mid-Trimester Abortions," 9 FAM. PLAN./POPULATION REP. Dec. 1980, at 91 (1980) [hereinafter referred to as "Donovan"]. The adverse impact of travel necessitated by hospitalization requirements and the significant burden thereby imposed results in a significant relationship between a woman's distance from an abortion facility and the likelihood that she will obtain

an abortion. Margaret S. v. Edwards, 488 F. Supp. at 193-94 nn. 33 & 39.

As with any medical procedure, delay operates to increase the medical risk. The earlier in the pregnancy an abortion is performed, the lower the risk of complications or death. Courts have recognized that any risk to the woman presented by the abortion procedure increases the later the abortion is performed, affecting both her mental and physical health. See e.g., Planned Parenthood Association v. Ashcroft, 483 F. Supp. 679, 696 (W.D. Mo. 1980), aff'd in pertinent part, 655 F.2d at 866; Women's Community Health Center, Inc. v. Cohen, 477 F. Supp. at 551. Even a delay of two to seven days can pose a

major health risk to women undergoing abortions. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. I, 70, 82; III, 167-68).[7]

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[7] Expert testimony presented to the trial court in Akron indicated that generally, every week of delay beyond eight weeks' gestation increases the risk of morbidity by 20% and of mortality by 50%. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198 (Tr. IV, 156-57).

These serious consequences of delay must, however, be viewed in the context of the overall risks associated with pregnancy, childbirth, and abortion. All pregnancies pose health risks. These risks range from injury from falls occasioned by the unusual weight distribution of advancing pregnancy to death from hemorrhage, pulmonary embolism and toxemia, among other causes. McRae v. Califano, 491 F. Supp. 630, 668-71 (E.D.N.Y. 1980). The health problem is particularly acute for indigent pregnant teenagers, who suffer from higher maternal mortality rates and are more likely to suffer health complications from pregnancy. See McRae v. Califano, 491 F. Supp. at 680-81; Alan Guttmacher Institute, 11 Million Teenagers 23 (1976).

In fact, the risk of death from childbirth is significantly greater than the risk of death from abortion. The Court in Roe v. Wade, 410 U.S. 113 (1973), cited medical data as evidence that maternal mortality rates for early abortions "appear to

(Footnote continued)

Thus, by causing delays in the abortion procedure the challenged restrictions force women to jeopardize their health.

2. The controlled consent and attending physician counseling requirements interfere with medical judgments about a woman's care and have a direct, detrimental impact on a woman's health.

By intruding directly into the decision-making process at a critical time, the controlled consent and attending physician counseling requirements of the Akron ordinance are aimed at influ-

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be as low as or lower than the rates for normal childbirth" and concluded that in early abortion, "maternal mortality in abortion may be less than mortality in normal childbirth." Id. at 149, 163 (emphasis added). More recent statistics make clear that abortion is substantially safer than childbirth. McRae v. Califano, 491 F. Supp. at 65. Mortality in childbirth for white women in 1974 was 10 per 100,000 live births; mortality in abortion was 0.5. For "black and other" women, mortality in childbirth was 35.1 per 100,000 live births; in abortion, 2.4. Id.

encing the woman to continue her pregnancy. The government seeks to do this regardless of the woman's own decision-making choices, and heedless of the fact that the pregnancy may be life endangering or health-threatening.

The consent restriction challenged in Akron prescribes a script to be read, word-for-word, by the attending physician.[8] The provisions substitute the

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[8] In pertinent part, the ordinance requires the physician to tell a woman:

> (3) [t]hat the unborn child is a human life from the moment of conception and that there has been described 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, but not limited to, appearance, mobility, tactile sensitivity, including pain, perception or response, brain and heart function, the presence of internal organs and the presence of external
>
> (Footnote continued)

legislature's medical judgment for that of the attending physician. Not only does this straitjacket the physician's exercise of medical judgment, but its effect is to encumber the exercise of

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members;

(4) [t]hat her unborn child may be viable, and thus capable of surviving outside of her womb, if more than twenty-two (22) weeks have elapsed from the time of conception, and that her attending physician has a legal obligation to take all reasonable steps to preserve the life and health of her viable unborn child during the abortion;

(5) [t]hat abortion is a major surgical procedure, which can result in serious complications, including hemorrhage, perforated uterus, infection, menstrual disturbances, sterility and miscarriage and prematurity in subsequent pregnancies; and that abortion may leave essentially unaffected or may worsen any existing psychological problems she may have, and can result in severe emotional disturbances.

