No. 19-1392

In the
SUPREME COURT OF THE UNITED STATES

THOMAS E. DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, et al.,
Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, et al.,
Respondents.

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

BRIEF OF THE CATHOLIC MEDICAL ASSOCIATION, THE NATIONAL ASSOCIATION OF CATHOLIC NURSES-USA, IDAHO CHOOSES LIFE AND TEXAS ALLIANCE FOR LIFE AS *AMICI CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF THE AMICI[1]

Amici Curiae, the Catholic Medical Association ("CMA") and the National Association of Catholic Nurses-USA ("NACN"), are national nonprofit professional health care organizations. CMA's members include board certified obstetricians and gynecologists, pediatricians, neonatologists, and other health care providers in various practice specialties and stages of medical training. NACN's members include nurses who also work in these specialties. In the course of their normal practices, these health care professionals are called upon to make predictions of viability and/or to provide care to unborn and newly born babies that are near the limits of viability. Both of these organizations are dedicated to providing quality medical care to all members of the human family, including those not yet born.

Amici Curiae, Texas Alliance for Life and Idaho Chooses Life are state-wide nonprofit prolife organizations that are dedicated to the restoration of legal protection for unborn human life throughout pregnancy. These organizations regularly participate as *amici curiae* in cases involving protection for vulnerable human life.

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[1] No counsel for any party authored this brief in whole or in part, and no party, person or entity other than the *amici*, their members and counsel have made any monetary contribution intended to fund the preparation or submission of this brief. Counsel for all parties have filed blanket consents.

This brief will provide the Court with a better understanding of the complexity of the medical aspects of making a viability assessment. In addition, it will highlight the significant difficulties associated with attempting to apply the medical concept of viability as a legal standard in the context of abortion.

All *amici* seek to have the Court overturn *Roe v. Wade,* which prevents States from providing any meaningful protection for unborn children.

SUMMARY OF THE ARGUMENT

Roe's selection of viability as the time in pregnancy to assign value to the unborn child's life and allow the State to intervene on the child's behalf constituted an arbitrary policy choice. Neither the parties nor any *amici* had argued that the concept of viability was critical, or even relevant, in addressing the constitutionality of the statutes at issue.

In *Casey*, the Court stated that courts may not draw arbitrary lines without offering adequate justification for those lines. Yet, this is precisely what *Roe* did. It chose an arbitrary "line" of viability and gave no principled justification for doing so.

Roe's choice of viability was particularly unsuitable because the Court appears to have had little understanding of the complexity of the medical aspects involved in assessing viability. And, the Court's references to viability reflect a lack of even a

rudimentary understanding of the nature of and purpose for a viability assessment.

Likewise, the Court failed to appreciate the inappropriateness of attempting to apply that medical concept as a legal standard in the context of abortion. Some of the most critical criteria for determining viability in the non-abortion context—the type and amount of prenatal and postnatal care that is provided—are not even relevant in the context of abortion.

Reliance on viability has proven to be completely unworkable in practice because it is incapable of being applied and enforced in a principled, consistent fashion. The Court has left the viability determination entirely in the hands of the abortion provider. In so doing, it has ceded to a third party the ability to determine both the scope of the right to abortion and the value to be accorded to the unborn child.

Despite the Court's repeated assurances that the right to abortion is not absolute, *Roe* prevents States from providing any meaningful protection for unborn children prior to viability and, as a practical matter, thereafter. Given that the "central holding" of *Roe* is unworkable and irredeemably flawed, *Roe* should be overruled.

The Court should extricate itself from the arbitrary line-drawing that *Roe* and *Casey* engaged in while attempting to settle the abortion controversy. There is no non-arbitrary line during pregnancy that the Court can draw, because the

lives of unborn children are on a continuum toward adulthood from conception (fertilization) forward. Any arbitrary line that the Court might seek to replace the viability cut-off with would simply amount to yet another act of judicial legislating.

Therefore, the issue should be returned to the elected representatives of the people so that they can exercise their rightful authority to provide protection for all members of the human family, including those not yet born.

