No. 88-605

In the

Supreme Court of the United States

OCTOBER TERM, 1988

WILLIAM L. WEBSTER, et al.,
Appellants,

v.

REPRODUCTIVE HEALTH SERVICES, et al.,
Appellees.

On Appeal from the United States Court of Appeals for the Eighth Circuit

BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF CHILD AND ADOLESCENT PSYCHIATRY, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN FERTILITY SOCIETY, AMERICAN MEDICAL WOMEN'S ASSOCIATION, AMERICAN PSYCHIATRIC ASSOCIATION AND AMERICAN SOCIETY OF HUMAN GENETICS AS *AMICI CURIAE* IN SUPPORT OF APPELLEES

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QUESTIONS PRESENTED

Amici curiae will address the following questions:

1. Whether the Court should reaffirm that the "liberty" and privacy rights embodied in the Due Process Clauses of the Constitution fundamentally protect, *inter alia*, individual medical treatment decisions.

2. Whether Sections 188.029 and 188.205 of the Missouri statute unconstitutionally infringe the fundamental right of patients to make medical treatment decisions in consultation with their physicians.

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INTEREST OF *AMICI CURIAE*

Amici curiae are eight major organizations of health care professionals. *Amici* share an abiding dedication to promoting the public welfare through the maintenance of the highest professional standards and the provision of quality health care. *Amici*'s interest is not in debating the philosophical, ethical, moral or religious issues surrounding abortion. Indeed, their members hold widely divergent views on the various issues raised in *Roe* v. *Wade*, 410 U.S. 113 (1973). *Amici* recognize that reasonable people differ about how to balance the woman's privacy right against the state's interest in maternal and fetal health, and in particular about whether the state has a compelling interest in fetal health before viability. Given the diversity of views of *amici*'s members, this brief neither endorses nor opposes the Court's holding in *Roe* that the state's compelling interest begins at viability. However, our members all agree that every individual has a fundamental right to make an individual medical treatment decision free of state interference unless the state has a compelling justification for the restrictions it imposes.

Amicus American Medical Association ("AMA") is a private, voluntary, nonprofit organization of physicians. The AMA was founded in 1846 to promote the science and art of medicine and the improvement of public health. Today, its membership exceeds 280,000 physicians and medical students.

Amicus American Academy of Child and Adolescent Psychiatry ("AACAP") is a national professional organization of over 4,200 child and adolescent psychiatrists, who engage in research, prevention, diagnosis and treatment of developmental and psychiatric disorders in children, adolescents and families.

Amicus American Academy of Pediatrics ("AAP") is a nonprofit association of approximately 30,000 physicians certified in the specialized care of infants, children and adolescents. The AAP's principal purpose is

to ensure the attainment by all children of their full potential for physical, emotion and social health.

Amicus American College of Obstetricians and Gynecologists ("ACOG") is a private, voluntary, nonprofit organization of physicians who specialize in obstetric and gynecologic care. ACOG is the leading group of professionals providing health care to women; its 28,000 members represent approximately ninety percent of all obstetricians and gynecologists practicing in the United States.

Amicus American Fertility Society ("AFS") is a voluntary, nonprofit organization of 11,000 physicians and scientists—the vast majority of whom are obstetrician-gynecologists—dedicated to advancing knowledge about and treating the disorders of the reproductive system.

Amicus American Medical Women's Association, Inc. ("AMWA") is a nonprofit organization of 12,000 women physicians and medical students, one of whose primary missions is to promote quality health care for women. AMWA strongly opposes laws which adversely affect the health of women, or impose constraints on the right of the pregnant patient, in consultation with her physician, to make a personal and medically informed decision whether or not to continue a pregnancy.

Amicus American Psychiatric Association ("APA") is the nation's largest professional association specializing in psychiatry, with a membership exceeding 30,000 physicians. APA's purposes include promoting the welfare of patients who require psychiatric services.

Amicus American Society of Human Genetics ("ASHG") is a scientific association whose members include more than 3,800 physicians, scientists, genetic counselors and allied health specialists who are involved in research and the delivery of genetic services to families with, or at risk for, a broad array of genetic disorders.

The provisions in the Missouri statute, which require physicians to undertake specific medical examinations and tests concerning the development of the fetus and which

prohibit a physician from counseling a woman concerning abortion as a treatment option, interfere with the woman's right to seek and obtain medical care and prevent her physician and other health care providers from exercising their best medical judgment in providing quality medical care. The outcome of this case will directly affect the professional services *amici*'s members provide and the health of the patients whom they serve. Accordingly, *amici* wish to present their views concerning the important issues raised in this appeal.[1]

MEDICAL BACKGROUND

Amici firmly believe that any attempt by the Court to evaluate the individual's legal rights in the abortion context should be undertaken only after the Court has a relatively full appreciation of the medical facts surrounding pregnancy and the abortion procedure. Accordingly, *amici*, who have unique expertise in this area, offer in this section of the brief an extended discussion of the medical background of pregnancy and abortion to provide a context within which to present our analysis of the fundamental legal issues presented in this case.

This discussion of the medical background, which includes the relative health effects of abortion and childbirth, is not provided to suggest that this Court's ultimate constitutional analysis can or should turn solely on the relative health risks, but instead to demonstrate clearly that both abortion and childbirth are significant medical procedures which carry what are sometimes significant health risks.

I. General Background on Abortion

Although commonly understood to encompass all terminations of pregnancy, abortion is technically defined as the termination of a pregnancy in any way before the fetus has reached the stage of viability. *Williams Ob-*

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[1] Pursuant to Rule 36 of the Rules of this Court, the parties have consented to the filing of this brief. The parties' letters of consent have been filed with the Clerk of the Court.

stetrics 467 (J. Pritchard, P. MacDonald & N. Gant 17th ed. 1985); D. Danforth & J. Scott, *Obstetrics & Gynecology* 231 (5th ed. 1986). Viability refers to the point at which the fetus would have a reasonable potential for survival if it were removed from the pregnant woman's uterus. *Williams Obstetrics* at 467. See *infra* at 5-8.[2]

An abortion may be spontaneous (unintentional) or induced (intentional). Since this Court's decision in *Roe* v. *Wade*, the number of lawful, induced abortions has doubled from roughly 750,000 to nearly 1.6 million a year. Henshaw, Forrest & Van Vort, *Abortion Services in the United States 1984 and 1985*, 19 Fam. Plann. Persp. 63, 64 (1987). Almost all of the increase occurred by 1980. *Id.; Obstetrics & Gynecology* at 256. By way of comparison, the annual number of live births has increased from about 3.1 million to 3.8 million since 1973. National Center for Health Statistics, 37 *Monthly Vital Health Statistics Report* 15 (Supp. No. 3, July 12, 1988). Abortion services are concentrated in metropolitan areas; 79% of women in rural America live in counties which have no abortion services, and, in 1985, only two percent of abortions were performed in rural communities. *Henshaw, Forrest & Van Vort* at 64-65.

Induced abortions are primarily performed on young women, unmarried women, white women, and women who

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[2] If the termination of a pregnancy occurs after the fetus has become viable but before the 38th week of gestation, then the termination is referred to as the preterm delivery of a premature infant. *Williams Obstetrics* at 467. (Gestational age is measured from the first day of a pregnant woman's last menstrual period, rather than from the more uncertain date of fertilization, which is approximately two weeks later, or of implantation of the fertilized egg in the woman's uterus, which is nearly three weeks later. *Id.* at 139.) If the premature infant of a preterm delivery shows no signs of life at birth, it is classified as stillbirth. *Obstetrics & Gynecology* at 289. Thus, while third-trimester terminations of a pregnancy are commonly characterized as abortions, they technically are not. Nevertheless, for convenience, we will characterize all terminations of pregnancy as abortions.

are having their first abortion. Henshaw & Silverman, *The Characteristics and Prior Contraceptive Use of U.S. Abortion Patients*, 20 Fam. Plann. Persp. 158, 159 (1988). Among women age 15-44, more than 21% have had an abortion; if current abortion rates continue, 46% of all American women will have had an abortion by the time they are 45. Forrest, *Unintended Pregnancy Among American Women*, 19 Fam. Plann. Persp. 76, 76-77 (1987).

Ninety percent of abortions are performed during the first trimester of pregnancy. Henshaw, *Characteristics of U.S. Women Having Abortions, 1982-1983*, 19 Fam. Plann. Persp. 5, 6 (1987). Only 1% of abortions are performed after 20 weeks of gestation, and approximately 100 abortions a year, or 0.01% of all abortions, occur during the third trimester of pregnancy. *Id.* at 6.

II. Fetal Viability

This Court has observed that "[v]iability is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks." *Roe*, 410 U.S. at 160. Since then, improvements in health care have resulted in greater survival of infants born at a gestational age of 24-28 weeks, which corresponds to a birthweight of approximately 500-1,000 grams, although survival is not common with birthweights between 500 and 600 grams. The earliest point at which a fetus can survive is 23-24 weeks.

The improvements in prognosis for infants weighing between 500 and 1,000 grams have been striking. (These infants are commonly characterized as extremely low birthweight infants or ELBW infants. Yu, *The Extremely Low Birthweight Infant: Ethical Issues in Treatment*, 23 Aust. Paediat. J. 97, 97 (1987).) In the 1950's approximately 2% of ELBW infants survived delivery, and almost all were seriously handicapped. Poland & Russell, *The Limits of Viability: Ethical Considerations*, 11 Sem. Perinat. 257, 257 (1987). By 1960, ELBW infant survival had increased to about 10% and, by 1970, to

about 20%. *Poland* at 257. Recent studies on the ELBW infant indicate that as many as 40-50% will survive. *Yu* at 98; Amon, Sibai, Anderson & Mabie, *Obstetric Variables Predicting Survival of the Immature Newborn (≤1,000 gm): A Five-Year Experience at a Single Perinatal Center*, 156 Am. J. Obstet. Gynec. 1380, 1382 (1987).[3]

As fetal weight rises from 500 to 1,000 grams (or gestational age increases from 24 to 28 weeks), survival gradually improves from about 10% to as much as 80%. At 26 weeks, or 750 grams, approximately half the infants survive. The New York State Task Force on Life and the Law, *Fetal Extrauterine Survivability* 9-10 (1988); Nwaesei, Young, Byrne, *et al.*, *Preterm Birth at 23 to 26 Weeks Gestation: Is Active Obstetric Management Justified?*, 157 Am. J. Obstet. Gynec. 890, 893 (1987); *Yu* at 98. In short, if viability is defined as the point at which 50% of fetuses will survive, then it has moved from 28 weeks to 26 weeks since 1973. If viability is defined as the point at which a fetus has any prospect of extrauterine survival, then it has moved from 24 weeks to 23-24 weeks.

The ELBW infants who survive today are also suffering fewer handicaps than those born 15 years ago. While a majority of these infants were seriously handicapped at one time, *Poland* at 257, approximately 70% of surviving ELBW infants now go on to be free from major handicaps like blindness, deafness, cerebral palsy and mental retardation. *Id.* Approximately two-thirds of the survivors have significant educational problems. Sell, *Outcome of Very Very Low Birth Weight Infants*, 13 Clin. Perinat. 451, 457-58 (1986).