AKRON, CH., ORDINANCE No. 160 § 1870.06B(3),(4),(5) (1978).

the woman's constitutionally protected right "by placing obstacles in the path of the doctor upon whom she was entitled to rely for advice ...." Whalen v. Roe, 429 U.S. 589, 604 n.33 (1977), quoted in Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d 1198, 1207. See Planned Parenthood v. Danforth, 429 U.S. 52 (1976).

The challenged restriction requires the woman to be "informed" of "facts" that are incorrect,[9] prejudi-

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[9] See Planned Parenthood Ass'n v. Ashcroft, 655 F.2d at 868 (physicians' testimony that they do not believe there are long-term physical and psychological effects of abortion); Charles v. Carey, 627 F.2d at 784 (medical testimony characterizing possibility of "organic pain" to fetus as "medically meaningless, confusing, [and] medically unjustified"); Leigh v. Olson, 497 F. Supp. 1340, 1345 (D.N.D. 1980) (medical experts dispute validity of statement that abortion increases the risks of sterility, premature births, tubal pregnancies and still births in future pregnancies); Wynn v. Scott,

(Footnote continued)

cial[10] and irrelevant.[11] Rather than provide necessary information, the restrictions are calculated to inflict emotional distress, anxiety or physical

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449 F. Supp. 1302, 1317 (N.D. Ill. 1978) (studies have not supported statement that there is danger of subsequent sterility).

[10] See Planned Parenthood League v. Bellotti, 641 F.2d at 1021 (fetal descriptions and information on medical complications would cause many women emotional distress, anxiety, guilt or physical pain which might influence the decision, especially for those who were rape victims or who carried a potentially deformed fetus); Charles v. Carey, 627 F.2d at 784 (mandatory information was found to cause "cruel and harmful stress to . . . patients"). See also Planned Parenthood League v. Bellotti, 641 F.2d at 1022 (purpose of required information more moral than factual; "[t]he state may not add to its presentation of material facts such a moral overlay, an attempted imposition of ideas that is particularly objectionable in connection with the exercise of fundamental rights").

[11] See Planned Parenthood v. Danforth, 428 U.S. at 67 n.8 (consent requirement limited to "the giving of information . . . as to just what would be done and as to its consequences"); Planned Parenthood League v. Bellotti, 641 F.2d at 1021-23 (information must be material to medically relevant considerations).

trauma.[12] Planned Parenthood League v. Bellotti, 641 F.2d at 1021; Leigh v. Olson, 497 F. Supp. at 1345. Indeed, in addition to believing that some of the required information is detrimental to the best health interests of their patients, medical experts assert that the risks from abortion may be increased due to the woman's heightened tension and anxiety. Planned Parenthood Association v. Ashcroft, 655 F.2d at 868.

The Akron ordinance makes no exception, but inflicts the punitive "required reading" on all women, far surpassing any conceivable interest the

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[12] E.g., the majority of women would not want to hear fetal descriptions prior to an abortion and most doctors would not consider it good medical practice to provide them. Planned Parenthood League v. Bellotti, 641 F.2d at 1022.

state may have in assuring that the decision is knowingly made. See Charles v. Carey, 627 F.2d at 784.

Denominating the attending physician as the one who must provide the prescribed "information" similarly ignores the health needs of the woman. This requirement forces the physician to provide the information even though, in his or her professional judgment, a trained counselor would be much more effective in imparting certain information and obtaining consent. Women's Medical Center of Providence, Inc. v. Roberts, 530 F. Supp. 1136, 1147-48 (D.R.I. 1982); see Leigh v. Olson, 497 F. Supp. at 1346. It denies the physician this flexibility and may deprive

the woman of critically important support at an emotionally trying time.