ARGUMENT

In *Roe v. Wade*, 410 U.S. 113 (1973) the Court was presented with two competing arguments. One side argued that a woman has an "absolute right" to abortion throughout pregnancy. *Id.* at 156. The other argued that the State could "protect prenatal life" throughout pregnancy. *Id.* In response, the Court held that there was a fundamental constitutional right to abortion,[2] but repeatedly stated that this right was not absolute and that it could be limited by the State's important and legitimate interest in protecting "potential" life. *Id.* at 153, 154, 162.

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[2] The many flaws in the approach taken by the Court in finding such a right are not addressed in this brief, but they have been rightly criticized in numerous scholarly articles ever since *Roe* was handed down. *See*, John T. Noonan, Inquiry 5 "On the Constitutional Foundation of the Liberty," in A Private Choice: Abortion in America in the Seventies, 20 (1979) (providing an overview of the early scholarly response to *Roe*).

In reaching this conclusion, the Court decided that the State's interest did not become sufficiently compelling to override the woman's right to abortion until the point of viability, and that the States could not prohibit any abortion prior to viability. Thus, in attempting to balance the competing interests, the Court determined that the unborn child's life was not sufficiently *valuable* to be protected until the stage of viability was reached—the point when the unborn child is "potentially able to live outside the mother's womb, albeit with artificial aid." *Roe* at 160.

As set forth below, the choice of viability was particularly poor for a number of reasons.

I. *ROE'S* CHOICE OF VIABILITY WAS ARBITRARY AND LACKED ANY REASONED JUSTIFICATION.

A. The Court's Selection of Viability as the Time in Pregnancy to Assign Value to the Unborn Child Was an Arbitrary Policy Choice.

The statutes challenged in *Roe* and *Doe v. Bolton*, 410 U.S. 179 (1973), did not make any distinctions based on viability. And neither the parties nor any *amici* argued that the concept of viability was relevant. Indeed, it was not until well after oral argument and circulation of the second draft opinion, that viability appears to have been discussed as a possible dividing-line within the framework that the Court was crafting to regulate abortion.

That second draft opinion in *Roe* drew the line at the end of the *first trimester*; not at viability. Justice Harry A. Blackmun, *Unpublished Second Draft Opinion in Roe v. Wade*, No. 70-18 (Nov. 22, 1972) (on file with Library of Congress, Manuscript Division, Box 151, Folder 6, Harry A. Blackmun Papers). And, although viability was ultimately settled upon by the Court, Justice Blackmun described both the "end of the first trimester" and "viability" as being "*equally arbitrary*." Justice Harry A. Blackmun, *Memorandum to the Conference, Re: No. 70-18—Roe v. Wade* (Nov. 21, 1972) (on file at Library of Congress, Manuscript Division, Box 151, Folder 6, Harry A. Blackmun Papers).

The internal papers of the Court also suggest that the choice of viability was based primarily on pragmatic policy concerns and personal preferences with respect to allowing more time to obtain an abortion.[3] It was not based on any evidence

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[3] For example, Justice Blackmun states: "I could go along with viability if it could command a court." Justice Harry A. Blackmun, *Letter to Justice Lewis Powell,* (Dec. 4, 1972) (on file at Library of Congress, Manuscript Division, Box 151, Folder 6, Harry A. Blackmun Papers). Justice Blackmun also states that, as a "practical" matter, the choice of viability would allow women "who may refuse to face the fact of pregnancy" more time to obtain an abortion. Justice Harry A. Blackmun, *Memorandum to the Conference*, (Dec. 11, 1972) (on file at Library of Congress, Manuscript Division, Box 151, Folder 6, Harry A. Blackmun Papers). See also, Clarke D. Forsythe, *Abuse of Discretion: The Inside Story of Roe v. Wade* 133-140 (2013) for further discussion and support.

presented to the Court or on any constitutional or statutory text.