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[3] *See also* Johnson, Cox & McKim, *Outcome of Infants of Very Low Birth Weight: A Geographically Based Study*, 136 Can. Med. Ass'n J. 1157, 1159 (1987); Gerdes, Abbasi, Bhutani & Bowen, *Improved Survival and Short-Term Outcome of Inborn "Micropremies,"* 25 Clin. Pediat. 391, 392 (1986); Hack & Fanaroff, *Changes in the Delivery Room Care of the Extremely Small Infant (<750g)*, 314 New Eng. J. Med. 660, 663 (1986).

While even more of the 500-1,000 gram (24-28 week) infants are expected to survive in the near future, there is an "anatomic threshold" for fetal survival of about 23-24 weeks of gestation (500 grams). This is because the fetal lung does not mature sufficiently to permit normal or even mechanically-assisted respiration (*i.e.*, breathing assisted by a ventilator) before week 23-24 of gestation. *New York State Task Force*, at 7.

In order for enough oxygen to be able to enter the bloodstream, there must be an extensive network of interfaces between the air spaces in the lung and the blood vessels of the lung. Effective oxygenation also requires that there be a very thin barrier of tissue separating the red blood cells from the air spaces. J. West, *Respiratory Physiology—the Essentials* 1-2, 21-22 (3d ed. 1985).

Until weeks 23-24 of gestation, however, the network of air spaces and blood vessels is not extensive enough nor is the tissue barrier thin enough for effective oxygenation of the blood. *New York State Task Force* at 6-7; T. Sadler, *Langman's Medical Embryology* 218-29 (5th ed. 1985); Whittle, *Lung Maturation*, 11 Clin. Obstet. Gynec. 353, 354 (1984).[4] Thus, while substantial strides have occurred in saving infants born between 24 and 28 weeks, the earliest point at which an infant can survive has changed little. Compare *Williams Obstetrics*, at 748-49, with *Williams Obstetrics* 493 (L. Hellman & J. Pritchard 14th ed. 1971).[5]

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[4] The anatomic threshold for development of the network of interfacing blood vessels and air spaces explains why ventilators or injection of pulmonary surfactant have not lowered the threshold of viability below 23-24 weeks. These measures can only help a sufficiently developed lung work to its full potential.

[5] There is an analogous biologic limit at the end of life. While the maximum lifespan has not changed during the course of recorded history and remains at about 100 years, an increasingly higher percentage of people survive to the maximum lifespan. J. Brocklehurst, *Textbook of Geriatric Medicine and Gerontology* 4 (3d ed. 1985).

The anatomic threshold in lung development could be overcome in theory by "extracorporeal membrane oxygenation" (ECMO), which involves diversion of the bloodstream into a machine that takes the place of the lung. The machine removes the blood, oxygeneates it and then returns it to the body for circulation. ECMO is commonly used in heart surgery to bypass the heart and lung while the surgeons are operating on the heart. S. Schwartz, G. Shires, F. Spencer & E. Storer, *Principles of Surgery* 811-14 (4th ed. 1984).

There are significant limits, however, to the use of ECMO. Its use results in bleeding tendencies, damage to the blood cells and deterioration of lung and kidney function. *Id.* at 813-14. Because of the risk with premature infants of bleeding into the brain, it is contraindicated in infants whose gestational age is less than 35 weeks or whose birthweight is less than 2,000 grams. Stork, *Extracorporeal Membrane Oxygenation in the Newborn and Beyond*, 15 Clin. Perinat. 815, 821 (1988). Improvements in ECMO may someday permit its use in premature infants. However, such improvements are not expected in the foreseeable future. *New York State Task Force* at 8; see generally, Hack & Fanaroff, *How Small is Too Small? Considerations in Evaluating the Outcome of the Tiny Infant*, 15 Clin. Perinat. 773, 782 (1988).[6]

III. The Health Effects of Childbirth and Abortion

Many women experience medical complications during childbirth (*i.e.*, a term pregnancy, labor and delivery), and, in rare instances, death results.[7] Abortion also can

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[6] It has taken over 50 years from the time laboratory investigation of extracorporeal circulation began to reach the current limits. *Principles of Surgery* at 811.

[7] There are certain health benefits to childbearing. For example, women who do not bear children are at greater risk of breast cancer, uterine cancer, colon cancer and ovarian cancer. *Rovinsky & Guttmacher's Medical, Surgical, and Gynecologic Complications of Pregnancy* 502-04 (S. Cherry, R. Berkowitz & N. Kase 3d ed. 1985).

have adverse health effects, including death, but the severity and frequency of harm is significantly less than in childbirth.

In 1973, this Court observed that maternal mortality from abortion was lower than maternal mortality from childbirth until the second trimester of pregnancy. *Roe* v. *Wade*, 410 U.S. at 149, 163. Since that time, advances in medical knowledge and surgical technque have made both childbirth and abortion safer. In addition, abortion has remained safer than childbirth.[8] LeBolt, Grimes & Cates, *Mortality from Abortion and Childbirth: Are the Populations Comparable?*, 248 J.A.M.A. 188, 190 (1982). By 1981, for example, the risk of a woman dying from an abortion had dropped to 0.5 per 100,000 procedures from 4.1 per 100,000 in 1972. *Id.* at 191; Binkin, *Trends in Induced Legal Abortion Morbidity and Mortality*, 13 Clin. Obstet. Gynec. 83, 85 (1986).[9] The risk of death from childbirth declined less sharply, to 8.5 per 100,000 live births in 1981 from 18.8 per 100,000 in 1972. U.S. Dep't of Health and Human Services, 2A *Vital Statistics of the United States 1981* 64.[10]

The reported mortality figures may understate the relative safety of abortion compared to childbirth. According to a number of studies, mortality statistics published by the federal government underestimate the num-

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[8] Induced abortion is one of the most commonly performed and safest surgical procedures in the United States, with half the risk of death involved in a tonsillectomy and one one-hundredth the risk of death involved with an appendectomy. W. Hern, *Abortion Practice* 23-24 (1984).

[9] The most common causes of death from abortion are uncontrolled bleeding (hemorrhage), complications of anesthesia, infection and pulmonary embolism. *Binkin* at 90.

[10] The most common causes of maternal death from childbirth are pulmonary embolism, pregnancy-induced hypertension, ectopic pregnancy, uncontrolled bleeding (hemorrhage) and cerebrovascular accidents (stroke). Rochat, Koonin, Atrash & Jewett, *Maternal Mortality in the United States: Report from the Maternal Mortality Collaborative*, 72 Obstet. Gynec. 91, 93 (1988).

ber of maternal deaths from childbirth by as much as 37%-50%. Cates, Smith, Rochat & Grimes, *Mortality from Abortion and Childbirth: Are the Statistics Biased?*, 248 J.A.M.A. 192, 194 (1982); Rochat, Koonin, Atrash & Jewett, *Maternal Mortality in the United States: Report from the Maternal Mortality Collaborative*, 72 Obstet. Gynec. 91, 92 (1988).[11] The data on abortion mortality, on the other hand, are highly accurate. This is because efforts to detect maternal mortality from abortion have been very thorough. *Cates, Smith Rochat & Grimes* at 193-94.

The risk of other medical complications is also higher in childbirth than in abortion. While 63% of women suffer some adverse health effect during pregnancy, Placek & Taffel, *Recent Patterns in Cesarean Delivery in the United States*, 15 Obstet. Gynec. Clin. N.A. 607, 612, 615 (1988), approximately 12% of abortions result in some medical complication. J. Hodgson, *Abortion and Sterilization: Medical and Social Aspects* 159 (1981). Moreover, the risk of major surgery is higher in childbirth. While nearly 25% of women deliver by cesarean section, *Placek & Taffel* at 607, fewer than one percent of abortions result in the need for intra-abdominal operations. Cates, *Legal Abortion: The Public Health Record*, 215 Sci. 1586, 1587 (1982).

The difference in maternal mortality and morbidity between abortion and childbirth is significantly affected by the gestational age of the fetus. When the fetus is eight or fewer weeks old, abortion is more than 20 times safer than childbirth. *LeBolt* at 191. The difference in maternal complications narrows thereafter with abortion remaining safer until at least 16 weeks of gestation.[12] *LeBolt* at 191.

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[11] The underreporting stems chiefly from the fact that official statistics are based solely on information from death certificates, which frequently provide inadequate information regarding the cause of death. *Cates, Smith, Rochat & Grimes* at 193.

[12] By 1981, the maternal mortality rate for abortions between 16 and 20 weeks dropped to 7.8 deaths per 100,000 abortions.

Abortions have become increasingly safer for three reasons. First, like any other surgical procedure, abortions have fewer complications as physicians gain experience performing them. *Binkin* at 90 (1986); Grimes & Schulz, *Morbidity and Mortality from Second-Trimester Abortions*, 30 J. Reprod. Med. 505, 506 (1985). Second, a higher percentage of abortions are performed on women whose characteristics place them at a relatively low risk of complications. For example, the risks are lowest when abortions are performed before week eight of gestation, and the fraction of abortions occurring in that time period has increased from about one-third to one-half. *Binkin* at 88. Finally, the risks to maternal health from abortion have decreased because of a shift to safer techniques for performing abortions. *Id.*

There have been two important advances in technique. First, during the first trimester, suction curettage (vacuum aspiration), the safest method of abortion, has replaced mechanical curettage as the dilation and evacuation method of choice;[13] almost all first trimester abortions are performed by suction. Stubblefield, *Surgical Techniques of Uterine Evacuation in First- and Second-Trimester Abortions*, 13 Clin. Obstet. Gynec. 53, 53 (1986); E. Quilligan & F. Zuspan, *Douglas-Stromme Operative Obstetrics* 182 (4th ed. 1982). Use of vacuum aspiration results in an abortion that requires less time, results in less damage to the uterus and causes minimal blood loss. *Id.*

The second important improvement in technique has been the greater use of dilation and evacuation to perform second trimester abortions. Previously, physicians believed that dilation and evacuation could be performed

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Binkin at 87. Also in 1981, the official maternal mortality rate in childbirth was 8.5 per 100,000 live births. *Obstetrics & Gynecology* at 288.

[13] Dilation and evacuation methods involve two steps: (a) widening of the cervix until it is large enough to permit insertion of instruments into the uterus for removal of the fetal tissue (dilation) and (b) removal of the fetal tissue (evacuation).

only through the 12th week of gestation. *Stubblefield* at 63; *Rovinsky & Guttmacher* at 688-89. In addition, alternative techniques were not considered safe enough for widespread use before the 16th week of gestation. As a consequence, a woman who decided to have an abortion during weeks 13-15 had to wait until week 16, when an abortion was more dangerous. *Binkin* at 88.