3. The challenged restrictions increase the financial and emotional costs for the woman deciding to terminate her pregnancy.

The challenged restrictions further burden the exercise of the constitutional right to reproductive decision-making by unnecessarily increasing the financial costs of such medical care. The cost of having a second trimester abortion performed in a hospital on an inpatient basis is not insubstantial. It has been found to be at least twice the cost of the same procedure performed in an outpatient clinic. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parent-

hood Association v. Ashcroft, slip op. at 7 n.9,11 and text (W.D. Mo. Oct. 2, 1981); Donovan, 91.[13]

The travel frequently required to comply with hospitalization requirements and mandatory waiting periods imposes an additional significant economic burden on the abortion decision because of the expenses incurred for transportation, lodging and child care, as well as because of the loss of income due to the additional time required. These economic impediments to the decision to end a pregnancy by abortion are particularly critical in light of federal and state

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[13] On remand in Ashcroft, the district court found that the additional expense of having a second trimester abortion performed in a hospital as compared to a clinic, ranged from $150 to $1,650. Planned Parenthood Ass'n v. Ashcroft, slip op. at 7 n.9 and text (W.D. Mo. Oct. 2, 1981).

restrictions on the public funding of abortions.[14]

Although the Court has recognized that a woman's fundamental interest in personal privacy protects her choice of whether to continue or to terminate her pregnancy, Roe v. Wade, 410 U.S. 113 (1973), in reality, only those women able to pay the cost of their medical care can effectuate their constitutional choice between these two alternatives

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[14] Indeed the federal government has acted to deny funds for almost all abortions precisely because it wishes to subvert the reproductive choice of women seeking to terminate their pregnancies. For example, the chief sponsor of the funding restriction, Rep. Henry Hyde, declared his intention "to forbid the use of Federal funds to promote or encourage anyone to have an abortion," 122 CONG. R. H26784 (daily ed. August 10, 1976) (statement of Rep. Hyde). See also McRae v. Califano, 491 F. Supp. 630, 640-46 (E.D.N.Y. 1980).

free from state interference.[15] Where the physician cannot afford to work for no fee, and the woman cannot afford to pay, safe medical abortion is not a realistic alternative. See Singleton v. Wulff, 428 U.S. 106, 118-19 n.7 (1976). Governmental regulations designed to unnecessarily increase the cost of abortions, combined with virtual elimination of public funding, undoubtedly will have the intended effect upon many women: lacking feasible alternatives they will be forced to continue their unwanted pregnancies. And, for some, this will mean the unwilling continuation of a

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[15] As the Court recognized in Maher v. Roe, 432 U.S. 464, 474 (1977), by funding the childbirth alternative for the Medicaid-dependent woman and excluding the abortion alternative, the state deliberately influences the woman's reproductive choice. See Harris v. McRae, 448 U.S. 297 (1980).

life-endangering or health threatening pregnancy. The merger of increased regulation and decreased funding will have an additional, critical effect: emotionally distraught and unable to raise the money for a legal abortion, some women will turn in desperation to less costly and less safe illegal abortions.[16] The most recent statistics available show that in 1977, for the first time since 1972, reported deaths due to illegal abortions increased.[17]

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[16] U.S. Dep't of Health, Education and Welfare, Center for Disease Control, Abortion Surveillance Annual Summary 1977 12-14 (1979).

[17] Id. at 1. See Petitti and Cates, "Restricting Medicaid Funds for Abortions: Projections of Excess Mortality for Women of Childbearing Age," 67 Am. J. Pub. Health 860, 861 (1977).

Still other women will risk their lives by attempting one of the numerous dangerous methods of self-abortion.[18]

Thus, the increased emotional, health and financial costs resulting from the challenged restrictions impermissibly jeopardize and burden the health and well-being of women.