Thus, in creating the trimester framework of *Roe*, the Court was not engaged in the traditional judicial function of reviewing the text of the Constitution or any relevant statute.[4] Nor was the Court examining the intent of the framers in drafting the Fourteenth Amendment.[5] Instead, the Court was primarily acting in a quasi-legislative capacity—making judgments not about what any duly enacted law said, but rather, on what it deemed to be "practical" solutions to social problems related to unwanted pregnancies.

B. *Roe* Did Not Provide Any Reasoned Justification for Choosing Viability.

Courts may not draw arbitrary lines without offering adequate justification for those lines. *Casey,*

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[4] In *Webster v. Reproductive Health Serv*. 492 U.S. 490, 518 (1989), Justice Rehnquist stated: "The key elements of the *Roe* framework—trimesters and viability—are not found in the text of the Constitution or in any place else one would expect to find a constitutional principle." This has resulted in a "web of legal rules that have become increasingly intricate, resembling a code of regulations rather than a body of constitutional doctrine." *Id.*

[5] Dividing pregnancy into three distinct terms "partakes more of judicial legislation than it does of a determination of the intent of the drafters of the Fourteenth Amendment." *Roe* at 174, 175 (Rehnquist, J. dissenting) (noting that at the time that the Fourteenth Amendment was adopted, the laws in 36 states and territories "limited abortion.")

505 U.S. at 870. Yet, this is precisely what *Roe* did. It chose an arbitrary "line" of viability and gave no principled justification for doing so.

In defending its adherence to *Roe, Casey* claimed that *Roe's* selection of viability was "a reasoned statement, elaborated with great care." *Casey* at 870. However, *Roe's* explanation for its selection of viability as the critical point upon which to balance the competing interests in the abortion controversy was superficial and conclusory, at best. In fact, the Court's entire "elaboration" of its reasoning consists of three sentences making bald assertions—not one of which was supported by any actual explanation.

First, *Roe* asserted that the State's interest in protecting potential life "grows in substantiality as the woman approaches term and, at a point during pregnancy, . . . becomes 'compelling.'" 410 U.S. at 162-63. The Court provided no explanation as to *why* the State's interest in protecting human life should grow substantially as the unborn child grows and develops during the pregnancy. Nor did the Court attempt to explain *why* the State's interest in protecting unborn human life just prior to viability should be nonexistent and then suddenly appear just after viability, if it is growing in substantiality throughout pregnancy.

Certainly, a State's interest in protecting the life of a newborn baby is no less than its interest in protecting the life of a toddler, a teenager or an adult. An unborn child, like a newborn, is on a

continuum toward adulthood. The State's interest in protecting both is the same.

This is especially true if, as *Roe* claimed, the State's interest is only in protecting "potential" life. As Justice O'Connor noted in *Akron v. Akron Center for Reproductive Health*, "*potential* life is no less potential in the first weeks of pregnancy than it is at viability or afterward." 462 U.S. 416, 461 (1983) (O'Connor, J. dissenting) (emphasis in original).

Next, the Court stated that the compelling point is at viability, "because the fetus then presumably has the capability of meaningful life outside the mother's womb." *Id.* at 163. The Court did not explain what it meant by "meaningful life."[6] Nor did it offer any explanation of *why* the capability of "meaningful life" outside the womb should mark the time at which a State may protect prenatal life.

Surely the State's interest in protecting the most vulnerable—a newborn or the mentally disabled (whom some may consider lacking in "meaningful life")—is at least as great as its interest in protecting the lives of competent adults, not less.

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[6] Years later, in *Thornburgh v. A.C.O.G*, Justice Stevens seemed to suggest that "meaningful life" referred to the capacity to "feel pain, to experience pleasure, to survive, and to react to [one's] surroundings." 476 U.S. 747, 778 (1986) (Stevens, J., concurring).

Finally, the Court asserted that the choice of viability "has both logical and biological justifications." *Id.* Again, it did not attempt to explain these "justifications." Indeed, there is a certain *illogic* in the notion that the State should be able to protect prenatal life by prohibiting abortion only *after* viability (when the unborn child could live independently and is least in need of protection), but not before viability (when the unborn child is most vulnerable and in need of protection). The "logic" would seem to have matters backward.