It is now clear that dilation and evacuation can be used safely through week 20 of gestation, and, since 1980, has been the most commonly used method for mid-trimester abortions, accounting for two-thirds of such abortions. American College of Obstetricians and Gynecologists, *Methods of Midtrimester Abortion* 1 (Technical Bulletin 109, Oct. 1987). Dilation and evacuation is safer than other mid-trimester abortion techniques until week 16 when it becomes as risky as some of the alternatives, but is still preferred for weeks 16-20 because it is simpler, cheaper and less traumatic for patients. *Stubblefield* at 66; *Rovinsky & Guttmacher* at 690.

Improvements in the safety of abortion have also occurred because lawful abortions are much safer than unlawful ones. Between 1940 and 1972, more than 75% of abortion deaths were the consequence of unlawful abortions and, in 1972, women having unlawful abortions were eight times more likely to die than women having lawful abortions. Cates & Rochat, *Illegal Abortions in the United States: 1972-74*, 8 Fam. Plann. Persp. 86, 91-92 (1976). After *Roe*, abortion deaths dropped sharply. Between 1972 and 1974, for example, the total number of abortion deaths declined from 88 to 48, and deaths from unlawful abortions declined from 39 to 5. *Cates & Rochat* at 87. In other words, 85% of the decrease in abortion deaths between 1972 and 1974 reflected reductions in mortality from unlawful abortions. *Id.*[14]

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[14] In nearly 70% of the deaths from unlawful abortions in 1972-74, the woman belonged to a minority racial group. *Cates & Rochat* at 91.

Non-fatal complications of abortion also have declined following legalization. For example, hospital admissions for septic abortion in California dropped by 68-75% following liberalization of the state's abortion laws in 1967. Bracken, Freeman & Hellenbrand, *Hospitalization for Medical-Legal and Other Abortions in the United States 1970-1977*, 72 Am. J. Pub. Health 30, 30 (1982). Moreover, in countries in which abortion is still illegal, the likelihood of major complications is much higher than in the United States. In South Africa, for example, the incidence of complications requiring hysterectomy is 50-100 times greater. Richards, Lachman, Pitsoe & Moodley, *The Incidence of Major Abdominal Surgery After Septic Abortion—An Indicator of Complications Due to Illegal Abortion*, 68 S. African Med. J. 799, 800 (1985).

In sum, what the Court found in 1973 is even more true today: the medical risks to a woman of childbirth are greater than the risks of abortion. In the next section, we discuss some of the individual risks of childbirth and abortion.

IV. Individual Physical and Psychiatric Effects of Pregnancy and Abortion

A. *Individual Physical Effects from Pregnancy*

Pregnant women may experience a wide range of adverse health effects. As many as 90% of pregnant women develop gastrointestinal symptoms, including nausea and vomiting. *Obstetrics & Gynecology* at 334-35. Other common problems include fatigue, varicose veins, hemorrhoids, headache and backache. *Williams Obstetrics* at 260-63.

Many pregnant women confront potentially more serious health problems. Hypertension,[15] for example, complicates about 8%-10% of pregnancies. C. Pauerstein, *Clinical Obstetrics* 645 (1987). In the majority of cases,

[15] Pregnancy may induce hypertension as well as aggravate preexisting hypertension.

the hypertension can be controlled, and no permanent consequences result. *Clinical Obstetrics* at 645, 655-56; R. Creasy & R. Resnik, *Maternal-Fetal Medicine* 801 (2d ed. 1989). However, hypertensive pregnant women are at higher risk for cerebrovascular accidents (strokes), abruptio placentae (premature separation of the placenta from the uterus), and disseminated intravascular coagulation (a severe bleeding disorder). *Clinical Obstetrics* at 656.

About 0.1% of deliveries are complicated by eclampsia, a severe form of pregnancy-induced hypertension. *Williams Obstetrics* at 539. Eclampsia is characterized by headaches, visual disturbances, abdominal pain and seizures. *id.* at 544, and it has a maternal mortality rate that ranges from less than 1% to 17%, *Clinical Obstetrics* at 647, depending upon the adequacy of prenatal care and the access to health care facilities. Because of the seriousness of eclampsia, the standard approach for pregnant women with any degree of hypertension is to induce labor as soon as the fetus is mature and the woman's cervix is favorable for induction. *Obstetrics & Gynecology* at 458; *Williams Obstetrics* at 542.

The pregnant woman also bears a risk of hemorrhage during pregnancy, labor and delivery, and the puerperium (the immediate post-delivery period).[16] During the third-trimester, for example, bleeding occurs in 2%-3% of pregnancies, most commonly from the placenta. *Obstetrics & Gynecology* at 433. Third-trimester bleeding is of particular concern because of its potentially fatal outcome for both the mother and fetus. *Id.* Indeed, the standard response to any third-trimester bleeding is im-

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[16] The most common period during which serious blood loss in obstetrics occurs is after delivery, and the main causes are uterine atony (failure of the uterus to contract and close off the woman's blood vessels that previously entered the placenta), lacerations of the birth canal from delivery or retention of placental tissue in the uterus. *Obstetrics & Gynecology* at 764-65; *Williams Obstetrics* at 707-15.

mediate hospitalization to determine the cause of the bleeding so that appropriate treatment can be instituted.[17]

If third-trimester bleeding is caused by placenta previa (obstruction of the birth canal by the placenta) or by abruptio placentae, cesarean section may be required to prevent uncontrolled hemorrhage. *Id.* at 437-42. Potential complications of uncontrolled hemorrhage include kidney failure, stroke, loss of pituitary gland function and death. *Id.* at 438, 441-42. There are also potentially serious complications of the treatments for third-trimester hemorrhage. These include hepatitis or other diseases from blood transfusions, severe infections, and, if a hysterectomy is required, infertility. *Id.* at 438.

Pregnancy-induced diabetes occurs in approximately 1-3% of pregnancies. G. Burrow & T. Ferris, *Medical Complications During Pregnancy* 41 (3d ed. 1988). In addition, there are approximately 1.5 million women of childbearing age who are already known to have diabetes. *Maternal-Fetal Medicine* at 925. Diabetes has a number of adverse effects on the pregnant woman: there is a fourfold increase in the likelihood of hypertensive disease; infection occurs more often and with greater severity; injury to the birth canal during vaginal delivery is more common; cesarean sections are required more frequently; and hemorrhage after delivery (postpartum hemorrhage) is more likely. *Williams Obstetrics* at 600.

Three rare but life-threatening complications of childbirth are amniotic fluid embolism, pulmonary embolism and disseminated intravascular coagulation. Amniotic fluid embolism occurs in less than 0.1% of deliveries, but, because it is fatal in over 80% of cases, is responsible for up to 10% of maternal deaths in childbirth. *Clinical Obstetrics* at 779. In amniotic fluid embolism, amniotic fluid or other fetal tissue enters the woman's circulation where it obstructs the blood vessels in the mother's lung and/or precipitates disseminated in-

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[17] Since attempts to determine the source of the bleeding may precipitate massive hemorrhage, investigation must take place where full medical and surgical treatments are available.

travascular coagulation. *Clinical Obstetrics* at 779. Pulmonary embolus is a leading cause of maternal deaths after childbirth, although it occurs in less than 0.1% of deliveries. *Clinical Obstetrics* at 781. It is caused by obstruction of the lung's blood vessels from blood clots that originate in the veins of the legs. Disseminated intravascular coagulation, a severe bleeding disorder that results from a breakdown in the blood's system of coagulation, is seen in women with hypertensive disease of pregnancy, severe infections or abruptio placentae, as well as amniotic fluid embolism. *Obstetrics & Gynecology* at 540-41.

The nearly 25% of women who deliver by cesarean section are exposed to significantly higher risks of death and other, less severe side effects when compared with women who deliver vaginally. *Maternal-Fetal Medicine* at 530. Complications are very common. In 25%-50% of cesarean sections, the woman suffers some compromise of her health, including infection, hemorrhage, laceration of her reproductive, urinary or intestinal tract, and pulmonary embolism.[18] Miller, *Maternal and Neonatal Morbidity and Mortality in Cesarean Section*, 15 Obstet. Gynec. Clin. N.A. 629, 630 (1988); Rogers, *Complications at Cesarean Section*, 15 Obstet. Gynec. Clin. N.A. 673, 676, 679-80 (1988); *Obstetrics & Gynecology* at 738. The risk of maternal death is two to four times greater with cesarean section than with vaginal delivery. *Clinical Obstetrics* at 877.

In addition to causing new disease and complications, pregnancy may aggravate preexisting illnesses. A number

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[18] Other rare, but potentially fatal complications, may result from anesthesia. *Rogers* at 682-83. During general anesthesia, the woman's stomach contents may be aspirated into her lung where their acidity makes them extremely toxic, with death occurring in more than 50% of the cases. *Clinical Obstetrics* at 777; Hood, *Anesthesia for Cesarean Section: Minimizing Risk and Complications*, 15 Obset. Gynec. Clin. N.A. 639, 640-41 (1988). Spinal anesthesia can cause excessive paralysis of the nerves, leading to a profound decrease in blood pressure, loss of respiratory function and even cardiac arrest. *Hood* at 644.

of the conditions that increase the risk of pregnancy to the mother's health will make abortion strongly advisable. For example, for a woman who suffers from a congenital heart disease that causes severe malformations of the heart, the additional stress on her heart from pregnancy could pose as much as a 50 percent possibility of causing her death. *Obstetrics & Gynecology* at 494-97; *Abortion, Medicine & the Law* 251 (J. Butler & D. Walbert 3d ed. 1986). Pregnancy also jeopardizes the life of a woman with advanced coronary artery disease or severe impairment of a heart valve, *Clinical Obstetrics* at 630, and all pregnant women with heart disease have a higher risk of congestive heart failure, cardiac infections and arrhythmias (abnormal heart rhythms). *Obstetrics & Gynecology* at 492-97; *Maternal-Fetal Medicine* at 749-58.

Pregnancy also threatens the woman's life or is likely seriously to impair her health when she suffers from chronic renal failure, myasthenia gravis [19] or pulmonary embolism in a previous pregnancy.[20] *Abortion, Medicine & the Law* at 252-54. Cancer is the second leading cause of death among women in their reproductive years, and can threaten the fetus as well as the woman. Williams & Bitran, *Cancer and Pregnancy*, 12 Clin. Perinat. 609 (1985). If treatment of the disease requires radiation or chemotherapy, a choice must be made between the life of the patient and the fetus, since these forms of therapy are likely to result in fetal malformation or death.[21]

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[19] 40% of women with myasthenia gravis (a degenerative nerve disease similar to polio) suffer an exacerbation during pregnancy and 3.4% die. *Abortion, Medicine & the Law* at 253.

