Roe! Doe! Where Are You?: The Effect of the Supreme Court's Abortion Decisions

I. INTRODUCTION

On January 22, 1974, more than 1000 persons gathered on the steps of the Federal Building in San Francisco and rallied against abortion.[1] The occasion for the protest was the first anniversary of *Roe v. Wade*[2] and *Doe v. Bolton*,[3] two abortion cases that had been decided by the United States Supreme Court. The Court's decision in these two cases, in effect, rendered every state's anti-abortion statute unconstitutional.[4] Besides sparking nation-wide protest one year later,[5] these abortion decisions have inspired a plethora of law review articles examining the Court's rationale contained therein.[6] This article will discuss the effect of *Roe* and *Doe*, with emphasis on their effect in California. The discussion will consider the questions raised by the Court's holdings as well as the questions answered by the Court in these cases.

II. THE THREE TRIMESTERS[7]

In *Roe*, the Court held that the right of a woman to terminate her pregnancy was a "fundamental right" grounded on the right of privacy and protected by the Constitution.[8] Any regulation limiting

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[1]San Francisco Chronicle, Jan. 23, 1974, at 4, col. 3.
[2]Roe v. Wade, 410 U.S. 113 (1973).
[3]Doe v. Bolton, 410 U.S. 179 (1973).
[4]The New York abortion statute is the only state statute arguably left totally unaffected.
[5]*See* TIME, Feb. 4, 1974, at 60 [hereinafter cited as TIME].
[6]*E.g.*, Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 FORDHAM L. REV. 807 (1973); Comment, *Roe v. Wade and Its Critics*, 53 B.U. L. REV. 765 (1973); Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920 (1973) [hereinafter cited as Ely]; R. Epstein, *Substantive Due Process by Other Name: The Abortion Cases*, 1973 S.CT. REV. 159.
[7]The period of pregnancy is divided into three "trimesters." The Court notes in *Roe* at 125, that the normal period of gestation is 266 days. This would make each trimester approximately 12 weeks long. Each trimester is a rough parallel of each period of pregnancy marked off by the Court's holdings.
[8]410 U.S. at 153 (1973).

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this fundamental right could be justified only by a "compelling state interest."[9] The Court went on to find that 1) there was no compelling state interest in regulating abortion during the first trimester of the pregnancy and that if the decision to abort was reached by a patient and her doctor during this time, the abortion could be effectuated free of interference from the state;[10] 2) that the State's important and legitimate interest in the health of the mother became "compelling" at approximately the end of the first trimester and the State could regulate the abortion procedure to the extent that the regulation reasonably related to the preservation and protection of maternal health;[11] and 3) that the State's other important and legitimate interest in protecting the potentiality of human life became "compelling" at viability of the fetus, and the State could go so far as proscribing abortion altogether during that period except when the abortion was necessary to preserve the life or health of the mother.[12]

The Court, thus, separated the length of pregnancy into three periods and made separate holdings for each period. This article will discuss the effect of these holdings with respect to each separate period of pregnancy as delineated by the Court.

A. THE FIRST TRIMESTER

1. WHEN CAN REGULATION BEGIN?

Any application of a rule which depends on the stage of pregnancy must face the initial difficulty of determining in which stage the pregnancy is. In order to make such a determination, a physician must often rely on the statements of his patient concerning the time of her conception. These reports to the physician by the patient may be inaccurate for any number of reasons, including the possibility of deliberate mis-information given by the patient intent on fitting her case within the legal limit for an abortion.

With accurate information from his patient, the physician can normally approximate the gestational age of the fetus; yet, at best, it remains an estimation. Even in the most experienced hands, the length of the gestational period can be difficult to determine. As one eminent physician has related:

> At Cornell Medical Center, one of our cases — a twin pregnancy — was estimated to be 22 weeks' gestational age at the time the abortion was performed. Yet, one of the twins was born alive and

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[9] 410 U.S. at 154 (1973).
[10] 410 U.S. at 163 (1973).
[11] *Id.*
[12] *Id.* at 163-164.

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weighed 840 grams. Obviously, our determination of gestational age was off by some weeks.[13]

A second difficulty in determining when State regulation of abortion may begin occurs because of the Court's own inexactness on the subject. The Court holds that the State's interest in maternal health becomes compelling at "approximately" the end of the first trimester.[14] Does this mean that the legislature may determine that this compelling point occurs at any particular time within the approximate end of the first trimester? Or does this mean that the "compelling point" must be determined on a case by case method? For that matter, at what point does the first trimester reach its "approximate end?" These questions, and the general one of when is the exact point at which regulation becomes legitimate, may perhaps remain academic ones, since any regulation immediately after this point will necessarily be minimal.[15]

2. *THE EFFECT OF RELYING ON MEDICAL KNOWLEDGE*

The Court makes its holding "in the light of present medical knowledge."[16] Thus, as medical knowledge changes, so may the Court's holding change. Yet, Chief Justice Burger has noted in a different case: "The commands of the Constitution cannot fluctuate with the shifting tides of scientific opinion."[17] Prevailing medical opinion on the dangers of abortion is a particularly unsteady foundation on which to build a constitutional decision. Because of the general illegality of abortion in the last one-hundred years and longer, the data on the risks of abortion are still quite limited and far from conclusive.[18] For example, it is as yet too early to assess possible delayed complications due to abortions, such as infertility, spontaneous abortions, premature labor, or long-term emotional

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[13] Statement made by Dr. Fuchs, *Symposium on Legal Abortion*, in *Legal Abortions in New York State: Medical, Legal, Nursing, Social Aspects* (G. Schaefer, M.D. ed.), 14 CLIN. OBST. AND GYNEC. 304 (1971) [hereinafter cited as *Abortion in New York*].

[14] 410 U.S. at 163 (1973).

[15] Though the State may begin abortion regulation some time near the end of the first trimester because of its compelling interest in preserving the health of the pregnant woman, any legislative enactment must be narrowly drawn to express only that interest. 410 U.S. at 155 (1973). Of course, though the restriction may be minimal, its disregard by a physician may expose him to the serious charges of criminal abortion. *See infra* note 54.

[16] 410 U.S. at 163 (1973).

[17] Eisenstadt v. Baird, 405 U.S. 438, 470 (1972) (dissenting opinion of Chief Justice Burger); *see also*, Ely, *supra* note 6, at 942, n. 117.

[18] From the 19th Century until the last few years, every state in the Union has had strict criminal statutes against abortion. Until recent reform in England, for example, the criminal statute against abortion dated back to 1803. *See* Schwartz, *Psychiatry and the Abortion Laws: An Overview*, 9 COMPREHEN. PSYCHIAT. 99 (1968).

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problems — for the simple reason that legal abortion is such a recent phenomenon.[19] As the studies come in and are tabulated, it is quite possible that they will show that abortion in the first trimester is more dangerous than continuing the pregnancy. Even now, in the light of some of the experiences of legal abortions, physicians are questioning the presumed safety of the abortion operation.[20] If medical authorities feel constrained to reverse their opinion on the dangers of abortion, would the Supreme Court, in turn, feel constrained to reverse its opinion?