Likewise, there is little, if any, "biological" justification for choosing viability as the point when the State's interest in protecting fetal life becomes compelling. A 23-week-old unborn child who would be viable today is no different, *biologically*, than a 23-week-old unborn child who would not have been viable in 1973. There is simply no *intrinsic* biological difference between these two children.

Thus, contrary to *Casey's* assertion, *Roe's* selection of viability was not "reasoned" and "elaborated with great care." None of the three sentences in *Roe* that relate to the choice of viability as the critical point in time to assign value to unborn human life explain any actual rationale for choosing it. Instead, it would appear that the Court simply decided that a line must be drawn and determined that, of the various arbitrary lines available,

viability was the most desirable from their personal perspectives.

II. VIABILITY IS A COMPLEX MEDICAL ASSESSMENT BASED ON NUMEROUS FACTORS OF VARYING DEGREES OF ACCURACY AND APPLICATION.

The Court's adoption of viability as a significant dividing-line within pregnancy was an apparent afterthought. This may explain its flawed and incomplete understanding of the medical concept of viability which is evident in the Court's descriptions of viability in *Roe* and later cases.

A. Viability Is Not a "Simple Limitation" or Determination.

Casey referred to viability as though it is a well-defined line (or point in time) that can be determined with some precision—a "simple limitation." 505 U.S. at 855. However, viability is not a defined line at all. Rather, it is a *prediction*—an educated guess—about the statistical probability that a baby has of surviving if born prematurely.

This is a complex estimation based on assessing multiple factors—many of which are difficult to accurately ascertain. The assessment usually is made in the context of managing a pregnancy at risk of premature birth or in the context of determining the type and amount of care

to be provided to a baby that has already been born prematurely.[7]

The American College of Obstetricians and Gynecologists, in conjunction with the Society for Maternal-Fetal Medicine, has published a joint paper discussing viability assessments. *See*, Am. Coll. of Obstetricians & Gynecologists & Soc'y for Maternal-Fetal Medicine, *Obstetric Care Consensus: Periviable Birth*, 130 Obstetrics & Gynecology e187 (Oct. 2017) ("*Obstetric Care Consensus*").[8] As noted therein, viability is currently predicted by examining numerous factors, all of which have varying degrees of accuracy and application.

1. Some factors are intrinsic to the baby—his or her gestational age, weight, and sex—and are considered "nonmodifiable." *Id*. at e190. But each of these factors has limitations with respect to its accuracy of determination—especially during pregnancy.[9]

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[7] The medical journal articles cited in this brief all discuss assessments of viability in these two situations. As will be discussed in Part III of this brief, many aspects of making a viability assessment in these circumstances are inapposite in the context of abortion.

[8] "Periviable birth" is defined as a "delivery occurring from 20 0/7 weeks to 25 6/7 weeks of gestation." *Id*. at e188.

[9] S*ee*, Paul Benjamin Linton and Maura K. Quinlan, *Does Stare Decisis Preclude Reconsideration of Roe v. Wade? A Critique of Planned Parenthood v. Casey*, 70 Case W. Rsrv. L. Rev. 283, 296-298 (2019) ("*Stare Decisis"*) for a more detailed

Take gestational age, for example. The most accurate method for determining gestational age is by using fetal ultrasound during the first trimester, based on crown-rump length. Am. Coll. of Obstetricians & Gynecologists Committee on Obstetric Practice et al., *Methods for Estimating the Due Date* at 2 (2017) ("*Due Date*"). However, even at this stage of pregnancy, the margin of error is plus-or-minus five to seven days. *Id.* Other less accurate methods of determining gestational age, such as those based on physical examination or the patient's recollection of the first day of her last menstrual period, may have much greater margins of error. *Id.*

Therefore, even if a woman has had a first trimester ultrasound, the estimated gestational age of the baby might still be off by a week. And, an error of this magnitude during the periviable period can make a difference between a determination of viability or nonviability.