[20] There is a high risk of a recurrence in subsequent pregnancies. *Id.*

[21] Abortions are sometimes performed because diagnostic testing has revealed severe fetal abnormalities, *e.g.*, the fetus may suffer from a devastating genetic or other congenital defect such as anencephaly or Tay-Sachs disease. Or, the woman may have ingested substances that are harmful to the fetus. *Abortion, Medicine & the Law* at 254-55. A third fetal indication for abortion arises when the woman has developed certain viral infections, such as AIDS, during pregnancy. Finally, if the woman is exposed during

Rovinsky & Guttmacher at 512-15. Furthermore, diagnosis and treatment of cancer in pregnant women is often delayed because the symptoms of pregnancy can mask the symptoms of cancer. *Id.* at 507, 508 and 512. Diagnosis of breast cancer, for example, is typically delayed by two to seven months in pregnant women. *Williams & Bitran* at 612. Other conditions exacerbated by pregnancy include asthma,[22] arthritis,[23] inflammatory bowel disease[24] and epilepsy.[25]

B. *Individual Physical Effects from Abortion*

As indicated previously, abortion can also involve adverse health effects. They are less frequent and generally less severe than those of childbirth. This difference reflects the fact that the stress from abortion is smaller in magnitude and has a shorter duration than the stress from childbirth. Nevertheless, a wide range of adverse health effects can result from abortion.

Many women suffer discomfort from the procedure, including pain, headache and nausea. Approximately 12% of women suffer more serious complications, and

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early pregnancy to radiation in doses as high as those used to treat cancer, the fetus usually will be malformed, if not spontaneously aborted. *Id.* at 256.

[22] Asthmatics have increased risks of complications during pregnancy such as toxemia or hemorrhage. Greenberger, *Asthma in Pregnancy*, 12 Clin. Perinat. 571, 579 (1985). Moreover, asthma is more difficult to treat during pregnancy because certain medications may be harmful to the fetus. *Greenberger* at 580.

[23] The pregnant woman may experience excessive pain because, with the exception of aspirin, all of the anti-inflammatory drugs generally prescribed for arthritis present a substantial risk of harm to the fetus. *Rovinsky & Guttmacher* at 73.

[24] Women with Crohn's disease or ulcerative colitis have a 50% risk of aggravation of their disease. *Abortion, Medicine and the Law* at 252.

[25] The frequency of seizures increases in 24-45% of pregnant women with epilepsy. Noronha, *Neurological Disorders During Pregnancy and the Puerperium*, 12 Clin. Perinat. 695, 695-96 (1985).

about 0.4% will suffer a major complication such as perforation of the uterus or hemorrhage severe enough to require a blood transfusion. Buehler, Schulz, Grimes & Hogue, *The Risk of Serious Complications from Induced Abortion: Do Personal Characteristics Make a Difference?*, 153 Am. J. Obstet. Gynec. 14, 16 (1985); J. Hodgson, *Abortion and Sterilization: Medical and Social Aspects* 155, 159-60 (1981).

The risk of an adverse health effect depends upon a number of factors, including the gestational age of the fetus, the procedure used to perform the abortion and the woman's age and general health. *Buehler* at 19. Problems that may arise during or after an abortion include perforation of the uterus or laceration of the cervix by the instruments used in dilation and evacuation. *Obstetrics & Gynecology* at 257; *Stubblefield* at 58. Small perforations or lacerations will heal without any treatment, *Williams Obstetrics* at 481, while larger tears must be repaired with sutures (stitches). In rare cases, an uterine perforation has severe consequences. It may require a hysterectomy, and it increases the risk of a fatal infection or hemorrhage by more than 100-fold. Grimes, Schulz & Cates, *Prevention of Uterine Perforation During Curettage Abortion*, 251 J.A.M.A. 2108, 2108 (1984).

Infections and hemorrhage are potential complications of all abortion techniques. As in a delivery, see *supra* at 14, hemorrhage may result from uterine atony or retention of placental tissue in the uterus. Rayburn & LaFerla, *Mid-Gestational Abortion for Medical or Genetic Indications*, 13 Clin. Perinat. 71, 78 (1986). Post-abortion infections, in contrast to other pelvic infections, generally respond rapidly to antibiotics and curettage of the uterine cavity. *Obstetrics & Gynecology* at 218. Spread of an infection beyond the uterus is a major risk factor for the development of a severe infection. *Id.* at 219.

Amniotic fluid embolism, pulmonary embolism and disseminated intravascular coagulation are three rare but

particularly fatal complications in abortion, as they are in childbirth, *supra* at 15-16. Amniotic fluid embolism, for example, accounts for more than 10% of abortion deaths. Mulder, *Amniotic Fluid Embolism: An Overview and Case Report*, 152 Am. J. Obstet. Gynec. 430, 430 (1985).

It is unclear whether abortion compromises the outcomes of subsequent pregnancies. *Williams Obstetrics* at 483. Some studies have found that later pregnancies had a greater, though still slight, risk of spontaneous abortions, preterm deliveries and low birthweight infants. *Id.; Abortion, Medicine & the Law* at 259. More recent studies have not found a statistically significant increase in risk for any of these three complications. Linn, Schoenbaum, Monson, Rosner, Stubblefield & Ryan, *The Relationship Between Induced Abortion and Outcome of Subsequent Pregnancies*, 146 Am. J. Obstet. Gynec. 136, 140 (1983); Frank, Key, Scott, Hannaford & Haran, *Pregnancy Following Induced Abortion: Maternal Morbidity, Congenital Abnormalities and Neonatal Death*, 94 Br. J. Obstet. Gynec. 836 (1987). Nor does there appear to be an increase in infertility following abortion. Stubblefield, Monson, Schoenbaum, Wolfson, Cookson & Ryan, *Fertility After Induced Abortion: A Prospective Follow-Up Study*, 63 Obstet. Gynec. 186 (1984).

C. *Individual Psychiatric Effects from Pregnancy and Abortion*

As others have observed, including the U.S. Surgeon General, the research on the psychiatric effects of abortion is not sufficiently rigorous to yield a complete understanding of the extent to which abortion results in psychiatric problems. Nevertheless, certain observations can be made.

First, serious psychiatric disease after either abortion or childbirth is unusual.[26] Most women respond to abor-

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[26] Serious psychiatric disease is generally defined as mental illness severe enough to require hospitalization in a psychiatric facility. It is usually referred to as post-abortion or postpartum psychosis. David, Rasmussen & Holst, *Postpartum and Postabortion*

tion with relief, see *infra* at 22. Fewer than 0.3% of pregnant women will go on to develop serious mental illness after either abortion or childbirth. *Comprehensive Textbook of Psychiatry/IV* 1054 (H. Kaplan & B. Sadock 4th ed. 1985); Robinson & Stewart, *Postpartum Psychiatric Disorders*, 134 Can. Med. Ass'n J. 31, 42 (1986); David, Rasmussen & Holst, 13 Fam. Plann. Presp. 88, 88-89 (1981); Brewer, *Incidence of Post-Abortion Psychosis: A Prospective Study*, [1977] 1 Br. Med. J. 476, 476-77. Similarly, the vast majority of women derive very significant emotional and psychological benefits from bearing and raising children.

Second, transient negative feelings that are not serious enough to constitute psychiatric disease are commonly seen following either abortion or childbirth. Somewhere between 50% and 70% of mothers experience the "postpartum blues," which begin during the first week after delivery and last anywhere from a few hours to two weeks, usually 24-48 hours. *Robinson & Stewart* at 32; Zuckerman & Beardslee, *Maternal Depression: A Concern for Pediatricians*, 79 Pediat. 110, 111 (1987). Typical symptoms include sadness, weepiness, poor concentration, anxiety and confusion. *Robinson & Stewart* at 32. After abortion, 15%-40% of women experience feelings of regret, guilt and sadness that are mild and which generally disappear within two weeks. Lazarus & Stern, *Psychiatric Aspects of Pregnancy Termination*, 13 Clin. Obstet. Gynec. 125, 125-27 (1986); Blumberg & Golbus, *Psychological Sequelae of Elective Abortion*, 123 West J. Med. 188, 190-92 (1975).

Third, while a significant percentage of women suffer from mild to moderate psychiatric illness after childbirth, it is not clear to what extent abortion is followed by mild to moderate psychiatric illness. In any event, it appears that postpartum illness is more common than post-

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Psychotic Reactions, 13 Fam. Plann. Persp. 88, 88 (1981); Brewer, *Incidence of Post-abortion Psychosis: A Prospective Study*, [1977] 1 Br. Med. J. 476, 476.

abortion illness. Approximately 20% of mothers develop "postpartum depression," a depression whose symptoms are typical of depressions generally and which usually lasts for 6-8 weeks. *Zuckerman* at 111; Hopkins, Marcus & Campbell, *Postpartum Depression: A Critical Review*, 95 Psychol. Bull. 498, 503 (1984). Experts disagree on the frequency of mild to moderate post-abortion psychiatric illness, with estimates ranging from a fraction of a percent to as much as 15%. The majority of experts estimate frequency at the low end of that spectrum. *Lazarus* at 125-27; Ashton, *The Psychosocial Outcome of Induced Abortion*, 87 Br. J. Obstet. Gynec. 1115, 1121 (1980); Ewing & Rouse, *Therapeutic Abortion and Prior Psychiatric History*, 130 Am. Psych. 37 (1973).

To the extent that there is psychiatric illness after abortion, it appears generally to be temporary and limited to those women who have a history of psychiatric problems or who choose to abort because of risks to their health or their fetuses rather than because the fetus is unwanted. *Lazarus* at 125-27; Lloyd & Laurence, *Sequelae and Support After Termination of Pregnancy for Fetal Malformation*, 290 Br. Med. J. 907 (1985); *Blumberg* at 193. Moreover, the predominant response to abortion is relief, and the positive feelings increase over time as the negative feelings diminish. *Adolescent Abortion: Psychological and Legal Issues* 84 (G. Melton, ed. 1986); Adler, *Emotional Responses of Women Following Therapeutic Abortion*, 45 Am. J. Orthopsych. 446, 447 (1975).

Women who have abortions also are less likely to suffer psychiatric disability than women who are denied abortions. When compared to women who have abortions, women denied abortions have a greater likelihood of both significant psychiatric disease and serious psychiatric disease. *Comprehensive Textbook* at 1055.

In sum, what this discussion of the medical background of abortions, fetal viability and the physical and psychiatric implications of childbirth and abortion reveals is

that the Court in *Roe* was correct that "the abortion decision in all its aspects is inherently, and primarily, a medical decision. . . ." 410 U.S. at 166.

SUMMARY OF ARGUMENT

I.

Amici do not argue here that the specific balance struck in *Roe* v. *Wade*, 410 U.S. 113, 153 (1973), between a woman's fundamental right to make a personal medical decision and the state's interest in protecting potential life should be reaffirmed or rejected. But *amici* do argue that the "right of privacy" embodied in the concept of personal liberty protected by the Fourteenth Amendment is, as held in *Roe*, "broad enough to encompass a woman's decision whether or not to terminate her pregnancy." The Court should reaffirm that specific holding for three reasons.

A. In part, the Court reached its conclusion about the privacy right because it found that the nature of the woman's interest in the choice confronting her during pregnancy was essentially the same as other inherently private, individual decisions which the Constitution protects. Compare *Griswold* v. *Connecticut*, 381 U.S. 479 (1965). Specifically, the Court recognized that, by denying the woman a choice, "[s]pecific and direct harm medically diagnosable even in early pregnancy may be involved." *Roe*, 410 U.S. at 153. The Court's reasoning on that point is just as valid today as it was in 1973.