There is a more basic objection to reliance on medical opinion in these abortion cases. The Court holds that at the end of the first trimester the State's interest in the protection of maternal health becomes compelling and overrides the woman's right to terminate her pregnancy

> because of the new established medical fact . . . that until the end of the first trimester mortality in abortion is less than mortality in normal childbirth.[21]

The Court, in effect, has switched the basic issue from the question whether a woman has the right to an abortion free of interference from the State to whether the abortion is as safe or safer than childbirth. By making the constitutional question turn on whether the abortion in question is more or less safe than childbirth, the Court risks anomalous results. For example, suppose new breakthroughs in pregnancy care and childbirth make it safer to have a child than to have an abortion in the first trimester. Under the rationale of *Roe* and *Doe*, this would make the same anti-abortion laws struck down in those cases suddenly constitutional. Or suppose abortion techniques themselves became safer, yet improvements in childbirth techniques outpaced the abortion technique improvements. Then state regulation of abortion would be constitutional, even though the State would be regulating abortions that were safer than those in question in both *Roe* and *Doe.*

However, given abortion's new legal status and acceptance, it is more likely that unhampered medical research and experience will result in improved techniques that will make abortions performed well beyond the first trimester safer than childbirth. In that case, the argument could equally well be made under *Roe* that abortions well into the second trimester cannot be regulated by the State. Due to recent advances in obstetric practice, suggestions were made even prior to the *Roe* and *Doe* decisions that abortions be permitted as

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[19]*See* the Court's discussion in *Roe* of the recent development of the liberalized abortion laws, 410 U.S. at 140 (1972).
[20]*See, e.g.,* Stallworthy *et al., Legal Abortions: A Critical Assessment Of Its Risks,* 2 LANCET 1245 (1971); *see also,* Good, IV BR. MED. J. 270 (1971).
[21]410 U.S. at 163 (1973).

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late as 15 weeks of gestation.[22] However, the Court in *Roe* has chosen not to consider the dangers in themselves of abortion in order to determine when State regulation of abortion becomes legitimate; rather, the Court precludes such an approach by comparing the respective dangers of abortion and childbirth in order to determine when abortion regulation becomes legitimate.

3. ABORTION . . . IN THE OFFICE?

Though the Court holds that the State cannot regulate an abortion performed during the first trimester by a licensed physician, one wonders how literally such a holding is to be read. Does this mean that a physician is free to perform an abortion in his office? The Court's opinion in *Roe* indicates as much, when it gives as an example of some of the permissible state regulations during the second trimester:

> . . . the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status . . . the licensing of the facility; and the like.[23]

By saying that this is one kind of regulation permissible in the second trimester, the Court implies that the State cannot regulate the type of abortion facility used in the first trimester. Yet, an argument consistent with *Roe* and *Doe* can be made for the constitutionality of state legislation which outlaws any abortion performed in a physician's office, even during the first trimester.

Reflection on the abortion situation in New York at the time when *Roe v. Wade* was handed down may be helpful here. In 1970, New York passed an abortion act which is more similar to what the Court outlines in these two cases than any other abortion statute in the country. It permits an abortion to be performed for any reason up to the 24th week of pregnancy, provided that the abortion is performed by a licensed physician. The law does not specify that abortions must be performed in a hospital setting. After the law went into effect, a few horrendous cases of office abortions in New York City were reported.[24] There were six office abortion deaths in New York City alone in the first three and a half months after abortion

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[22] Glanville, *The Legalization of Medical Abortion*, 56 EUGENICS REV. 19, 23 (1963-65) [hereinafter cited as Glanville]. Here, too, is an example of the confusing terminology regarding pregnancy dating. Actually, Glanville suggests here that abortions be permitted until the 17th week of pregnancy. However, he then goes on to say, "If this 17 weeks were reckoned according to the usual medical method of dating pregnancy, it would mean that the fetus would on average be only 15 weeks only, not 17."

[23] 410 U.S. at 163 (1973).

[24] Overstreet, *Logistic Problems of Legal Abortions*, 61 AM. J. PUBLIC HEALTH 496, 499 (1971) [hereinafter cited as Overstreet].

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was legalized.[25] Yet, there were only thirteen deaths in New York altogether that were associated with induced abortions in the first six months after the new law went into effect, and more than 98% of abortions reported in New York during that time were performed in hospitals.[26]

In view of this, the Board of Health of the City of New York adopted a resolution on Sept. 17, 1970, which provides that abortions be performed only by physicians operating in a place or facility where there is qualified supervision in obstetrics or surgery and where equipment, staff, and facilities are provided to handle any complications that may arise.[27] The regulation goes on to specifically set forth in great detail the requisite facilities for the performance of an abortion, with the practical result that few private doctors' offices in New York City will be able to meet these requirements.[28]

The question remains whether such a regulation as New York City's is now permissible after the *Roe* and *Doe* cases. Obviously, it should be incumbent upon public health authorities to ensure that the risks of abortion are absolutely minimal. It is no answer to say that the State cannot specify the facilities where abortions may be performed because it doesn't do so for other kinds of operations. The question is whether it would be unconstitutional, not unorthodox, for the State to restrict abortions from being performed in doctors' offices.

Implicit in the Court's use of facility-regulation as an example of permissible state regulation in the second trimester is the idea that the State can make regulations to protect the health of the mother. Indeed, the thrust of the Court's holdings in these two cases is that the State has a legitimate and overriding interest in protecting the health of its citizens, and the constitutionality of any abortion regulation (at least until the State's interest in protecting the life of the fetus becomes legitimate) depends on whether such regulation reasonably relates to that interest.[29] Thus, if it can be shown that office abortions are unduly dangerous, legislation by a State which outlawed abortion performed in a doctor's office could be defended as consistent with the Court's holdings in *Roe* and *Doe* despite language in those opinions which suggest the contrary.

The primary argument for disallowing abortions performed in a

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[25] *Id.*
[26] Ingraham *et al., Abortion in New York State Since July 1970,* in *Abortion in New York, supra* note 13, at 7 [hereinafter cited as Ingraham].
[27] McLaughlin, *Abortion Standards, New York City Board of Health,* in *Abortion in New York, supra* note 13, at 25.
[28] Holtzman, L., *Medical-Legal Considerations of Abortions in New York State Under the New Abortion Law,* [hereinafter cited as Holtzman] in *Abortion in New York, supra* note 13, at 46.
[29] 410 U.S. at 163 (1973).

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physician's office is that they are more dangerous than childbirth. Since this is the yardstick that the Court is using to determine the "compelling point" at which State regulation of abortion can begin, it follows that the compelling point at which abortions performed in physicians' offices can be regulated occurs in the first trimester. If it could be shown only that abortions performed in physicians' offices are distinctly more dangerous than abortions performed in a hospital setting, though still less dangerous than childbirth, the alternative argument is that a regulation outlawing abortions performed in doctors' offices would still be constitutional because it would then be a valid exercise of the State's right to preserve the health of its members.