Moreover, the accuracy of ultrasound assessments of gestational age *decreases* as the pregnancy progresses. For example, an ultrasound obtained between the beginning of the twenty-second week and the end of the twenty-seventh week has a margin of error of plus-or-minus ten to fourteen days. *Due Date,* at 3.

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description of the limitations inherent in making an accurate viability determination based on these and other factors.

2. In addition to the above intrinsic factors that are considered in assessing viability, there are a number of other factors that relate to extrinsic conditions (which may or may not be present). The most important of these factors are the type of *prenatal* treatments given to the pregnant woman and the *postnatal* care administered to the newborn. *Obstetric Care Consensus*, at e194-e195.

There are currently several different types of prenatal care that can greatly increase the unborn child's chance of survival and reduce the incidence and severity of long-term disability. *Id.* These include the administration of corticosteroids and magnesium sulfate to the mother in advance of her anticipated premature birth to assist in the baby's lung maturation and improve neurologic outcomes. *Id.* at e194. And, there are additional methods available to delay delivery when a premature birth is expected. *Id.* at e195.

With respect to postnatal care, the most important factors are providing immediate resuscitation to the newborn at delivery and the provision of intensive care thereafter. *Id.* at e191-e192. During the periviable period, both are critical to survival. *Id.* Optimally, then, the delivery should take place in a hospital with a neonatal intensive care unit ("NICU"). *Id.*

Thus, the location of the anticipated delivery and the provision of prenatal and postnatal care significantly impact survival rates for newborns. See, Carl H. Backes et al., *Outcomes Following a Comprehensive Versus a Selective Approach for Infants Born at 22 Weeks of Gestation*, 39 J. Perinatology 39 (2019) (*"Outcomes")* (citing study reporting that when prenatal and postnatal care was given to infants born between 22 and 25 weeks, each showed reductions in the risk of death similar to those associated with a one week increase in gestational age).

B. Probabilities of Survival Vary Greatly Depending on the Type of Prenatal and Postnatal Care Provided.

Numerous medical studies report wide ranges of survival rates at various gestational ages during periviable birth. *See*, *Obstetric Care Consensus* at e188 and studies cited therein.[10] Significant disparities can arise due to a variety of factors. Many of the studies contain biases that can skew the data. *Obstetric Care Consensus* at e189. For example, a study that includes outcomes for newborn infants who are provided only palliative care and die soon

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[10] *See also*, Matthew A. Rysavy et al., *Between-Hospital Variation in Treatment and Outcomes in Extremely Preterm Infants*, 372 New Eng. J. Med. 1801 (2015) and studies cited therein; Katrin Mehler et al., *Survival Among Infants Born at 22 or 23 Weeks' Gestation Following Active Prenatal and Postnatal Care*, 170 JAMA Pediatrics 671 (2016).

after birth will report substantially lower survival rates than one that only includes infants that are provided with both prenatal corticosteroids and advanced postnatal care in a NICU. *Id.* Likewise, significantly higher statistical probabilities for survival outcomes are associated with studies based on more recent data that reflects newer technological advances, than on those based on older data. *Id.*

Even where controls are in place, though, wide ranges of survival rates still have been reported. A recent study comparing infants born at 22 weeks of gestation at two different hospitals reported survival-to-discharge rates of between 8 and 53 percent. *Outcomes*, at 39. Both hospitals had large NICUs, but each took a different approach to the provision of care. The hospital that routinely provided prenatal corticosteroid administration, neonatal resuscitation, and intensive care had substantially higher survival rates (53 percent) than the hospital that only selectively provided such care (8 percent). *Id.* at 43. "[C]enter variability in the provision of treatment at 22 weeks of gestation accounts for 78% of the variation in survival." *Id.* at 45.

C. There is No Consensus Within the Medical Community Regarding What Constitutes Viability.

There is no single reliable source upon which a consensus rests for predicting survival rates at

various ages. *Obstetric Care Consensus* at e190-e191. Moreover, even if such a uniform and accurate source were available, there is no consensus within the medical community with respect to how great the chance of survival at a particular age must be in order for a baby to be deemed "viable." Some doctors or medical facilities may deem a baby to be viable when there is, say, a 5 percent chance of survival, while others may not do so unless there is a 25 percent (or even greater) chance of survival.