B. The Court's privacy holding is also supported by the fact that individual medical decisionmaking is a process "deeply rooted in this Nation's history and tradition," *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (Powell, J.). The Court has held that the liberty guaranteed by the Fourteenth Amendment includes "the right of the individual . . . to enjoy those privileges long recognized at common law. . . ." *Meyer* v. *Nebraska*, 262 U.S. 390, 399 (1923). And no right "is more carefully guarded by the common law, than the right of every in-

dividual to the possession and control of his own person." *Union Pacific Ry.* v. *Botsford*, 141 U.S. 250, 251 (1891). Thus, the quintessentially private choice of medical treatment options is entitled to constitutional protection.

C. The holding that a patient has a fundamental right drawn from the liberty component of the Due Process Clause to make a medical treatment decision is "rooted in accepted principles." U.S. Brief at 12. This Court has recognized in applying the broad mandates of both the Fourth and the Eighth Amendments that medical treatment is entitled to substantial protection from governmental interference or neglect. See, *e.g.*, *Winston* v. *Lee*, 470 U.S. 753, 767 (1985). The logic of those cases supports the holding that a privacy right derived from the Liberty Clause of the Fourteenth Amendment shields individual medical treatment choices from interference absent a compelling state interest.

D. The compelling interest analysis triggered by an infringement by the state of the fundamental right to terminate a pregnancy contains two components which must be independently satisfied: 1) the specific means chosen must be reasonably related to a compelling interest and thus consistent with sound medical practice and 2) the specific requirements of the state must be carefully tailored to the state's purposes. *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983).

II.

A. Section 188.029 of the Missouri statute, which the court of appeals construed to require a physician in making a viability determination to perform certain tests in order to support findings concerning the gestational age, weight and lung maturity of a fetus, is medically inappropriate and not reasonably related to any legitimate goal of the state. Instead, Missouri attempts to interfere with the physician's judgment and in so doing imposes needless risk to the mother's health without any corresponding gain to the state's interest in protecting the fetus.

Accordingly, the statute is unconstitutional. See *Colautti* v. *Franklin*, 439 U.S. 379 (1979).

B. Section 188.205 of the Missouri statute, which the court of appeals held literally precludes a physician from "consulting," i.e., making any comment, about having an abortion unless necessary to save the mother's life, is unconstitutional. The statute clearly interferes with a physician's ethical obligations to discuss fully and accurately all information necessary to permit the patient to make an informed treatment choice. By mandating "a state-imposed blackout on the information necessary to make a decision" (851 F.2d at 1080), Section 188.205 forces a constitutionally impermissible "straightjacket" upon the physician's efforts fully to inform his or her patient. *City of Akron*, 462 U.S. at 445; *Planned Parenthood* v. *Danforth*, 428 U.S. 52 (1976).

ARGUMENT

I. INDIVIDUALS HAVE A FUNDAMENTAL RIGHT TO MAKE DECISIONS ABOUT THEIR MEDICAL CARE, AND STATE LAWS WHICH INTERFERE WITH THAT RIGHT CAN BE JUSTIFIED ONLY IF THEY ARE NARROWLY TAILORED TO FURTHER A COMPELLING STATE INTEREST.

Appellants and their *amici curiae*—particularly the United States—ask this Court to overrule a decision interpreting the Constitution: *Roe* v. *Wade*, 410 U.S. 113 (1973). In so doing, they ask the Court to take two major steps. First, they propose altering the balance struck previously by the Court between the interests of the pregnant woman and those of the state. Second, they ask the Court to declare that no fundamental privacy right exists in this case at all. They make this second, extraordinary request because they believe that the privacy right recognized in *Roe* cannot properly be derived from the Constitution. See U.S. Brief at 9-24.

Given the diversity of views of *amici*'s members, this brief does not take a position on whether the balance of

interests struck in *Roe* should be modified. However, *amici* firmly believe that the Court should reject the invitation of the federal government to deny constitutional protection to the well-established right of privacy that this Court applied in *Roe* v. *Wade*.

In the first place, the holding of this Court on the privacy issue was a common sense application of settled constitutional principles to a situation where a woman must make an individual choice about a matter which the Court found would have profound implications for her health and life. Since the same profound individual implications the Court identified in 1973 still exist (see *supra* at 3-23), the decision should be reaffirmed. Second, the holding on the privacy issue simply reflected the historic tradition, embodied in our common law, of recognizing that all medical treatment decisions ordinarily should be made by the patient, after consultation with a physician concerning the risks and benefits of treatment. Third, the holding on the privacy issue is fully consistent with the holdings of this Court in applying other abstract constitutional principles to medical treatment situations, where the Court has always respected the dignity of the individual and his or her right to obtain desired medical care. Each of these reasons independently supports the Court's holding that the decision to terminate a pregnancy implicates a fundamental right.

A. The Individual's Fundamental Privacy And Liberty Right To Be Free Of Governmental Interference Extends To Medical Treatment Decisions.

This Court has long recognized that, as part of the "liberty" protected by the Constitution's Due Process Clauses, the Constitution guarantees to each individual certain areas or zones of privacy which remain free from unjustified government interference or intrusion. See *Carey* v. *Population Serv. Int'l*, 431 U.S. 678, 684 (1977). The Court's privacy rulings rest on the theory that the constitutional text does not, on its face, specify all rights

that warrant constitutional protection from executive or legislative intervention.[27]

The essence of the liberty interest denominated as the right to privacy is the concept that an individual in certain circumstances has a right to be let alone, *Olmstead* v. *United States*, 277 U.S. 438, 478 (1928) (Brandeis, J., dissenting), and that the individual must thus have "independence in making certain kinds of important decisions." *Whalen* v. *Roe*, 429 U.S. 589, 599-600 (1977). As this Court has recognized, that right encompasses matters concerning marriage and procreation. The specter of governmental agents unnecessarily interfering with such inherently private, individual decisions is antithetical to basic concepts of individual liberty in a free society. See *Griswold* v. *Connecticut*, 381 U.S. 479 (1965); *Loving* v. *Virginia*, 388 U.S. 1 (1967); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972). See also *Skinner* v. *Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942).[28]

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[27] The concept of "liberty" in the Due Process Clause of the Fourteenth Amendment is a "broad" one. *Board of Regents* v. *Roth*, 408 U.S. 564, 572 (1972). For this reason, it has long been recognized as protecting certain personal choices. *See, e.g., Pierce* v. *Society of Sisters*, 268 U.S. 510, 534-535 (1925); *Meyer* v. *Nebraska*, 262 U.S. 390, 399-400 (1923).

Moreover, privacy is hardly the only value that has received constitutional recognition without being expressly specified in the constitutional text. For example, this Court found a right to travel in the Constitution without requiring any explicit textual basis. *Shapiro* v. *Thompson*, 394 U.S. 618 (1969). In addition, although "federalism" is nowhere mentioned in the Constitution, the doctrine is part of the constitutional scheme. *See Coyle* v. *Smith*, 221 U.S. 559, 565 (1911); *Garcia* v. *San Antonio Metro. Transit Auth.*, 469 U.S. 528 (1985).

[28] The United States seems to accept *Griswold* v. *Connecticut*, 381 U.S. 479 (1965), as a legitimate decision on the ground that enforcement of a statute prohibiting the use of contraceptives would require wholly impermissible governmental prying into the private lives of individuals. (U.S. Brief at 12 n.9.) Having accepted *Griswold*, however, the government's textual theory (U.S. Brief at 23-28) for rejecting *Roe* v. *Wade* collapses, because this Court did not locate the right recognized in *Griswold* in a specific constitutional provision and could not, as the United States suggests, have

Moreover, and of particular significance to *amici* and their members, the right to privacy which is derived from the concept of liberty also encompasses the right of an individual to make decisions about his or her medical care and treatment. As our discussion of the health implications of pregnancy and abortion makes clear, the Court's assumptions about the importance of this particular medical treatment decision are as true today as they were in 1973. Women face physiological and psychological risks and burdens when they become pregnant. Under this Court's decisions, individual choices become fundamental rights because they have a powerful and perhaps irreversible impact on who we are and who we will become. See *Fitzgerald* v. *Porter*, 523 F.2d 716, 719-20 (7th Cir. 1975): "These cases do not deal with the individuals' interest in protection from unwarranted public attention, comment, or exploitation. They deal, rather, with the individual's right to make certain unusually important decisions that will affect his own, or his family's destiny." Accordingly, it seems plain that the health effects of pregnancy and abortion, by themselves, should be sufficient to support the holding in *Roe* that the woman's choice should be constitutionally protected.

In holding that the abortion decision involved a fundamental right, the Court correctly noted that considerations of protecting the woman's health were vital. Specifically, the Court observed that:

> The detriment that the State would impose upon the pregnant woman by denying this choice altogether is apparent. Specific and direct harm medically diagnosable even in early pregnancy may be involved.

Roe, 410 U.S. at 153. Similarly, in explaining the basis for the protections afforded first trimester abortions, the

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located it in the Fourth Amendment alone. *See Carey* v. *Population Serv. Int'l*, 431 U.S. 678, 687 (1977). The United States' brief therefore bears "witness that the right of privacy which passes for recognition here is a legitimate one." *Griswold*, 381 U.S. at 485.

Court identified the important health concerns implicated by the woman's choice. "[U]ntil the end of the first trimester mortality in abortion may be less than mortality in normal childbirth . . . . This means . . . that . . . the attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated." *Id.* at 163. See also *City of Akron* v. *Akron Center for Reproductive Health, Inc.*, 462 U.S. 416, 429 n.11 (1983).

The full extent of the importance attached to the pregnant woman's interest in being able to preserve her life and health is perhaps most apparent, however, in the context of third trimester abortions. At this stage, the State's interest in protecting fetal life is considered compelling. *Roe*, 410 U.S. at 163-165. Nonetheless, this Court has recognized that protection of the pregnant woman's health interests is still considered "paramount." *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747, 769 (1986). Consequently, while *Roe* otherwise permitted proscription of third trimester abortions, it did not do so in instances where abortion "is necessary to preserve the life or health of the mother." *Roe*, 410 U.S. at 163-164.

The importance of the health considerations underlying *Roe*'s holdings has led this Court to observe:

> In concluding that the freedom of a woman to decide whether to terminate her pregnancy falls within the personal liberty protected by the Due Process Clause, the Court in *Wade* emphasized the fact that the woman's decision carries with it significant personal health implications—both physical and psychological . . . . [I]t could be argued that the freedom of a woman to decide whether to terminate her pregnancy for health reasons does in fact lie at the core of the constitutional liberty identified in *Wade*.

Harris v. *McRae*, 448 U.S. 297, 316 (1980).

To the extent that the right in this case depends upon the importance to the woman of the consequences of her

choice (see *supra* at 3-23), the decision whether or not to have an abortion should be considered a fundamental right.

B. This Court's Recognition That Every Individual Has A Fundamental Right To Make Decisions About His Or Her Medical Treatment Is Supported By The History And Traditions Of This Nation.