There are studies which would back up such arguments by the State. For example, in Hungary, in cases where abortions were all performed within twelve weeks of gestation and in hospitals, the early complication rate was 1.8%.[30] In cases where abortions are performed in a physician's office rather than a hospital, then, serious complications such as hemorrhage are suffered in a setting unsuitable for providing remedial care. This fact becomes even more significant when it is noted that the complication rate in the United States may very well be higher than in Hungary due to the general lack of experience in performing these operations in this country.

Furthermore, the evidence on which the Court bases its conclusions that abortions performed in the first trimester are as safe or safer than childbirth was gleaned from studies of abortions performed in a hospital setting. But to say that abortion is as safe as childbirth is not to say that abortions performed in a doctor's office are as safe as childbirth. In fact, there are doctors who flatly assert that office abortions are unsafe.[31] And even if an early abortion performed in a doctor's office is considered a fairly safe operation, this should not mean that restrictions which would make the operation even safer ought to be precluded. It must be recognized that terminations of pregnancy at any of its stages carries at least some medical risk, and the State has the right, if not the duty, to minimize that risk.

4. *ABORTION . . . ON DEMAND?*

a. *In General*

The most controversial issue surrounding the *Roe* and *Doe* decisions has been that of "abortion on demand." Has the Supreme Court, in fact, created abortion on demand? The concurring opinion

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[30] Hall, *Abortion: Physician and Hospital Attitudes*, 61 AM. J. PUBLIC HEALTH 517, 518 (1971) [hereinafter cited as Hall].
[31] *Id.*

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of Chief Justice Burger says, in effect, "of course not."[32] The dissenting opinion of Justice White suggests the contrary.[33]

Justice Blackmun's majority opinion assumes it has not created abortion on demand. In *Roe*, Justice Blackmun admits that "the right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy."[34] However, he is quick to add in the next paragraph that he does not agree that "the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses."[35]

Of course, the question is not really whether the Court has created an absolute right to abortion on demand; the answer to such a question is clearly no. However, the Court has opened the way to what might be called a "limited abortion on demand," at least during the first trimester.

During the first trimester the attending physician, in consultation with his patient, is free to determine that in his medical judgment the patient's pregnancy should be terminated, and may without further ado perform the abortion.[36] To determine if this entails abortion on demand it is necessary to understand what "medical judgment" means in this context. The majority opinion notes some of the many factors that would necessarily be considered by a physician in making his judgment:

> Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is the distress . . . associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases . . . the additional difficulties and continuing stigma of unwed motherhood . . . .[37]

Justice Douglas in his concurring opinion in these two cases mentions the following hardships which "may be properly embraced . . . as part of a broader medical judgment based on what is 'appropriate' in a given case, though perhaps not 'necessary' in the legal sense":[38]

> . . . childbirth may deprive a woman of her preferred life style and force upon her a radically different and undesired future. For example, rejected applicants under the Georgia statute are required to endure the discomfort of pregnancy; to incur the pain, higher mortality rate, and aftereffects of childbirth; to abandon educational

[32]410 U.S. at 208 (1973) (Burger, C.J., concurring).
[33]410 U.S. at 221 (1973) (White, J., dissenting).
[34]410 U.S. at 153 (1973).
[35]*Id.*
[36]*See supra* page 433.
[37]410 U.S. at 153 (1973).
[38]410 U.S. at 216 (1973) (Douglas, J., concurring)

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> plans; to sustain loss of income; to forego the satisfaction of careers; to tax further mental and physical health in providing childcare; and in some cases, to bear the lifelong stigma of unwed motherhood, a badge which may haunt, if not deter, later legitimate family relationships.[39]

Almost every woman seeking an abortion will be affected by at least some of these factors mentioned by the Court. Since the Court explicitly permits physicians to consider all these factors, it seems quite likely that *Roe* and *Doe* will result in at least "abortion on request," if not "abortion on demand." Though the patient cannot demand an abortion from her physician, in almost every instance a physician could grant his patient's request for an abortion by basing his decision on one of the factors mentioned by the Court.

b. In California

Some commentators on abortion practice in California maintain that abortion "on request" has effectively been practiced since passage of the 1967 Therapeutic Abortion Act.[40] The statistics seem to bear out such a conclusion. Legal abortion in California had an explosive four-year development after the act was passed. For example, the rate of annual increase in the number of abortions was threefold from 1968 to 1969, and was still 160% from 1970 to 1971.[41] In 1971 the number of abortions exceeded 100,000 for an estimated ratio of 270 abortions per 1,000 births.[42] It has been reported that in 1972, San Francisco hospitals alone were responsible for almost 15,000 therapeutic abortions.[43] While it is uncertain how many of these abortions might have been performed illegally in any case, the increase in the number of legal abortions being performed in California is nevertheless dramatic.

To protect against abortion on request, the California legislators had included in the Act the requirement that if an abortion were to be performed for mental or physical health reasons, there must be a substantial risk of grave health impairment if the abortion were not performed.[44] It further specified that mental health was defined in this context as

> mental illness to the extent that the woman is dangerous to herself

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[39] *Id.* at 214-215.

[40] *See, e.g.*, Kummer, *New Trends in Therapeutic Abortion in California*, 34 OBSTET. GYNECOL. 883 (1969) [hereinafter cited as Kummer]; Moyers, *Abortion Laws: A Study in Social Change*, 7 SAN DIEGO L.J. 238, 241 (1970) [hereinafter cited as Moyers].

[41] California State Dept. of Public Health, Bureau of Maternal and Child Health, *California Statistics for 1971. Annual Report on the Implementation of the California Therapeutic Abortion Act.*

[42] *Id.*

[43] San Francisco Chronicle, *supra* note 1.

[44] CAL. HEALTH & SAFETY CODE § 25951 (West Supp. 1973).

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> or to the person or property of others or is in need of supervision of others.[45]

Yet, even with such seemingly strict guidelines, hospital committees in California had been approving requests for abortion simply on the assumption that an unwanted pregnancy is in itself a threat to the emotional stability of the woman and therefore a threat to mental health.[46]

There is growing evidence to support just such an assumption. Some psychiatric studies have shown that to force a woman to carry a pregnancy against her will is almost inevitably a detriment to her own mental health and to that of the child as well.[47] In fact, one California physician knowledgeable on the abortion question contends that abortion is an instinct and defense against mental illness in susceptible women.[48] Given this trend of thought in the medical world, it seems likely that "abortion on request" will be the result of the *Roe* and *Doe* decisions in areas, like California, where physicians are generally less inhibited about performing abortion. At the very least, it seems unlikely that the medical judgment of the physician who permits an abortion to be performed will ever seriously be questioned by the Courts.

5. THE RELATED QUESTION OF "ABORTION MILLS"

In the past, a back office set up by a doctor whose sole function was to perform an abortion on any woman who asked for one was referred to as an "abortion mill." However, in the modern parlance of legalized abortion, these "mills" may well be referred to as "private clinics specializing in terminations of pregnancy." The question that devolves from this is whether the State has a remedy to protect itself from such clinics that confine themselves to terminations of pregnancies in the first trimester.