All of these factors combined contribute to the fact that there is no current consensus regarding what statistical probability of survival constitutes viability, and they make it unlikely that any consensus will be forthcoming in the near future.

III. THE MEDICAL CONCEPT OF VIABILITY CANNOT LOGICALLY BE APPLIED IN THE ELECTIVE ABORTION CONTEXT.

The Court's application of the medical concept of viability as a legal standard for elective abortions is like trying to fit a square peg into a round hole. It doesn't fit.

In a normal healthy pregnancy, there is no need to make an assessment regarding the baby's ability to survive outside the womb, because there is no expectation that the baby will be outside the womb prematurely. It is only when something threatens the continuation of the pregnancy that viability becomes relevant.

A. The Reasons for Making a Viability Determination in the Non-Abortion and Abortion Contexts Are Quite Dissimilar.

1. In the non-abortion context, something (largely *outside of the control* of the pregnant woman and her physician) has gone wrong and the pregnancy is about to terminate prematurely. Treatment decisions must be made regarding the medical care to be provided to the mother and her baby. And, these decisions are informed by making an estimation of the baby's potential ability to survive outside the womb.

If the baby is deemed to be viable, steps may be taken to delay the premature birth for as long as possible. Likewise, if conditions permit, the mother also may be given corticosteroids and magnesium sulfate and transferred to a hospital with a NICU so that the baby can be immediately resuscitated upon birth and provided with intensive care. *Obstetric Care Consensus,* e192, e194.

All of these actions are taken with the purpose of *enhancing* the baby's chances of *survival*.[11]

2. In the context of an elective abortion, however, nothing is amiss with the pregnancy. It will continue to term and a healthy baby will be

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[11] If the baby has no chance of surviving outside the womb even with artificial support, however, it would be deemed non-viable and futile actions to enhance survival would not be pursued.

delivered unless the pregnancy is *intentionally* disrupted prematurely by the actions of the pregnant woman and her physician which are *entirely within their control.*

In this circumstance, a viability determination has no actual medical purpose. It is not done for the medical benefit of the pregnant woman or her baby. Instead, it serves only to mark the legal boundary for the performance of an abortion and to accord value (or not) to the unborn child's life.

This intentionality and control that is present in the abortion context, but lacking in other circumstances, distorts the meaning of viability and its usefulness as a "medical judgment" in the two different situations.

B. The Extrinsic Criteria That Are Usually Considered in Making a Viability Determination Do Not Apply in the Context of Elective Abortion. Consequently, the Two Situations Are Not Comparable.

The Court ignores these essential differences between the non-abortion context and the abortion context when it tries to graft the medical concept of viability onto an abortion procedure as a legal standard. However, these differences are crucial.

When premature birth cannot be prevented due to factors beyond the control of the medical team, the availability of prenatal and postnatal care

are critical factors that significantly affect a baby's survivability. "[P]eriviable infants do not survive without life-sustaining interventions immediately after delivery." *Obstetric Care Consensus,* at e191.

However, these critical factors that would normally affect a baby's potential survivability (and, thus, "viability") are never considered where an elective abortion is sought. When a pregnancy is *intentionally* terminated, the death of the baby is the desired outcome. Indeed, survival of the baby is generally considered to be a *complication* of abortion; not its object.[12] It is inconceivable, then, that any prenatal or postnatal care needed to *enhance survivability* during the periviable period would even be contemplated by the doctor, let alone be consented to by a pregnant woman seeking an elective abortion.[13]

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[12] *See*, Liz Jeffries and Rick Edmonds, "Abortion: The Dreaded Complication," *Philadelphia Inquirer*, Aug. 2, 1981 (describing the secrecy surrounding the lack of care given to babies that survive abortion and the difficulty in prosecuting those physicians who do late term abortions that result in live births but do not attempt to provide those newborn infants with life-sustaining treatment).