The Court's treatment of the woman's choice as a protected interest under the Constitution is supported by more than a common sense application of this Court's liberty and privacy rulings to the medical facts surrounding abortions. The Court's handling of the constitutional status of a medical treatment decision by the individual is also supported independently by the traditional respect this nation has always granted to the individual's interest in making personal medical treatment decisions in consultation with a physician.

The substantive guarantees afforded by the Due Process Clause encompass the protection of interests that are "deeply rooted in this Nation's history and tradition." *Moore* v. *City of East Cleveland*, 431 U.S. 494, 503 (1977) (opinion of Powell, J.). In deciding whether a particular interest is so embedded, the Court's judgment has historically been informed by whether the interest was protected at common law. The Court has stated that the liberty guaranteed by the Fourteenth Amendment encompasses "the right of the individual . . . to enjoy those privileges long recognized in common law as essential to the orderly pursuit of happiness by free men." *Meyer* v. *Nebraska*, 262 U.S. 390, 399 (1923).

In this regard, it is significant that: "No right is held more sacred, [n]or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person." *Union Pacific Ry.* v. *Botsford*, 141 U.S. 250, 251 (1891). An individual's interest in being permitted to make personal decisions

affecting bodily security, free from government coercion, is thus a traditionally protected interest.[29]

The interest in protecting the physical security and health of one's body is an ancient one. Blackstone classified this interest as one of the three principal articles—later embodied in our Constitution as "life, liberty and property"—constituting the "rights of the people of England." "[T]he preservation of a man's health from such practices as may prejudice or annoy it . . . are rights to which every man is entitled . . . ." W. Blackstone, *Commentaries* 1:134 (1765).

Indeed, both the common and statutory law of this country have consistently recognized the importance of the individual's interest in being able freely to make decisions designed to limit risks to his or her own health. In the law of torts, this interest is reflected, for example, in the requirement of informed consent to medical treatment. The principle which supports this doctrine is that the patient has a right to weigh whatever risks attend the particular treatment and to decide if they are intolerable.

> The root premise is the concept, fundamental in American jurisprudence, that '[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body. . . .'

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[29] Our general tradition of protecting the individual against coerced medical decisions posing a threat to health is more relevant than the narrow history of abortion regulation for determining the fundamental rights issue before this Court. That history of abortion is misleading because restrictions on the practice arose during an era when the procedure was dangerous. As noted in *Roe*, 410 U.S. at 148-49, "when most criminal abortion laws were first enacted, the procedure was a hazardous one for women . . . [;] [a]bortion mortality was high." Even then, abortion was frequently permitted when superceding health risks were present, *e.g.*, when necessary to preserve the life of the woman. *Id.* at 138-39. However, "[m]odern medical techniques have altered this situation," as this Court recognized in *Roe*, *id.* at 149, so that abortion restrictions that once served to protect the woman's health could now jeopardize her health. *See supra* at 8-13.

Canterbury v. *Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) (quoting *Schloendorff* v. *Society of New Hosp.*, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914) (Cardozo, J.)). Accord *Natanson* v. *Kline*, 186 Kan. 393, 410, 350 P.2d 1093, 1106, *clarified*, 187 Kan. 186, 354 P.2d 670 (1960); F. Harper & F. James, *The Law of Torts* § 17.1 (2d ed. 1986).

Similarly, in order to guard the patient's ability to take steps essential to protecting his or her health, virtually every state in this country has recognized a physician-patient privilege. "The rationale of this privilege is to promote health by encouraging a patient to fully and freely disclose all relevant information which may assist the physician in treating the patient." *Huzjak* v. *United States*, 118 F.R.D. 61, 63 (N.D. Ohio 1987). See 8 J. Wigmore, *Evidence* § 2380a (McNaughton ed. 1961).

These examples illustrate this country's long-standing tradition of treating potential infringements upon an individual's ability to protect his or her health and autonomy with the utmost seriousness. That tradition is, in turn, constitutionally reflected in the Due Process Clause's substantive protection of life and liberty. "[T]he right to personal security constitutes a 'historic liberty interest' protected substantively by the Due Process Clause." *Youngberg* v. *Romeo*, 457 U.S. 307, 315 (1982). Accord *Ingraham* v. *Wright*, 430 U.S. 651, 673 (1977) ("Among the historic liberties so protected was a right to be free from, and to obtain judicial relief for, unjustified intrusions on personal security"). For that reason, the right to protect one's bodily security, and to make medical decisions to that end, has always been deemed to require more than a mere minimal justification for government infringements. Under those principles, a woman's choice whether or not to terminate her pregnancy should be deemed a fundamental liberty interest protected by the Due Process Clause.

C. This Court's Recognition That Every Individual Has A Fundamental Right To Make Decisions About His Or Her Medical Treatment Is Supported By This Court's Approach To The Protection Of Health Under Specific Constitutional Provisions.

The United States criticizes (U.S. Brief at 12) the holding that a woman has a fundamental right embodied in the liberty component of the Due Process Clause to choose the medical treatment that she wishes her physician to provide as not "rooted in accepted principles." But the legal reasoning that supports the right in this context is essentially the same as the approach taken by this Court in applying other constitutional provisions, with language that is equally inexact, to issues concerning the provision of medical treatment generally. Thus, in the Fourth Amendment context, this Court has held that "our society recognizes a significantly heightened privacy interest" when government interference in medical decisions creates any increased risk to individual health. *Winston* v. *Lee*, 470 U.S. 753, 767 (1985).

In *Winston*, the government sought to perform a surgical procedure to remove a bullet from a criminal defendant's body. Presented with conflicting evaluations of the risk of the surgery, the court of appeals concluded that "the statistical risk of actual physical harm . . . is . . . very low [and could] be considered minimal." *Lee* v. *Winston*, 717 F.2d 888, 900 (4th Cir. 1983). Nonetheless, this Court reasoned:

> The operation sought will intrude substantially on respondent's protected interests. The medical risks of the operation, although apparently not extremely severe, are a subject of considerable dispute; *the very uncertainty militates against finding the operation to be "reasonable."*

Winston, 470 U.S. at 766 (emphasis supplied). The Court held that, in the absence of compelling countervailing interests, the very possibility of even marginal medical risk precluded the endangering government action. *Id.* As a matter of constitutional interpretation,

the *Winston* Court's derivation of a privacy interest from the Fourth Amendment's general protection against "unreasonable searches and seizures" to protect a patient's medical treatment choice cannot be distinguished from the *Roe* Court's derivation of a privacy interest from the liberty clause to protect a conceptually identical right to make a medical treatment choice.

Similarly, the constitutional value attached to protection of personal health is also evident in this Court's decisions under the Eighth Amendment. This Court has held that the Eighth Amendment's proscription of cruel and unusual punishments is violated by 'deliberate indifference to serious medical needs of prisoners." *Estelle* v. *Gamble*, 429 U.S. 97, 104 (1976). Thus, even an individual whose liberty interest has been constitutionally abridged retains a privacy right to receive medical care as part of the abstract protection against cruel and unusual punishment. Again, there is no basis for arguing that the process of recognizing this fundamental right of a prisoner to receive medical care is derived from anything more concrete or more settled than the right to make an individual treatment decision which can be drawn from the Due Process Clause.

Not only is the process of analysis under these other provisions similar to what *amici* propose here for the Due Process Clause, but also the entire fabric of the Court's holdings regarding medical treatment decisions reflects a basic pattern in the Constitution which supports the right asserted in this case. See *Memorial Hosp.* v. *Maricopa County*, 415 U.S. 250, 259 (1974) (medical care constitutes "a basic necessity of life"). Repeated protection for a right under disparate sections of the Constitution indicates that the right is fundamental to and underlies the design of the Constitution itself. That is the case here.

The consistent close scrutiny by this Court of government attempts to interfere with personal interests in health and bodily security is not inadvertent. Rather, it demonstrates that these interests warrant the "funda-

mental" constitutional status that they have been granted throughout this Court's decisions. In sum, the Court should reaffirm both that there is a right of privacy generally incorporated into the "liberty" component of the Due Process Clauses and that the right extends to individual medical treatment decisions, including whether or not to terminate a pregnancy.

D. State Interference With A Fundamental Right Triggers Searching Judicial Examination Pursuant To The Compelling State Interest Test.

State "interference" with or "infringement" of a fundamental right triggers a searching judicial examination pursuant to the compelling state interest test. See *Roe* v. *Wade*, 410 U.S. at 155; *City of Akron*, 462 U.S. at 427. See also, *Shapiro* v. *Thompson*, 394 U.S. 618 (1969); *Miami Herald Publishing Co.* v. *Tornillo*, 418 U.S. 241 (1974). A state law which infringes a fundamental right is "presumptively unconstitutional," *Harris* v. *McRae*, 448 U.S. 297, 312 (1980) (quoting *Mobile* v. *Bolden*, 446 U.S. 55, 76 (1980)). It cannot withstand judicial scrutiny unless the state has a "compelling interest" and, in the abortion context, two elements of the compelling state interest test are met: the specific means chosen must be "reasonably related" to the state's compelling goals and thus consistent with sound medical practice; and those specific requirements must be carefully tailored to the state's purposes. Failure to satisfy either of these elements is fatal to the state's effort to infringe the woman's fundamental right. *City of Akron*, 462 U.S. at 426-31.

In much fundamental rights adjudication, a holding of infringement will doom a law because the state has no constitutionally recognized "compelling interest" in such an infringing enactment. In the abortion context, however, this Court has clearly recognized two "compelling" goals which can justify regulation of the decision whether or not to terminate a pregnancy. Thus, the state has a compelling interest in protecting the mother's health. *Roe*

v. *Wade*, 410 U.S. at 162-163; *City of Akron*, 462 U.S. at 428. Similarly, the state has a compelling interest in preserving the potential life of the fetus. *Roe* v. *Wade*, 410 U.S. at 162-163; *City of Akron*, 462 U.S. at 428.

However, the presence of a compelling purpose does not, *ipso facto*, ensure the constitutionality of the state's particular infringement of the fundamental right. As the Court explained in *City of Akron*, 462 U.S. at 434, "the existence of a compelling state interest in health, however, is only the beginning of the inquiry." Thus, a state's requirements must be "reasonably relate[d]" to the compelling goals. *Roe* v. *Wade*, 410 U.S. at 163; *City of Akron*, 462 U.S. at 434 n.19 (quoting *Doe* v. *Bolton*, 410 U.S. 179, 194 (1973). Typically, this "reasonably related" element of the test involves an inquiry into whether the state's requirements have a reasonable medical basis. "The State's discretion to regulate . . . does not, however, permit it to adopt abortion regulations that depart from accepted medical practice." *City of Akron*, 462 U.S. at 431. See *Planned Parenthood* v. *Ashcroft*, 462 U.S. 476, 487 (1983) (Powell, J.); *Planned Parenthood* v. *Danforth*, 428 U.S. 52, 78-79 (1976).