The immediate response to this question is a further question: remedy for what? According to the considered judgment of many doctors, an abortion is appropriate on the bare facts that the patient desires the abortion and that the operation would entail no unusual risk.[49] Thus, the "abortion mill" is performing the same function as any doctor or hospital which permits abortions on this basis. Furthermore, a clinic which specialized in abortions would be fully equipped for the operation and would staff physicians who are com-

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[45] CAL. HEALTH & SAFETY CODE § 25954 (West Supp. 1973).
[46] Moyers, *supra* note 40, at 241.
[47] *See, e.g.,* Forseman and Thuwe, *120 Children Born After Application For Therapeutic Abortion Refused,* 42 ACTA PSYCHIAT. SCANDINAV. 71 (1966); Hood, *Refused Abortion,* 37 ACTA PSYCHIAT. 203 (1961).
[48] Kummer, *supra* note 40, at 883.
[49] *See supra* page 441.

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petent and experienced in terminations of pregnancy. Thus, no remedy is needed.

Granted, this would be a valid argument in favor of most clinics that specialize in abortion. And there is no reason why such clinics should not be permitted to function unhampered by the State during the first trimester. As Chief Justice Burger notes in answer to the dissent's expressed fear of "abortion on demand":

> the dissenting views discount the reality that the vast majority of physicians observe the standards of their profession and act only on the basis of carefully deliberated medical judgments relating to life and health.[50]

However, it is the function of law to deal not with the vast majority who obey the law, but with the small minority who don't; thus, the problem of the physician who caters indiscriminately to patients asking for abortions must be considered. We begin with the fact that a physician must necessarily be given a wide latitude in his discretion concerning the appropriateness of an abortion for his patient.[51] We add to that the fact that it may be difficult, if not impossible, to show an abuse of medical judgment when a physician has deemed an abortion appropriate.[52] We follow, nevertheless, with the conclusion that there are indeed cases where an abuse of medical judgment can occur.

For example, if before the operation the patient was not counseled by the physician or some other qualified person concerning her abortion, the physician would be abusing his "medical judgment." At the very least, the physician should determine prior to the operation that the woman truly desires an abortion. Acceptance at face-value of a patient's decision to terminate her pregnancy, perhaps made while under severe stress, is hardly the "carefully deliberated medical judgment" that Chief Justice Burger is talking about. Indeed, it is really no judgment at all. Such a case would give life to the Court's admonition:

> If an individual practitioner abuses the privileges of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available.[53]

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[50]410 U.S. at 208 (1973) (Burger, C.J., concurring).

[51]*See* 410 U.S. at 166 (1973), where the Court says that during the first trimester " . . . the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician."

[52]One physician has stated that the determination of the consequent stress on mental health from an unwanted pregnancy must be determined for an individual patient by consideration of no less than her total life situation. He concludes with the remark that these judgments by the physician are "difficult to make, impossible to prove." Dr. Pike, in *Therapeutic Abortion and Mental Health,* 111 CALIF. MED. 318 (1969).

[53]410 U.S. at 166 (1973).

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The judiciary could remedy such a situation through criminal sanctions and/or malpractice suits.[54] On the other hand, the medical profession could remedy the situation with other measures, such as stripping the offending physician of his license.[55] Absent such a plain showing of abuse, however, the State should not be permitted to restrain the operation of clinics that specialize in terminations of pregnancy during the first trimester. Such State action would be contrary to the Court's holdings in *Roe.*

6. *THE ESCAPE CLAUSE*

It is important to remember that it is "abortion on request," not "abortion on demand," which the Court has created through these cases. Since the Court has recognized that the decision to terminate a pregnancy is basically a medical one and that the patient's physician is the one most competent to make this decision,[56] it is unlikely that, absent unusual circumstances, the Court will question that decision. Certainly, the Court will not intervene if the physician decides not to terminate the pregnancy. None of the justices in the various opinions rendered in these two cases ever concedes the right of a woman to an abortion merely on her demand. The Court makes it quite clear that though it rules that the State cannot restrain a physician from performing an abortion in the first trimester, neither can the State or Court ever force a physician to perform an abortion:

> . . . the hospital is free not to admit a patient for an abortion . . . Further, a physician or any other employee has the right to refrain for moral or religious reasons from participating in the abortion procedure.[57]

This language is similar to that found in the "escape clause" of California's Therapeutic Abortion Act of 1967. That clause vindicates the right of any person employed to furnish direct personal health services to a patient to refuse to have anything to do with an abortion, if such refusal is based on moral, ethical, or religious reasons.[58]

The significance of such an escape clause cannot be overemphasized. A woman who is denied her request for termination of her pregnancy has no remedy, other than "shopping" for a physician

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[54] *See, e.g.*, CAL. PEN. CODE § 274 (West Supp. 1973).
[55] *See, e.g.*, CAL. BUS. & PROF. CODE § 2377 *et seq.* (West 1962).
[56] *See supra* note 51 and accompanying text.
[57] 410 U.S. at 197-198 (1973).
[58] CAL. HEALTH & SAFETY CODE § 25955 (West Supp. 1973).
[59] *See* TIME, *supra* note 5. And even in California there are areas where it is difficult to obtain an abortion. *See* Overstreet, *Experience with the New California Law* in ABORTION IN A CHANGING WORLD Vol. I 137 (R. Hall ed. 1970) [hereinafter cited as *New California Law*].

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who will agree to terminate her pregnancy. Inevitably, this clause serves to maintain the status quo, since the availability of abortion will depend on the availability of doctors and hospital staffs that are not averse to performing abortions.

While such an escape clause may not hinder a woman from obtaining an abortion in a state such as California, women in many areas of the United States are presently finding it difficult to obtain an abortion.[59] Of course, the pregnant woman with the means to do so can travel to a region where physicians are more inclined to judge that termination of a woman's pregnancy is the appropriate measure. Still, the presence of the escape clause in these decisions may render the impact of *Roe* and *Doe* almost inconsequential in many pockets of the country. Thus, even if the State cannot prohibit abortions during the first trimester, the prohibition of abortion, at least to some degree, will be internalized by the medical profession. The importance of this consequence re-surfaces, *infra,* during discussion of the Court's holding concerning the third trimester.[60]

A related question is whether the escape clause enables a physician who denies an abortion to a woman to escape all legal liability. Surely the physician has a duty to his patient beyond the bare decision of whether or not to terminate her pregnancy. It is important for the patient to understand what this decision means to her, and what courses of action are still open for her. Civil liability may arise if the physician fails to inform the patient that he has elected not to give advice on the question of abortion.[61] Liability might also attach to the physician who is unwilling to perform an abortion and fails to advise the patient as to her need for an abortion or the consequences of a failure to have an abortion.[62]