[13] Indeed, the choice of a dismemberment abortion procedure rather than an induction procedure may be deemed by some doctors to be preferable for the woman's "health" *because* it avoids the "complication" of a live birth and the potential need to provide postnatal care to a survivor. See, *Planned Parenthood v. Ashcroft*, 462 U.S. 476, 483 n.7 (1983) (discussing the testimony of Dr. Crist who supported the use of

As a consequence, these crucial factors that ordinarily would be taken into consideration in making a viability prediction are simply irrelevant in the context of abortion. Hence, it is virtually impossible for an abortion provider to make a viability assessment that is comparable to one made by other physicians in the non-abortion context. The two situations are incommensurable, and there is a significant bias in favor of finding that the baby is *not* viable when an elective abortion is sought.

Although *Roe* claimed that a viability determination is a "medical" decision, with respect to elective abortions it does not appear to be. Instead, it is just a legal construct dressed up to look like a medical decision. As such, the Court's insistence on treating it as a medical decision to be left solely to the "medical" judgment of the abortion provider is completely unwarranted.

IV. THE VIABILITY RULE ESTABLISHED IN *ROE* IS UNWORKABLE AS A LEGAL STANDARD.

One of the primary reasons for overturning a prior precedent is that it has proven to be "unsound in principle and unworkable in practice." *Garcia v. San Antonio Metro. Transit Auth*, 469 U.S. 528, 546-

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dismemberment procedures "well into the third trimester" and testified that he never attempts to save a fetus because as a general principle "there should not be a live fetus").

547 (1985). *See also*, *Janus v. Am. Fed'n. of State, County, & Mun. Employees*, 585 U.S. ___, 138 S. Ct. 2448, 2481-82 (2018).

However, *Casey* dismissed any concerns regarding the workability of *Roe's* "central" viability rule in a single sentence. 505 U.S. at 855. It stated that this rule had "in no sense proven unworkable, representing as it does a simple limitation beyond which a state law is unenforceable." *Id.* As set forth above, making a viability assessment is anything but simple, and it cannot be determined with any degree of consistency. Likewise, as set forth below, it is standardless and unenforceable. In short, *Roe's* viability rule is completely unworkable because it is incapable of being applied and enforced in any principled and consistent fashion.

A. *Roe's* Definition of Viability Was Vague, and the Court's Later Cases Did Not Cure This.

From its inception, *Roe's* reliance on viability has proven to be uncertain and unworkable. *Roe* referred to viability as occurring somewhere between 24 and 28 weeks of gestation (over a span of time), but it gave no guidance with respect to how the State could permissibly protect an unborn child during this gray area.

Immediately following *Roe*, numerous states drafted abortion statutes attempting to comply with *Roe's* dictates. These were challenged and the

district courts often reached diametrically opposed conclusions. For example, the Missouri and Pennsylvania statutes both defined viability in a manner similar to the definition contained in *Roe*—e.g., potentially able to survive outside the womb with artificial aid. Both definitions were challenged on vagueness grounds, with the plaintiffs (abortion providers) in each case arguing that the definitions could only withstand a constitutional challenge if they contained a specific gestational age cut-off, which neither did. See, *Planned Parenthood of Central Missouri v. Danforth*, 392 F. Supp. 1362, 1368 (E.D. Mo. 1975) and *Planned Parenthood v. Fitzpatrick*, 401 F. Supp. 554, 569 (E.D. Pa. 1975).

The *Danforth* district court received little trial evidence and rejected plaintiffs' claims. *Danforth* at 1368. In contrast, the *Fitzpatrick* district court received extensive testimony at trial from expert witnesses explaining the difficulties and uncertainties involved in making a prediction of viability—especially without any reference to gestational age. Based upon this testimony, the court struck the Pennsylvania definition of viability on vagueness grounds. *Fitzpatrick*, 401 F. Supp. at 569. The court noted that there was no direct way to determine the ability of a baby to live outside the mother's womb and that doctors would need to correlate certain probability of survival factors with the gestational age to determine viability. The court

continued:

> The evidence clearly demonstrates that the statistical data available to the physician concerning fetus survival is not precise; also other variables such as the mother's health and the quality of hospital facilities in the community must be taken into consideration. There is a lack of consensus within the medical community as to "the capability of a fetus to live outside the mother's womb albeit with artificial aid" when the gestational age of the fetus is determined to be between 20 and 28 weeks.