Second, state laws that interfere with or burden the right must be carefully tailored to the state's objective. See *Roe* v. *Wade*, 410 U.S. at 165; *Planned Parenthood* v. *Ashcroft*, 462 U.S. at 485 n.8; *City of Akron*, 462 U.S. at 438. The law must, in other words, not be overbroad and must, therefore, advance the compelling state interest without any additional and unnecessary interference with the fundamental right. *City of Akron*, 462 U.S. at 438-439.

Application of the compelling state interest test and its elements, and the striking of any balance between fundamental rights and compelling state interests, ultimately turns, of course, on the nature of the fundamental rights that are involved. The United States, however, proposes that in determining the permissible scope of state interference with the abortion decision, under either a "compelling interest" or "undue burden" analysis, this

Court should only take account of the effects of such interference on the woman's "interest in procreational choice." U.S. Brief at 22 n.16. This proposed approach is deeply flawed. It suggests that the Court should ignore the woman's fundamental interest in medical treatment decisions. Instead, abortions would be permitted only if the woman was "coerced" into becoming pregnant.

The United States' proposed analysis leaves no room for the woman to terminate a pregnancy to protect her own health or even to save her life. Obviously, denying her an abortion at that point is wholly irrelevant to the prior decision "whether or not to beget or bear a child," U.S. Brief at 22 (quoting *Carey* v. *Population Serv. Int'l*, 431 U.S. 678, 685 (1977)), which the government asserts should be the only "liberty interest" at stake. But, this Court already has held that the state cannot insist that there be a "trade-off" between the life of the mother and the survival of the fetus. *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747, 768 (1986), *Colautti* v. *Franklin*, 439 U.S. 379, 400 (1979).[30]

It is difficult to accept that the government believes that serious threats to a woman's health or even her life are not relevant in assessing the balance between the woman's right and the state's interests. The manifest shortsightedness of the government's reasoning undermines completely its proposed approach. In our view, it would be inconsistent with any reasonable notion of a "narrowly tailored" statute to hold that, in order to protect its interest in potential life, a state may, regardless

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[30] The direct one-to-one trade-off is what distinguishes this case from *Jacobson* v. *Massachusetts*, 197 U.S. 11 (1905). It is one thing to hold that the state can compel an individual to face a limited health risk in order to protect a significant number of other individuals and where even the specific individual's health is placed at significant risk if he or she is allowed to "opt out." It is fundamentally different to say that society can impose a direct and immediate burden and risk on one individual in order to benefit another.

of circumstances and irrespective of the severity of the threat to the woman's life or health, flatly prohibit all women from choosing, in consultation with their physicians, to have an abortion performed.

II. SECTIONS 188.029 AND 188.205 OF THE MISSOURI STATUTE UNCONSTITUTIONALLY INFRINGE THE FUNDAMENTAL RIGHT OF PATIENTS TO MAKE MEDICAL DECISIONS IN CONSULTATION WITH THEIR PHYSICIANS.

Given the fundamental nature of the woman's right in being able to decide whether to terminate a pregnancy, there are two types of state action which trigger heightened judicial scrutiny. First, heightened scrutiny is required when state laws interfere with the *woman's* decisions whether to enter into a physician-patient relationship with respect to abortion and whether or not to terminate her pregnancy. This Court has recognized specific situations when the compelling interest test should be applied: when a state abortion law imposes certain additional health risks on the woman; when a state law attempts to influence the woman's informed choice between abortion or childbirth through the physician-patient relationship; or when a state law imposes costs on a woman unique to the abortion procedure and out of proportion to any health benefits.[31]

Second, heightened scrutiny is appropriate when state laws interfere with a *physician's* ability to enter into a physician-patient relationship, to counsel the patient and to provide medically indicated care and treatment pertaining to the patient's pregnancy termination decision. Thus, there is infringement when a state law interferes with a physician's best medical judgment or is otherwise inconsistent with the state of medical knowledge and sound

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[31] *See, e.g., Harris* v. *McRae*, 448 U.S. at 328 (White, J., concurring) (additional health risks); *City of Akron*, 462 U.S. at 444 (influence woman's choice); *Planned Parenthood* v. *Danforth*, 428 U.S. at 69 (share decision-making authority); and *City of Akron*, 462 U.S. at 435, 438, 447 (costs unique to abortion).

medical practice, when a state law threatens the physician with sanctions which arise solely from abortion counseling and treatment, or when a state law imposes other burdens on a physician in the abortion context which could deter establishment of a physician-patient relationship or the discharge of professional obligations within that relationship.[32]

As explained below, two sections of the Missouri statute constitute infringements of this sort. These statutory sections deprive the physician of "the room he needs to make his best medical judgment" and to exercise that medical judgment "in the light of all factors . . . relevant to the well-being of the patient." *Doe* v. *Bolton*, 410 U.S. 179, 192 (1973). Moreover, these statutory sections also impermissibly burden the woman's decisionmaking ability by exposing her to unnecessary health risks and expense and by restricting her ability to obtain needed counseling. The net effect of these provisions is a regime of medically unsound practices that are contrary to the first principles of the patient-physician relationship. No legitimate state interest, much less a compelling one, justifies these departures from sound medical practice.

A. Section 188.029 Of The Missouri Statute Is An Unconstitutional Interference With The Right Of Patients To Make Important Medical Decisions In Consultation With Their Physicians.

Mo. Rev. Stat. § 188.029 provides that a physician must determine fetal viability before performing an abor-

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[32] See, *e.g.*, *Doe* v. *Bolton*, 410 U.S. at 195-200; *Planned Parenthood* v. *Danforth*, 428 U.S. at 453-54, *City of Akron*, 462 U.S. at 445, 450 (interference with best medical judgment); *Danforth*, 428 U.S. at 64, *City of Akron*, 462 at 448 (inconsistent with state medical practice); *Colautti* v. *Franklin*, 439 U.S. at 390, 394, 397 (sanctions solely from abortion role); *Danforth*, 428 U.S. at 79-80 (other burdens—record keeping requirement needs justification).

tion on any woman whom the physician has reason to believe is carrying a fetus of 20 or more weeks gestational age. *Amici* do not object to this requirement. Indeed, they recognize that it is reasonably related and narrowly tailored to the state's compelling interest in protecting viable fetal life.

The statute, however, goes on to require:

> In making this determination of viability, the physician shall perform or cause to be performed such medical examinations and tests as are necessary to make a finding of the gestational age, weight, and lung maturity of the unborn child and shall enter such findings and determination of viability in the medical record of the mother.

Significantly, this provision, as construed by the court of appeals,[33] is far more than a requirement that certain findings be made and that tests be performed if they are necessary to determine viability. Rather, the statute requires these specific findings and tests regarding gestational age, weight and lung maturity of the fetus in *all* cases--even those in which they are unnecessary to determine fetal viability. This inflexible requirement is medically inappropriate and not reasonably related to any legitimate goal of the state. To the contrary, it interferes with the physician's ability to follow sound medical

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[33] Missouri asserts that its statute only requires a physician to perform tests that are "necessary to make appropriate findings in the case before him." Brief for Appellant at 34. However, as recognized by the court of appeals:

> The state's argument appears premised on an entirely different statute . . .; the *Missouri* statute does not require doctors to make those tests necessary to determine viability. Rather, the statute plainly declares that in determining viability, doctors *must* perform tests to find gestational age, fetal weight and lung maturity.

851 F.2d 1071, 1075 n.5 (emphasis in original).

practices and impermissibly burdens the pregnant woman's fundamental right to make medical decisions in consultation with her physician.

A determination of viability represents a medical assessment of the fetus' chance of survival, *i.e.*, the physician's judgment that "there is a reasonable likelihood of the [particular] fetus' sustained survival outside the womb, with or without artificial support." *Colautti* v. *Franklin*, 439 U.S. at 388. The viability determination is dependent upon a large number of factors, each of which may require complex medical assessment. The importance of each of these factors and the medically appropriate method of measuring them will vary with the circumstances of the individual pregnancy. Indeed, this Court has consistently stressed that viability must be determined by the pregnant woman's physician in the exercise of his or her professional judgment considering the circumstances of the individual pregnancy. *Planned Parenthood* v. *Danforth*, 428 U.S. at 61, 64.

The challenged statute singles out three factors that can affect viability. First, the Missouri statute requires that physicians perform tests to determine fetal lung maturity. As the district court found below, 662 F. Supp. at 422 "the only method to evaluate [fetal] lung maturity is by amniocentesis." Requiring amniocentesis in all abortions after 20 weeks is contrary to sound medical practice. The medical literature clearly establishes that amniocentesis is a procedure that would be useless and contrary to accepted medical practice for the purpose of determining fetal lung maturity until about 34 weeks of gestation.[34] More important, "aminocentesis

[34] *Williams Obstetrics* at 273. Methods to assess fetal lung maturity were developed to allow physicians to select the appropriate time *in the third trimester* to intervene in a problem pregnancy, so that the infant delivered would be free of the respiratory distress syndrome, a common clinical problem encountered by preterm infants. *See* Cruikshank, *Amniocentesis for Determination of Fetal Maturity*, 25 Clin. Obstet. Gynec. 773 (1982).

imposes additional significant health risks for . . . the pregnant woman . . . ." [35] 662 F. Supp. at 422.

Second, the Missouri statute requires that physicians perform tests to determine gestational weight. However, *in utero* estimates of fetal weight are often not necessary or even useful in determining viability.[36] For example, a recent study observed that "obstetrical gestational age was found to be the best predictor of neonatal death, while sonographic estimated fetal weight [measured just 3 days before delivery] did not add significantly to this prediction." Chervenak, Berkowitz, Thornton, Kreiss, Youcha, Ehrenkranz, Hobbins & Berkowitz, *A Comparison of Sonographic Estimation of Fetal Weight and Obstetrically Determined Gestational Age in the Prediction of Neonatal Outcome for the Very Low-Birth Weight Fetus*, 152 Am. J. Obstet. Gynec. 47, 47 (1985).

Third, the Missouri statute requires that physicians perform tests to determine gestational age. Although gestational age is probably the best single determinant of fetal viability, it is often not necessary to perform any

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[35] Amniocentesis increases the risks of hemorrhage, infection and hematoma formation. Golde & Platt, *The Use of Ultrasound in the Diagnosis of Fetal Lung Maturity*, 27 Clin. Obstet. Gynec. 391, 396 (1984). At least one maternal death due to complications of amniocentesis has been reported. S. Elias & G. Annas, *Reproductive Genetics and The Law* 129 (1987). It can be difficult to tap the amniotic sac safely, because of the location of the placenta or fetus, or the absence of a significant amniotic fluid pocket. *Golde & Platt* at 397. Further, the delay necessary to schedule a non-emergency amniocentesis (about two weeks) increases the risk of an abortion. *See* 662 F. Supp. at 422 n.41.

[36] "[T]he best obstetric estimate of gestational age [based on LMP, pregnancy testing, and ultrasound if necessary is] a better predictor of neonatal mortality than birthweight." Verloove-Vanhorick, Verwey, Brand, Gravenhorst, Kiersc & Ruys, *Neonatal Mortality Risk in Relation to Gestational Age and Birthweight*, [1986] 1 Lancet 55, 55 .