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[18] "Among the non-medical procedures used for inducing abortion," according to the National Academy of Sciences Institute of Medicine, "are eating or drinking quinine or other drugs, introduction of chemicals into the vagina, and mechanical methods such as inserting blunt or sharp instruments into the uterus through the vagina. The drugs quite often lead to poisoning or vomiting so intense that it results in dehydration and eventual death unless fluid replacement compensates the loss. Inserting chemicals or instruments in the vagina or uterus can lead to: (1) infection; (2) injury to the membranes of the vagina; (3) perforation of the uterus with the possibility of injury to other organs in the abdominal area; (4) bleeding due to retained fetal or placental tissue; and (5) air embolism." National Academy of Sciences Institute of Medicine, Legalized Abortion and Public Health 64 (1975).

II

THE CHALLENGED RESTRICTIONS DO NOT WITHSTAND CONSTITUTIONAL SCRUTINY

A. Strict Scrutiny Is Required Where, As Here, The Challenged Restrictions Burden A Woman's Exercise Of Her Fundamental Right To Terminate Her Pregnancy

This Court has repeatedly held that a statutory scheme which infringes upon a woman's fundamental right to decide to terminate her pregnancy by abortion can survive constitutional scrutiny only if justified by a compelling state interest that is narrowly drawn to express the legitimate state interests at stake.[19]

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[19] The strict scrutiny standard is called into play if two conditions exist. First, the obstacle to the exercise of the fundamental right must have been created by the government. Maher v. Roe, 432 U.S. 464 (1977). Second, the restriction must impinge upon the exercise of the fundamental right. Planned Parenthood v. Dan-

(Footnote continued)

Roe v. Wade, 410 U.S. at 155. The Court in Roe accepted the assertion by the State of Texas that there are legitimate state interests during the pregnancy in the health of the woman and in protection of potential fetal life.[20] Finding these interests to be separate and distinct, and conflicting with the woman's right to decide to terminate a pregnan-

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forth, 428 U.S. 52 (1976). Since both conditions are present, the obstacle created by the Missouri, Virginia and Akron, Ohio legislation can stand only if justified by a compelling state interest narrowly drawn. Roe v. Wade, 410 U.S. 113 (1973).

[20] This Court declined to define the point at which life begins. "When those trained in the respective disciplines of medicine, philosophy, and theology are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." Roe v. Wade, 410 U.S. at 159. The Court rejected the attempt of Texas to define "life" as beginning at conception and thus to justify state interference throughout the pregnancy.

cy, the Court divided pregnancy into trimesters, defining the legitimate state interest, and therefore the parameters of state interference, at each juncture.

During the first trimester of pregnancy, neither the state's interest in the woman's health nor in potential fetal life can justify any state interference with the woman's right to decide. In the second trimester, state intrusion is permissible only if it promotes the state's legitimate interest in ensuring the woman's health. And in the third trimester, the state's interest in the potential life of the fetus is sufficient to justify significant intrusion, even a total proscription of

abortion, unless an abortion is necessary to preserve the life or health of the woman. See Roe v. Wade, 410 U.S. at 163-64; Harris v. McRae, 448 U.S. at 313. Thus, protecting the woman's health is the paramount state interest in the second and third trimesters of pregnancy. When measured against this interest, the challenged restrictions must fail, for they are nothing more than a thinly veiled attempt to limit the availability of abortions, in essence to accomplish through the back door what the Court forbade in Roe.

B. The Challenged Restrictions Cannot Withstand Strict Scrutiny And Are Invalid

1. The second trimester hospitalization requirement is not reasonably related to the state's legitimate interest in protecting the woman's health.

As discussed fully at Point I, supra, the requirement that all second trimester abortion procedures be performed in licensed hospital facilities has the effect of totally eliminating or significantly decreasing the availability of second trimester abortions. There can be no greater example of direct state interference infringing on the exercise of a fundamental right than denial of access to the means necessary to effectuate that right. Further, since these requirements drastically limit the availability of the two safest and most common methods of second trimester abortions,[21] the state's asserted interest

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[21] The techniques specifically addressed in these cases are the dilatation and evacuation and saline installation procedures. Recent medical studies demonstrate and courts have
(Footnote continued)

in protecting the woman's health is revealed to be not a justification, but a transparent excuse.