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[60]*See infra* pages 453-454.
[61]In Stewart v. Long Island College Hospital, 296 N.Y.S.2d 41, 58 Misc. 2d 432 (1968), a hospital committee, deadlocked 2-2, refused a therapeutic abortion to a woman with the chance of bearing a deformed child. No abortion was performed, and the child was born with severe physical and mental disabilities. The mother was awarded damages of $10,000, based on a finding that the doctor in the hospital told her that she did not need an abortion and should not seek one elsewhere. The Court found malpractice on the part of the hospital in that it failed to inform the plaintiff-mother of the risk of not having an abortion. However, a contrary result was reached by the New Jersey Court in Gleitman v. Cosgrove, 227 A.2d 689, 49 N.J. 22 (1967). In that case, a malpractice action was brought by the parents against defendant doctors for their alleged negligence in failing to inform the mother that it was possible that the child would be born with birth defects so that the mother could, if she so elected, terminate her pregnancy. The Court held that the mother's damages, including emotional distress, were not cognizable at law; and even if they were, a claim for them would be precluded by the counteracting public policy supporting the preciousness of human life. *But see* Chief Justice Weintraub's and Justice Jacob's dissenting opinions, wherein they argue that the mother should be allowed to recover. *See also,* for a fuller discussion of these cases, Holtzman, *supra* note 28, at 41-44.
[62]*Id.*

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7. *THE EFFECT IN CALIFORNIA; SUMMARY OF FIRST TRIMESTER CONSIDERATIONS*

The *Roe* decision strips the State of almost all authority to regulate abortions performed in the first trimester. It serves as a basis for wholesale invalidation of the Therapeutic Abortion Act passed by the California Legislature in 1967, at least as far as the first trimester is concerned. The only requirement of the Act still relevant to the first trimester is that which restricts the performance of an abortion to licensed doctors.[63]

A woman in the first trimester of her pregnancy is now free to decide with her doctor to terminate her pregnancy and to effect that decision without regulation by the State. By placing termination of pregnancy within the ordinary course of medical practice, the *Roe* decision makes it more likely that a woman will go to her doctor in her trouble. She knows that he will do his best for her, and, if he sees fit, will be able to terminate her pregnancy without impediment by the State. On the other hand, if her doctor sees fit, he may be able to dissuade her from the operation. Too often in the past, the troubled woman would go straight to the back-street abortionists, who would give her no advice, and who might sometimes operate on her even when she would not in fact be pregnant.[64]

Given the already-widespread practice of legal abortion in California, the criminal abortion racket had to a large degree disappeared in the state before *Roe* and *Doe*. However, fear had begun to be expressed about the possibility of a "therapeutic abortion racket" developing in California.[65] In order to qualify for legal abortion under the 1967 Act's mental health provision, it was usually necessary to consult with high-priced specialists such as gynecologists and psychiatrists. By cutting down on the delay and the attendant costs that the Act's red tape necessitated, the Court's decision should put an end to these fears and should open the choice of pregnancy termination to lower-income groups heretofore unable to afford an abortion.[66]

B. FROM THE END OF THE FIRST TRIMESTER TO VIABILITY OF THE FETUS

1. *IN ROE*

The Court's opinion in *Roe* makes it clear that the State may

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[63] CAL. HEALTH & SAFETY CODE § 25951 (West Supp. 1973).
[64] Glanville, *supra* note 22, at 24.
[65] *New California Law, supra* note 59, at 139.
[66] *But see* amendment added to HR 3135, 93d Congress, 1st Session (proposed Social Security Amendments) by New York Senator James L. Buckley, which bans any payments for abortion under Medicaid. The Constitutional questions of such legislation are considerable.

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regulate abortions performed at or after the end of the first trimester.[67] However, the State's right to regulate abortion is still severely restricted. During the second trimester, and until viability,

> a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health. Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to the licensure of that person; as to the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less than hospital status; as to the licensing of the facility, and the like.[68]

In *Roe* the Court goes no further than this to explain how and what the State can regulate with regard to abortions after the first trimester but before viability. It merely sets this general standard, and gives these few specific examples.

2. *IN DOE*

Doe v. Bolton, *Roe's* companion case, helps to clarify how far a State can go in regulating abortion at this time. In this case, petitioner Mary Doe[69] herself was only nine weeks pregnant, well within the first trimester. The Court could have ruled in her favor by simply citing *Roe v. Wade.* Instead, the Court chose to use the *Doe* case to elaborate on the basic decision in *Roe*. Whereas the Texas statute in question in *Roe* was over a century old,[70] the Georgia statute in *Doe* had been recently enacted as a "reform" measure.[71] The Court in *Doe* discussed the new procedures required by the Georgia Act and ruled on the constitutionality of their application to second trimester pregnancies. While the opinion is mainly dictum,the issues involved were well-considered and comprehensively discussed; furthermore, it is dictum from the highest court of the land and meant to guide the lower courts. Thus, the *Doe* decision can serve as a measure of the constitutionality of some of the more modern abortion statutes, including California's Therapeutic Abortion Act of 1967.[72]

While *Roe* indicates some of the kinds of permissible State regulation during the second trimester, *Doe* indicates some of the kinds of impermissible State regulation during this time. The Court in *Doe* struck down the requirement that two doctors must concur on the original abortion decision by the patient's physician.[73] It also struck

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[67]410 U.S. at 163 (1973).
[68]410 U.S. at 163 (1973).
[69]A psuedonym; *see* 410 U.S. at 184, n. 6 (1973).
[70]410 U.S. at 119 (1973).
[71]*Id.* at 140.
[72]Both California and Georgia, as well as a dozen other states, adopted some form of the American Law Institute's Model Abortion Act when they reformed their respective abortion laws. *See* 410 U.S. at 140, n. 37 (1973).
[73]410 U.S. at 198-199 (1973).

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down the further requirement that a hospital committee approve the abortion decision.[74] The Court's rationale was that the requirement in *Roe* that the decision be made by a doctor exercising his best judgment provided adequate protection to the mother. Thus, further ratifications of the decision were not necessary to protect the health of the mother. Neither did the requirement that the woman desiring an abortion be a resident of Georgia bear a reasonable relation to the preservation and protection of maternal health: that requirement was also struck down.[75] On the same basis, the requirement that the abortion be performed in a hospital accreditated by the Joint Committee on Accreditation of Hospitals (JCAH) also fell.[76]

These rulings demonstrate that the State's right to regulate abortion during the second trimester is sharply qualified. The Court will not hesitate to strike down a regulation which has no real relation to the protection of maternal health. And if petitioner has some evidence to show that a regulation does not reasonably relate to maternal health, the State must present "persuasive data" to show that its regulation does serve that interest.[77]

It is important, though, to realize that these rulings are of only limited value when used to determine the degree to which the State can restrict abortion at this time. We only know from *Doe* to what degree the State cannot restrict abortion. For example, when the Court holds unconstitutional the requirement that abortions must be performed in hospitals, it is "because it [the requirement] fails to exclude the first trimester of pregnancy."[78] Thus, the constitutionality of this and other types of State regulation during the second trimester is still open to question. But at least some measure of constitutionality is clear: for any regulation at this time, the State must be prepared to show that such regulation is necessary to meet its acknowledged interest in insuring the quality of the operation and the full protection of the patient.[79]

3. THE EFFECT IN CALIFORNIA; A SUMMARY:

While the *Roe* decision acknowledged the State's authority to regulate abortion during the second trimester, the *Doe* decision placed specific limits on that authority. The Court found that the decision to abort made by a doctor using his medical judgment was an adequate safeguard to protect the mother's health, and that to

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[74] *Id.* at 196-197.
[75] *Id.* at 200.
[76] *Id.* at 194.
[77] *Id.* at 195.
[78] *Id.*
[79] *Id.* at 196.