"test" or "examination" to make this determination. "An accurate report of the last menstrual period ["LMP"] is the single most reliable piece of clinical information" in predicting gestational age. Smith, Frey & Johnson, *Assessing Gestational Age*, 33 Am. Fam. Physician 215, 219 (1986).[37] Thus, for example, if the physician has been seeing the woman regularly and is satisfied that her LMP date is accurate, there would be no need to perform *any* tests to determine gestational age. A physician who is uncertain as to the woman's LMP may utilize other means of determining gestational age. In order to obtain a more objective assessment, physicians rely on ultrasound, which still provides only a range of ages and may incorrectly date a pregnancy by as much as three weeks. Sabbagha, Tamura & Socol, *The Use of Ultrasound in Obstetrics*, 25 Clin. Obstet. Gynec. 735, 737-38 (1982). Thus, it must be left to the woman's physician to decide whether, and to what extent, to rely on such tests.

In sum, viability is a complicated medical determination to be made by an individual physician in light of all the circumstances of an individual pregnancy. There is no set of tests that is always necessary or even indicated. By requiring specific tests for *all* pregnancies of 20 weeks or more gestational age, regardless of the physician's professional judgment as to whether they are necessary or even useful to determine viability, Missouri attempts to interfere with the physician's medical judgment of whether an individual fetus is viable and which

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[37] Although some authors advocate routine use of ultrasound to determine gestational age, lack of accessibility and the high cost of this examination are often prohibitive. Moreover, recent research indicates that clinical markers [including LMP, the first appearance of auscultated fetal heart tones, the fetal height, and quickening], when consistently . . . applied, can be as accurate as ultrasound in assessing gestational age.

Smith, Frey & Johnson at 215.

variables are to be considered in the viability determination in a particular pregnancy. Compelling all physicians to perform such unnecessary tests in all cases imposes needless risk and expense on the pregnant woman and unconstitutionally interferes with the "central role of the physician" in "consulting with the woman about whether or not to have an abortion." *Colautti* v. *Franklin*, 439 U.S. at 387. For these reasons, the Missouri statute is unconstitutional.[38]

B. Section 188.205 Of The Missouri Statute Impermissibly Burdens The Constitutional Right Of Patients To Make Informed Medical Decisions In Consultation With Their Physicians.

Mo. Rev. Stat. § 188.205 (1986) provides:

> It shall be unlawful for any public funds to be expended for the purpose of . . . encouraging or counseling a woman to have an abortion not necessary to save her life.

This prohibition applies to all publicly funded Missouri physicians. By its terms, it precludes these physicians from "encouraging" *or* "counseling" a woman to have an abortion, except when the woman's life itself is at stake.[39]

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[38] Even accepting that the state's interest in the preservation of potential life becomes compelling prior to viability, this provision of the statute would nevertheless be unconstitutional because it fails the second prong of the compelling state interest test. Specifically, as detailed above, the requirement of performing tests to establish specific fetal variables that may bear on viability "depart[s] from accepted medical practice," *City of Akron*, 462 U.S. at 431, and in at least one respect, significantly increases the risks to the mother's health. Therefore the law is not "rationally related" to the state's compelling interest.

[39] Appellants take the position that § 188.205 merely prohibits the use of public funds "for the purpose of directly urging a woman to have an abortion not necessary to save her life," Brief for Appellant at 38. A plain reading of the "encouraging or counseling" ban does not support this interpretation. Thus, the court of ap-

The result is to deprive the woman of a full understanding of her medical condition and options. This is contrary to the most fundamental principles of medical practice. It is justified by no state interest, compelling or otherwise.

1. It is a fundamental principle of medical practice in this country that the patient has a right to make his or her own decisions about medical treatment. See *supra* at 28-35. It follows that a physician must fully and accurately disclose all of the information necessary to permit the patient to make an informed choice. As stated in ¶ 8.07 of the American Medical Association's *Current Opinions of the Council on Ethical and Judicial Affairs*:

> The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice . . . . The physician's obligation is to present the medical facts accurately to the patient or to the individual responsible for his care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice.

In order to discharge the obligation to help the patient make an informed choice, a physician must be free to counsel a patient about all relevant facts within the physician's knowledge or expertise that bear upon the patient's decision. Comprehensive and appropriate counseling includes apprising the patient of his or her current medical condition and prognosis, explaining the need for further testing or treatment, disclosing the full spectrum

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peals found that "the scope of the encouraging or counseling ban appears literally to be much broader than the interpretation offered by the state." 851 F.2d at 1078. The breadth of the statutory language makes it virtually inevitable that at least some patients of publicly funded physicians will be denied " 'any . . . comment relative to abortion' ". *Id.* at 1078 n.11.

of available medical options [40] and referral, if necessary, to an appropriate specialist or other provider.

2. Missouri's prohibition on the use of public funds for counseling a woman to have an abortion not necessary to save her life severely restricts the ability of physicians who receive public funds to provide their patients with necessary and appropriate medical information. By forbidding comprehensive medical counseling, § 188.205 unduly constricts and distorts the physician-patient dialogue in a manner which is inconsistent with professional ethics and the provision of sound medical care.

Specifically, § 188.205 would limit the ability of certain physicians to provide needed medical information about abortion to pregnant women where abortion is not "necessary" to save the woman's life—even if the pregnancy poses a serious threat to her life or health. See *supra* at 13-18. It would apply, moreover, even if pregnancy termination is an option which the physician, in his or her medical judgment, normally would discuss with the patient. In addition to threatening the life or health of the pregnant woman, certain maternal disorders greatly increase perinatal mortality and morbidity. For example, 20-50% of pregnant women with AIDS pass on their infection to the fetus. Minkoff, *Care of Pregnant Women Infected With Human Immunodeficiency Virus*, 258 J.A.M.A. 2714, 2715 (1987). A physician must be free to disclose to a pregnant woman the serious threat that her medical condition poses to her fetus, and

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[40] For example, the American College of Obstetricians and Gynecologists, *Standards for Obstetric-Gynecologic Services* 57 (6th ed. 1985), provides:

> In the event of an unwanted pregnancy, the physician should counsel the patient about her options of continuing the pregnancy to term and keeping the infant, continuing the pregnancy to term and offering the infant for legal adoption, or aborting the pregnancy.

to counsel the woman, if appropriate in the circumstances of the patient's medical situation, that pregnancy termination is an option. The prohibitions of § 188.205 prevent such necessary medical counseling and thereby impair the ability of physicians to act in accordance with medical ethics and their best medical judgment.

In short, the prohibitions of § 188.205 severely limit the free flow of vital medical information between physician and patient. They require physicians to withhold needed medical counseling and thereby compel them to give their patients medically incomplete and potentially misleading information. By prohibiting counseling for abortion without regard to the patient's individual medical needs, the statute effectively precludes an informed dialogue between patient and physician about her particular circumstances. Section 188.205 seriously intrudes upon the integrity of the physician-patient relationship and compels physicians who receive public funding to turn their backs on principles of medical ethics, sound medical practice, their own best clinical judgment and the medical needs of their patients.

3. This Court repeatedly has warned against governmental intrusions into the informed consent dialogue between physicians and their patients. In *Thornburgh* v. *American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), the statute at issue compelled physicians to provide, *inter alia*, five kinds of information to a woman prior to receiving her consent for pregnancy termination. The Court declared that this type of governmental intrusion into the decisionmaking process "is the antithesis of informed consent," *id.* at 764, and that it "intrudes upon the discretion of the pregnant woman's physician." *Id.* at 762. See also *City of Akron*, 462 U.S. 416.

Section 188.205 provides an even more constricting "straitjacket" than did the statutes at issue in *Thornburgh* and *City of Akron*. There, although required to

provide certain information, physicians were free to supply their patients with any additional, medically appropriate information they wished to provide. Here, by contrast, physicians are *forbidden* from providing necessary and appropriate medical information that is responsive to the needs and requests of their individual patients.[41]

4. Missouri attempts to save its statute by analogizing § 188.205 to the statutes considered in *Harris* v. *McRae*, 448 U.S. 297 (1980), and *Maher* v. *Roe*, 432 U.S. 464 (1977). Brief for Appellant at 36-38. *McRae* and *Maher* are inapposite. In those cases, this Court held only that it was permissible for the government to exclude the *performance of abortions* from the medical procedures it was willing to fund. Neither case involved government distortion of the personal medical decisionmaking process that takes place between a physician and a patient. Indeed, in both cases the Court was careful to stress that a mere failure to pay created no obstacle to a woman's effectuation of her rights. *McRae*, 448 U.S. at 317.

By contrast, if the patient accepts the physician's state-limited information as trustworthy "medical advice," she will rely on the distorted consultation, often to her detriment. She will be given medically incomplete and

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[41] The court of appeals held that § 188.205 is unconstitutionally vague, "because the word 'counsel' is fraught with ambiguity; its range is incapable of objective measurement." 851 F.2d at 1078 (citing *Baggett* v. *Bullitt*, 377 U.S. 360, 367 (1967) (footnote omitted)). The court of appeals recognized:

> The prohibition on 'encouraging or counseling' implicates both first and fourteenth amendment rights of both physicians and their patients . . . .
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> * * * *
>
> [P]ossible targets of the statute are chilled into avoiding even speech that is normally afforded the utmost protection under the Constitution.

851 F.2d at 1078. *See supra* note 39. *Amici* agree with this analysis.

often misleading information. The court of appeals correctly identified the burden the statute imposes and why it is unconstitutional:

> Missouri is not simply declining to fund abortions when it forbids its doctors to encourage or counsel women to have abortions. Instead, *it is erecting an obstacle in the path of women seeking full and uncensored medical advice about alternatives to childbirth.*

851 F.2d at 1080 (emphasis added).[42]

Like the court below, "[w]e can perceive of few obstacles more burdensome to the right to decide than a state-imposed blackout on the information necessary to make a decision." *Id.*[43]

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[42] A state is not free to interfere with a patient's fundamental right to make an informed personal medical decision in consultation with her physician simply because that interference is accomplished as a condition for receipt of government funds. *See e.g., Perry* v. *Sindermann*, 408 U.S. 593, 597 (1972). Once the government undertakes to fund medical services, it may not interfere with the provision of sound medical advice by physicians who perform those services. To do so offends established standards of medical practice and ethics.

[43] The argument that the state's interest in protecting potential life is compelling prior to viability would not preserve the constitutionality of this provision of the statute. First, it is not rational for the state to effectuate even a compelling interest in fetal life by providing the woman with medically incomplete and misleading information in the context of the physician-patient dialogue. Second, the scope of the statute's restrictions is not narrowly tailored to any possible interest in protecting fetal life. For example, the statute would prohibit a physician from advising a pregnant patient about abortion as an option even in circumstances where there is no possibility that the fetus could survive, such as where an ultrasound examination has confirmed that the fetus is anencephalic.

CONCLUSION

The judgment of the court of appeals declaring Sections 188.029 and 186.205 of the Missouri statute unconstitutional should be affirmed.

Respectfully submitted,

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March 30, 1989

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