In view of the demonstrable burden placed on the abortion decision by requiring all second trimester abortions to be performed in hospitals, the state must show that such restriction promotes

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found, that D & E is now the most used and safest procedure for early second trimester abortions, Margaret S. v. Edwards, 488 F. Supp. at 195; Planned Parenthood Ass'n v. Ashcroft, 655 F.2d at 856; Wolfe v. Stumbo, 519 F. Supp. 22, 25 (W.D. Ky. 1980); see Poe v. Dep't of Public Health, No. 78 C 4126 slip. op. (N.D. Ill., May 11, 1981).

Use of the saline method was upheld by this Court in Planned Parenthood v. Danforth, 428 U.S. 52 (1976). In support of its holding, the Court found that saline is "an accepted medical procedure"; if utilized in a "substantial majority . . . of all post-first trimester abortions" it is "safer, with respect to maternal mortality, than even the continuation of the pregnancy until normal childbirth." 428 U.S. at 77, 78. See Colautti v. Franklin, 434 U.S. 379, 398-99 (1979).

its interest in the woman's health. To satisfy this constitutional burden, "the State must show . . . that only the full resources of a licensed hospital, rather than those of some other appropriately licensed institution, satisfy [its] health interests." Doe v. Bolton, 410 U.S. at 195.

The evidence submitted in each case before the Court does not support a conclusion that second trimester hospital abortions are significantly less dangerous to a woman's health than comparable procedures performed in non-hospital clinics. To the contrary, the records below amply demonstrate that the second trimester abortion methods used in these cases -- dilatation and evacua-

tion and saline instillation -- can safely be performed outside a hospital. Akron Center for Reproductive Health, Inc. v. City of Akron, 651 F.2d at 1209; Planned Parenthood Association v. Ashcroft, 664 F.2d at 690 (8th Cir. 1981); Simopoulos v. Commonwealth of Virginia, 221 Va. at 1075-76, 277 S.E.2d at 202-03.

It is particularly significant that the American College of Obstetricians and Gynecologists, reversing an earlier position, has concluded that second trimester abortions may be safely performed in non-hospital facilities. See American College of Obstetricians and Gynecologists, Manual of Standards for Obstetrician Gynecological Services at

16 (1982). ACOG has made clear its approval of the performance of abortions on an outpatient basis through the 18th week from the last menstrual period. The American Public Health Association advises that "[r]equirements that all abortions after [the first trimester] be performed in hospitals increase the expense and inconvenience to the woman without contributing to the safety of the procedure." Donovan at 91-92. Similarly, other medical experts have concluded that both procedures can be safely performed in non-hospital facilities. See Cates, Grimes, "Deaths from Second Trimester Abortion by Dilatation and Evacuation: Causes, Prevention, Facilities," 58 Obstetrics and Gynecology 401

(1981)[22]; Schulman, Kaiser, Randolph, "Outpatient Saline Abortion," 37 Obstetrics and Gynecology 521 (1971).

In view of the medical evidence demonstrating the safety of outpatient second trimester abortions, it is obvious that restrictions which require all second trimester abortions to be performed in hospitals are not reasonably related to the preservation of the woman's health, nor are they narrowly drawn to avoid overbroad interference with a woman's decision whether to bear a child. Planned Parenthood Association v. Ashcroft, 655 F.2d at 853-57; Wolfe v. Stumbo, 519 F. Supp. at 24-25; Marga-

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[22] These authors also suggest that policymakers reconsider laws requiring all second trimester abortions to be performed in hospitals.

ret S. v. Edwards, 488 F. Supp. at 194-96. Thus, there is no medical justification for the restriction.