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require ratification of that decision was unconstitutional. This serves as a basis to invalidate two of the requirements set forth in California's Therapeutic Abortion Act. These two requirements, namely, the JCAH hospital accreditation and hospital medical staff approval of the abortion decision, are essentially the same restrictions that were found unconstitutional in the Georgia statute.[80] However, what specific regulations the State is permitted to make during the second trimester remains unclear. What is certain is that any future legislation that California might want to adopt to control abortion during the second trimester must bear a reasonable relationship to the preservation of the woman's health.

C. AT AND AFTER VIABILITY OF THE FETUS

The Court's holding:

> With respect to the State's important and legitimate interest in potential life, the "compelling" point is at viability. This is so because the fetus then presumably has the capability of meaningful life outside the mother's womb. State regulation protective of fetal life after viability thus has both logical and biological justifications. If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period except when it is necessary to preserve the life or health of the mother.[81]

1. WHEN DOES VIABILITY OCCUR?

The initial problem with this holding is the difficulty of ascertaining when viability occurs. The Court defines "viability" clearly enough:

> [Viability is the] point at which the fetus becomes . . . potentially able to live outside the mother's womb, albeit with artificial aid.[82]

After saying this, however, the Court admits that when this point occurs is not very certain. Generally, it notes, viability is placed at about 28 weeks.[83] But, the Court adds, it may occur earlier, even at 24 weeks.[84] And actually, there are doctors who say that abortions performed beyond twenty weeks of gestation carry a risk of delivery of a live-born infant.[85] The problem of ascertaining when viability

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[80] *See* CAL. HEALTH AND SAFETY CODE § 25951 (West Supp. 1973). *See also* People v. Barksdale, 8 Cal. 3d 320, 105 Cal. Rptr. 1 (1972), where the California Supreme Court overturned a lower court decision (People v. Barksdale, 96 Cal. Rptr. 265, Cal. App. 813) which had ruled that these two requirements were unconstitutional on the same basis later adopted by the United States Supreme Court in *Doe.*

[81] 410 U.S. at 163-164 (1973).

[82] *Id.* at 160.

[83] *Id.*

[84] *Id.*

[85] *See, e.g.,* Ingraham, *supra* note 26, at 14; *see also* People v. Bakrsdale, 8 Cal.3d 320, 335, 105 Cal. Rptr. 1, 12 (1972).

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occurs is further aggravated by the aforementioned difficulty of dating the pregnancy.

In New York, for example, where a 24-week gestation limit is set for legal abortions, the New York City Department of Health, over a period of six months, received reports of eleven live births following abortion procedures.[86] Furthermore, two infants were discharged from hospitals and were reported to the Health Department, not as attempted abortions, but as live births.[87]

One commentator on abortion seems to have anticipated the Court's own language when he remarked:

> The notion of "viability" defined in any such simple fashion [as that time when the fetus is capable of living apart from its mother] is without biological and medical foundation.[88]

He adds, "The word does not even appear in standard medical indexes."[89] Then he suggests that if abortion of viable infants is really to be excluded, twelve weeks would be a more realistic time limit.[90]

Moreover, there are other factors than merely the gestational age that determine whether a particular fetus is viable or not. Besides the length of pregnancy, such factors as the weight and race of the fetus make a significant difference in determining viability.[91] Due to these other individual factors, a broad law defining when viability occurs is bound to be arbitrary. Perhaps the Supreme Court's failure to pinpoint the time when viability occurs was an implicit recognition of this fact; yet, how then is the State to implement the Court's holding that State restrictions on abortion can take account of the fetus only after viability?

2. A PUZZLE FOR THE LEGISLATOR

The uncertainty of the Court concerning when the fetus becomes viable creates a puzzle for the state legislator. When the Court notes that viability usually is placed at 28 weeks, is it suggesting to the

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[86] Ingraham, *supra* note 26, at 14.
[87] *Id.*
[88] G. GRISEZ, ABORTION: THE MYTHS, THE REALITIES, AND THE ARGUMENTS 32 (1970) [hereinafter cited as GRISEZ].
[89] *Id.*
[90] *Id.* at 462.
[91] Dr. Carl Erhardt and his colleagues (as reported by them in *Influence of Weight and Gestation on Perinatal and Neonatal Mortality by Ethnic Group*, 54 AM. J. PUBLIC HEALTH 1841 (1964)) studied mortality among infants born in New York City from 1958 to 1961. In general, they discovered that neonatal mortality — that is, deaths within the first 28 days of live birth — mounted steeply as the length of the pregnancy shortened below 30 weeks and as the birth weight dropped below 1500 grams (about 3 lbs., 5 oz.). About 45% of white and 58% of non-white babies born during the 26th or 27th week of pregnancy survived through the neonatal period. Even under twenty weeks of pregnancy, more than 20% of those born alive survived the neonatal period.

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legislator that a lower limit than that would be unconstitutional? Or by mentioning that viability may occur as early as 24 weeks, is the Court suggesting to the legislator that restrictions on abortion to protect fetal life may occur any time after 24 weeks? Or is the Court suggesting to the legislator that the State cannot make such a restriction on abortion before that time?

For example, suppose a state legislature made a particular finding that viability occurs at 22 weeks. Or, at least, due to the inherent inaccuracies of ascertaining gestational age, there is a risk of viable infants being born when the limit is more than 22 weeks. On that basis, it passed legislation outlawing abortions performed after 22 weeks. Would such regulation be contrary to the rule of *Roe v. Wade*? One might argue that the specific weeks mentioned by the Court wherein viability has been said to occur set boundaries within which the State, in its discretion, may determine viability; but that such a determination of viability by the State must be made within these boundaries.

Yet, perhaps the Court is saying that there are no boundaries. A patient-litigant and her doctor might make the alternate argument that by failing to designate a particular time for viability, the Court implies that no broad law designating the point of viability can be drawn by the State. Rather, the viability of the infant must be shown in each individual case as a matter of fact before the State's proscription of viable-fetus abortion becomes effective.