Moreover, by imposing a hospitalization requirement, the state is deliberately endangering a woman's health. The hospitalization requirement operates to make second trimester abortions unavailable for many women, as discussed at Point I, supra, and adds the burden of time delays for many more. As discussed at Point I, supra, each day of delay increases the woman's health risk. This puts the state's restrictive action in a head-on collision with its acknowledged interest in protecting the woman's health. Far from serving the woman's health interest, the hospitalization

restriction actually endangers the woman's health by effectively "proscrib[ing] the safest alternative presently available for post-first trimester abortions." Margaret S. v. Edwards, 488 F. Supp. at 193. This result may, "as a practical matter . . . forc[e] a woman and her physician [to continue her pregnancy or] to terminate her pregnancy by methods more dangerous. . . ." Planned Parenthood v. Danforth, 428 U.S. at 79.

Therefore, this restriction is an "unreasonable [or] arbitrary regulation designed to inhibit and having the effect of inhibiting" the vast majority of abortions after the first trimester. Planned Parenthood v. Danforth, 428 U.S. at 79. Accordingly, it is a restriction

that plainly contravenes the constitutionally protected right of women seeking second trimester abortions, and this Court's holdings in Roe v. Wade, Doe v. Bolton and Planned Parenthood v. Danforth.

2. The mandatory consent, attending physician counseling and waiting period restrictions constitute unjustified state interference in the exercise of a fundamental right and are unconstitutional.

a. The challenged restrictions are wholly impermissible when applied in the first trimester of pregnancy.

Roe v. Wade makes clear that there can be no interference with the woman's decision-making process during the first trimester of a pregnancy. 410 U.S. at

163. The challenged consent, attending physician counseling and waiting period restrictions directly interfere with -- indeed disrupt -- the exercise of the constitutionally protected right to abortion. As fully discussed at Point I, supra, these limitations impose substantial burdens on the decision to terminate a pregnancy by abortion. The restrictions add the state as a third party in the decision-making process -- invisible but present, both through words which must be spoken by a state-designated individual and through a forced "cooling off" period. These direct intrusions into the decision to undergo a first trimester abortion are

flatly contrary to the clear mandate of Roe v. Wade, and cannot stand.[23]

b. The challenged restrictions do not advance a compelling state interest when applied after the first trimester of pregnancy.

(1) The consent requirement.

Rather than furthering communication between the physician and patient to enhance understanding of the medical procedure, the mandated consent requirement in the Akron ordinance is a transparent attempt to control the woman's decision whether or not to terminate her pregnancy. It is a far cry from the

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[23] Many lower courts have invalidated similar provisions. See, e.g., Charles v. Carey, 627 F.2d at 784-86; Women's Medical Center of Providence v. Roberts, 530 F. Supp. at 1144; Margaret S. v. Edwards, 488 F. Supp. at 212; Women's Community Health Center v. Cohen, 477 F. Supp. 542, 551-52.

consent requirement upheld by this Court in Planned Parenthood v. Danforth, 428 U.S. 52 (1976). There, the Court scrutinized and upheld a statutory restriction that required a woman, prior to obtaining a first trimester abortion, to certify in writing that her "consent is informed and freely given and is not the result of coercion." Id. at 65. "Informed consent" was construed in Danforth as:

> [T]he giving of information to the patient as to just what would be done and as to its consequences. To ascribe more meaning than this might well confine an attending physician in an undeserved and uncomfortable straitjacket in the practice of his profession.

428 U.S. at 67 n.8; see Freiman v. Ashcroft, 584 F.2d 247 (8th Cir. 1978),

aff'd, 440 U.S. 941 (1979). The City of Akron has attempted to expand beyond recognition the exception carved out in Danforth -- building from this exception a scheme which would swallow the rule in Roe v. Wade.

The Akron restriction, unlike the provision in Danforth, dictates to the physician precisely what must be said. Apparently, in the City of Akron, being "informed" means a woman is to be told what the government decides she should be told, rather than what her physician believes is necessary to the making of a truly informed decision. Similar restrictive consent directions have been rejected by the courts, finding the language to be an intrusion into the

physician-patient relationship that is not justified by the state's interest in preserving the woman's health.