There are drawbacks to either argument. A definite, statutorily-set time of viability would inevitably cover some non-viable fetuses or leave out some viable fetuses — and possibly do both. On the other hand, leaving the physician free to determine in each case the viability of the fetus would entail *post facto* review for every case. Besides, in close cases, it would be impossible for a physician to determine whether a fetus were viable or not. Still, it must be remembered both that viability occurs at different times in different fetuses and that the determination of viability is a medical judgment in itself. Thus, it is probably more appropriate to leave the determination of viability to the discretion of the doctor in a case by case method. Again, "the usual remedies, judicial and intra-professional" should be available when the physician has abused his discretion.

3. VIABILITY, IN LIGHT OF MEDICAL PROGRESS

As we have seen, viability is relative to each fetus, and its occurence does not lend itself to a clear line of demarcation. Of course, before a certain point, there are no survivors. But this point, wherever it happens to be, is also relative: as methods of caring for the premature change, so too changes the point of viability. Because the Court recognizes this and includes in its definition of viability

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cases where the fetus is kept alive by artificial aid,[92] the point when the State could start prohibiting abortions may be moved up considerably if methods of caring for the premature improve. One commentator states:

> With improved techniques and equipment, going beyond the incubator towards the artificial womb, probably the vast majority of fetuses could survive apart from their mother after 12 or 14 weeks of pregnancy.[93]

Though not yet undertaken seriously, the project of an artificial womb to which an infant's umbilical cord could be attached is discussed among experts. Considered technically feasible, the project would be expensive and not very practical, since the infant would have to be removed surgically from the uterus. However, research toward this project has been widely reported.[94] Already, there have been experiments carried out on human fetuses.[95] If we ever reach the point where test-tube babies are possible — *à la* Huxley's *Brave New World*[96] — that is, where viability would occur at the point of conception, the broad State restrictions on abortion now permissible only during the third trimester could legitimately be applied to any abortion at any time of the pregnancy.

4. THE EXCEPTION CLAUSE:

To protect potential human life after viability of the fetus, the Supreme Court says that the State may go so far as to proscribe abortion altogether during this last period of pregnancy, except when necessary to preserve the life or health of the mother.[97]

The first question here is whether the State may go no further than this. The 14th Amendment specifically prohibits the State from depriving any person of life, liberty, or property without due process of law.[98] The Court's dictum here suggests that the 14th Amendment would be violated by a law proscribing abortion in cases where an abortion was necessary to preserve the woman's life or health. Certainly, violation of due process is clear in a case where a State prohibits a woman from undergoing an operation that would save her

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[92] 410 U.S. at 160 (1973).
[93] GRISEZ, *supra* note 88, at 33.
[94] *See* Chamberlain, *An Artificial Placenta*, 100 AM. J. OBSTET. GYNEC. 615 (1968) for a comprehensive list of reports of these experiments.
[95] One such experiment was on the fetus of a 14 year old girl admitted for termination of pregnancy. When the patient was seen, the uterus was at about 26 weeks gestational size and a hysterectomy was performed. The fetus was "hooked up" to the artificial placenta and evidence showed that the circuit kept the fetus alive, until it malfunctioned about five hours later and the fetus died 21 minutes after that. *Id.*
[96] A. HUXLEY, BRAVE NEW WORLD 1 (1932).
[97] 410 U.S. at 163 (1973).
[98] U.S. CONST., Amend. XIV.

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life. But the more difficult case is the one where a woman is forbidden an abortion necessary to preserve her *health*. Here, the potential life of the fetus must be balanced against the well-being of the mother, rather than her life. Surely the preservation of health is concomitant with the preservation of life. It is little comfort to the suffering mother deprived of her health by the State to know that her life cannot be so deprived. Thus, this exception enunciated by the Court may well be a constitutional demand.

A further question is whether the word "health" as used in this context includes mental health. In an earlier abortion decision, *United States v. Vuitch*,[99] the Supreme Court was faced with the construction of the word "health" used in a similar context. In that case, a District of Columbia statute prohibited abortion "unless the same were done as necessary for the preservation of the mother's life or health."[100] The Court cited with approval a lower federal court decision which construed the statute so as to permit abortions "for mental health reasons whether or not the patient had a previous history of mental defects."[101] The Court went on to say:

> We see no reason why this interpretation of the statute should not be followed. Certainly this construction accords with the general usage and modern understanding of the word "health," which includes psychological as well as physical well-being. Indeed Webster's Dictionary, in accord with the common usage, properly defines health as the "[s]tate of being . . . sound in body [or] mind."[102]

Yet, Justice Douglas' remarks in his dissent in that case bring to light the difficulties of applying such a standard. Each physician's judgment is highly subjective in these cases, "depending on the training and insight of the particular physician and his standard as to what is 'necessary' for the 'preservation' of the mother's life."[103] Justice Douglas also warns that in abortion cases, which are "heavily weighted with religious teachings and ethical concepts," there is always danger that doctors exercising their best medical judgment would face conviction by juries condemning what the jurors personally disapprove.[104]

However, Justice Douglas' first objection illustrates the weakness of his second objection. The greater the elasticity of such concepts as "health" and "necessary," the more difficult it would be for a juror to find that the physician did not act reasonably in making his judgment based on those concepts; conversely, the easier it would be for

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[99] United States v. Vuitch, 402 U.S. 62 (1971).
[100] D.C. CODE ANN. §§ 22-201 (1967).
[101] Doe v. General Hospital of the District of Columbia, 313 F. Supp. 1170 (D.D.C. 1970).
[102] 402 U.S. at 74.
[103] *Id.* at 74. (Douglas J., dissenting [and concurring]).
[104] *Id.* at 78-80 (Douglas J., dissenting [and concurring]).

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an appellate court to overturn an adverse jury decision. As Justice Blackmun notes in *Doe*, the very indefiniteness of these terms "allows the attending physician the room he needs to make his best medical judgment. And it is room that operates for the benefit, not the disadvantage, of the pregnant woman."[105]

On the other hand, one begins to wonder how much protection the viable fetus really enjoys under this standard. Because of the many intangible factors that make up one's physical and psychological health that must necessarily be considered in any abortion decision, the physician's medical judgment to abort would not normally be subject to review by the Court. Only if there were a flagrant abuse of discretion by the physician could his judgment be found wanting. And if an illegitimate child is a stigma on the mother, thereby affecting her health; if the added expense of another child in the family leaves the mother anxious, thereby affecting her health; if an additional child causes the mother to overtax herself, thereby affecting her health; if the unwanted pregnancy is itself a source of anxiety for the mother, thereby affecting her health; if these and all the other factors mentioned by the Court[106] affect the mother's health — then the standard for the third trimester doesn't seem very different than the standard for the first trimester.

5. A RETURN TO THE ESCAPE CLAUSE:

In practice, however, regulation of late-term abortions may be strict due to self-restraint by doctors and hospitals, rather than due to any State restrictions set up in accordance with the Court's guidelines in *Roe* and *Doe.* As noted, individual physicians and hospitals have the right to refrain altogether from terminating pregnancies.[107] Given this fact, it follows that hospitals and physicians are free to limit the conditions under which they will perform abortions and to determine their own procedures in deciding whether an abortion should be performed. Hence, the viability guidelines set up in *Roe* and *Doe* are not necessarily the final rule on the matter.

In New York, for example, abortions are permitted by the State until the 24th week of gestation; yet, abortions in fact are rarely performed after the 20th week.[108] To begin with, most gynecologists personally refuse to terminate a pregnancy beyond 20 weeks of gestation.[109] Furthermore, each hospital often sets its own regulations to qualify for the operation and its own standards for the operation, such as requiring the husband's signature or requiring overnight stay

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[105] Doe v. Bolton, 410 U.S. at 192 (1973).
[106] *See supra*, page 439.
[107] *See supra*, page 443.
[108] Ingraham, *supra* note 24, at 7.
[109] Schaefer, *Epilogue* in *Abortion in New York, supra* note 13, at 320.

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in the hospital. Some hospitals make the entire process so expensive that a woman cannot afford it, so time consuming that the pregnancy becomes too far advanced, or so restricted that the woman cannot qualify at all.[110]

It is likely that this will continue to be the case unless social mores evolve to the point where the act of abortion is generally accepted. Presently, abortions are not performed in a number of hospitals.[111] Moreover, probably the great majority of hospitals will refuse to perform an abortion after the 20th week of pregnancy. Hopefully, as early abortion becomes more and more accessible and as women and society in general become more aware of its accessibility, the need for late-pregnancy abortions will decrease and the question of whether the fetus was viable or not will not arise.

6. *THE EFFECT IN CALIFORNIA; SUMMARY OF THIRD TRIMESTER CONSIDERATIONS*

Under its Therapeutic Abortion Act of 1967, California does not permit an abortion unless the physician finds that

> There is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother.[112]

While this is an unconstitutional requirement when applied before viability of the fetus, it is a restatement of the maximum of regulation permitted to the State from viability onward; so, to that degree the restriction remains constitutional.[113] However, there is an additional regulation contained in the Act which states:

> In no event shall the termination be approved after the 20th week of pregnancy.[114]

This presents the aforementioned problem of ascertaining when viability occurs and the corollary question of who can make that ascertainment. If the Court's dictum that viability occurs somewhere between 24-28 weeks is taken as law, California has one remaining argument in defense of its clause. It could argue that such a restriction is a valid discretionary exercise of its right to protect viable infants, since the inexactness of pregnancy-dating results in the birth

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[110] Hall, *supra* note 28, at 519.
[111] In Utah, for example, many of the hospitals are affiliated with churches and refuse to perform abortions. TIME, *supra* note 5.
[112] CAL. HEALTH & SAFETY CODE § 25951 (c) (1) (West Supp. 1973).
[113] However, note that the California Supreme Court ruled that this section of the 1967 Abortion Act was a violation of due process and void for vagueness. The Court stated: " . . . we were unable to ascertain within the meaning of the statute either the nature of the diminished health required or that degree of diminution which stamps it as gravely impaired." People v. Barksdale, 8 Cal. 3d 320, 334, 105 Cal. Rptr. 1, 12 (1972).
[114] CAL. HEALTH & SAFETY CODE § 25953 (West Supp. 1973).

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of viable infants when abortion is permitted after 20 weeks.[115]

In any case, the blanket restriction on abortion after 20 weeks would be declared unconstitutional to the degree that it outlaws abortions necessary to preserve the life or health of the mother, if the exception enunciated in the *Roe* decision must be read into law. The question of whether an exception for life-saving terminations of pregnancies in their 20th week and later would be read into the act arose even before the *Roe* decision. One commentator rationalized the exception on grounds of self-defense, or, that the woman should not be deprived of life by a law which prevents her from receiving treatment which would save her life.[116] In *People v. Barksdale*, in dictum of its own, the California Supreme Court cited with approval dictum from one of its earlier decisions which suggested that the state may not prohibit an abortion where death from childbirth would be more likely than not.[117]

However, when it is a question of the woman's health, rather than her life, these arguments are less compelling. Here, the balance consists of the mother's health on the one hand and the life of the fetus on the other. Still, the argument for permitting an abortion in such a situation is strong. The preservation of health is coincident to the preservation of life. And as the Court implies, when a physician has judged that termination of pregnancy is necessary to preserve the health of the mother, a State law which proscribes an abortion in that situation would be an infringement on the basic right of the mother.

III. SUMMARY

From an analysis of the Court's decisions in these two abortion cases, it is evident that many legal problems concerning abortion remain unresolved. California's own abortion law needs to be entirely re-vamped, or perhaps scrapped.[118] The legal questions that surround abortion have not been put to rest by the Court; rather, some new questions have been raised and old questions have been left untouched.[119] While some have considered these abortion decisions as a

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[115] *See supra* note 85 and accompanying text.

[116] Leavy & Charles, *Therapeutic Abortion Act: An Analysis and Guide to Medical and Legal Procedure*, 15 U.C.L.A. L. REV. 1, 4 (1967).

[117] People v. Barksdale, 8 Cal. 3d 320, 335, 105 Cal. Rptr. 1, 12, 503 P.2d 257, 268 (1972), *citing* People v. Belous, 71 Cal. 2d 954, 969, 80 Cal. Rptr. 354, 363, 458 P.2d 194, 203 (1969).

[118] Seven states have already enacted laws which conform closely to the guidelines set out in *Roe* and *Doe*. They are: Georgia, Idaho, Illinois, Nebraska, North Carolina, South Dakota and Tennessee.

[119] The court purposely sidestepped such issues as the father's rights regarding termination of pregnancy. *See* 410 U.S. at 165, n. 67 (1973). *See also* where the Supreme Court let stand a lower court decision which denied the right of an unmarried father to restrain the mother from terminating her pregnancy because

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vindication of an important individual right, others have been assiduously working toward various measures to cut back on them.[120]

Plainly, there is no happy solution when the Court is faced with legal issues in the area of abortion. The solutions to the problems generated by the idea of abortion must ultimately be found in another place, and in another time. Ideally, as birth control at the time of conception becomes more widely practiced, and as education on all aspects of birth control becomes more widely disseminated, the time will come when a later, much happier society, brands as anachronistic these issues now pressed on the Court. Until that time the Court must sort out the controversies that surround abortion, must balance the conflicting values, and must, like Ferlingehetti's acrobat-poet, walk a tightrope, "constantly risking absurdity."[121]

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such a decision is a personal one to be made by the mother and her attending physician. Jones v. Smith, Fla. Ct. App. 4th Dist., 278 So. 2d 339, *cert. denied,* #73-1133_____ U.S. _____ (March 4, 1974) 42 U.S.L.W. 3499.

[120] Only days after these decisions were announced, Rep. Lawrence Hogan of Maryland proposed a constitutional amendment banning most abortions. At last count, 26 constitutional amendments restricting abortion had been proposed. San Francisco Examiner, Feb. 17, 1974, § B at 12, Col. 1-7.

[121] FERLINGHETTI, CONEY ISLAND OF THE MIND 30: ". . . constantly risking absurdity/and death/whenever he performs/above the heads/of his audience. . . "

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