The importance of a sensitive and individualized approach to the obtaining of consent was aptly described by the U.S. Court of Appeals in Planned Parenthood League v. Belotti:

> [T]he uncontradicted expert testimony . . . indicated that requiring women seeking abortions to read this information ["description of the stage of development of the unborn child"] would cause many of them emotional distress, anxiety, guilt, and in some cases increased physical pain -- and it is of course by its impact on women in that stressful situation, rather than on judges or other detached readers, that the information must be measured.

641 F.2d at 1021.

The likelihood of negative effects on the woman's health from such consent requirements was recognized by both of the lower courts in the Planned Parenthood Association v. Ashcroft litigation. 655 F.2d at 868. As discussed fully at Point I, supra, numerous other courts have examined statutes prescribing the content of the information to be given to a woman seeking an abortion. In none of those cases did the court find a positive relationship between the required information and the woman's health; indeed, courts have tended to find that such information can be damaging to health interests. See, e.g., Leigh v. Olson, 497 F. Supp. at 1345.

These elaborate prescriptions for controlled consent inject the state into the decision-making process by placing the doctor in the "undesired and uncomfortable straitjacket" warned against in Danforth, and are unconstitutional. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. at 1203, aff'd in pertinent part, 651 F.2d at 1207.

(2) The attending physician counseling requirement.

The attending physician counseling restriction prescribes a course of conduct without regard for the physician's professional judgment or the woman's medical needs. It applies to every woman who seeks an abortion, whether or not she has been counseled by her pri-

vate physician prior to referral to a clinic for the specialized services it provides. This state-imposed obligation creates the kind of "straitjacket" found objectionable by this Court in Danforth, and is impermissble under Roe. Akron Center for Reproductive Health, Inc. v. City of Akron, 479 F. Supp. at 1203, aff'd in pertinent part, 651 F.2d at 1207.

The attending physician requirement is not only burdensome, but inimical even to meet the asserted need: protection of the woman's health. Charles v. Carey, 627 F.2d at 784. Thus, strict scrutiny reveals no compelling state interest to justify this restriction.

(3) The mandatory waiting period requirement.

Similarly, statutes which fix inflexible requirements that abortions be postponed do not advance the state's interest in preserving the woman's health, and are thus unconstitutional. As discussed at Point I, supra, a state-mandated delay in the performance of an abortion deprives a woman of the right to end her pregnancy after she has voluntarily and knowingly decided to do so. This delay often, as noted at Point I, supra, results in postponing the abortion for a substantially longer period of time, since many facilities provide abortion services only once or twice a week. Such a delay can increase the risk to the woman's health. The fact

that imposition of a waiting period exacerbates, rather than ameliorates, the potential health risks has led the lower courts to invalidate such requirements. See, e.g., Planned Parenthood Association v. Ashcroft, 655 F.2d at 866 (48-hour waiting period),[24] Planned Parenthood League v. Bellotti, 641 F.2d at 1014 (24-hour waiting period); Charles v. Carey, 627 F.2d at 785 (24-hour waiting period); Margaret S. v. Edwards, 488 F.Supp. at 212 (24-hour waiting period); Women's Services, P.C. v. Thone, 483 F.Supp. 1022, 1050 (D. Neb. 1979), aff'd, 636 F.2d 206 (8th Cir. 1980), vacated and remanded on other grounds, 452 U.S. 911 (1981) (48-

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[24] The state has not sought review of this holding.

hour waiting period). This requirement reflects government attempts to coerce a woman to carry her pregnancy to term, irrespective of her physical and psychological condition; it fails to meet the strict scrutiny test.

CONCLUSION

For the foregoing reasons, the legislative provisions requiring that post-first trimester abortions be performed in hospitals, that physicians be required to convey specified information prior to obtaining a patient's consent for an abortion, that only the attending physician may counsel a patient at the stage of obtaining her consent, and that a woman must endure a mandatory waiting period after she has given her consent,

should be declared unconstitutional.

Respectfully submitted,

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