Id. at 570 (also noting that physicians had no uniform position on what probability (e.g., 10 percent or 30 percent) of survival would be sufficient to qualify for viability).

The *Fitzpatrick* court concluded "that while not every physician who testified would reach exactly the same determination as to gestational age, there would be a consensus within reasonable and tolerable limits," with respect to the method for determining gestational age. *Id.* at 569-570. Thus, the court noted that "if the statute had even limited viability to 24 weeks gestation, it would be in conformity with the pronouncement of *Roe*, and not subject to a successful challenge." *Id.*

The first of these two cases to reach the Supreme Court was *Danforth*. With little discussion,

the Court affirmed the district court's holding regarding the definition of viability:

> [W]e agree with the District Court that it is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician.

Planned Parenthood v. Danforth, 428 U.S. 52, 64 (1976). This was the first time that the Court actually defined viability and the Court indicated that it was impermissible for States to draw any bright-line cut-off to define viability.

There are two fundamental flaws with respect to the Court's conclusion. First, there is no reason why the States could not have set the line at, say, 28 weeks, given that there was broad agreement at the time that a baby at that age was viable. *See*, Louis Hellman & Jack Prichard, *Williams Obstetrics* 493 (14th ed. 1971) ("Attainment of a weight of 1,000 g [about 28 weeks] is therefore widely used as the criterion of viability.")

Second, the Court's pronouncement—that a viability determination must be specific to a

"particular fetus"—suggests an elementary misunderstanding of the concept of viability. Statistical survival probabilities are based on studies of survival rates within general populations of neonates at various gestational ages and do not predict the outcome for a *particular* newborn. *Obstetrics Care Consensus* at e191. "[W]hen a specific estimated probability for an outcome is offered, it should be stated clearly that this is an estimate for a population and not a prediction of a certain outcome for a particular patient in a given institution." *Id.*

Moreover, because viability simply marks the point in time when the *value* of the unborn child becomes sufficient to support protection by the State, there is no reason why one *particular* baby should have greater value than another of the same gestational age.

In *Colautti v. Franklin*, the Court revised the definition of viability again, stating:

> Viability is reached when, in the judgment of the attending physician, on the particular facts of the case before him, there is a *reasonable likelihood* of the fetus' *sustained survival* outside the womb . . .

439 U.S. 379, 388 (1979) (emphasis supplied).

Roe spoke of viability in terms of the fetus being "potentially able to live" outside the mother's

womb—not in terms of having a reasonable likelihood of sustained survival. As Justice White noted, in dissent, with this further refinement of the viability definition, *Colautti* withdrew from the States "a substantial measure of the power to protect fetal life that was reserved to them in *Roe v. Wade*." *Colautti,* 439 U.S. at 401.

As in prior cases, *Colautti* did not give any explanation regarding what the new "reasonable likelihood of sustained survival" standard entails. The definition is completely ambiguous and manipulable. Indeed, it is difficult to call it a standard at all because the Court's "definition" does not contain any objective criteria capable of being applied and enforced.

Does a 20 percent probability of survival constitute a "reasonable likelihood" of survival? Or must it be more than a 50 percent probability to qualify? And what is "sustained survival"? Does ten days qualify? Does discharge from the NICU qualify? Or, does it mean some other undefined time beyond that?

According to *Colautti*, these decisions must be left entirely to the subjective judgment of the abortion provider. "[N]either the legislature nor the courts may proclaim one of the elements entering into the ascertainment of viability—be it weeks of gestation or fetal weight or any other single factor—as the determinant" of viability. *Colautti* at 388-389.

So, legislatures have been forbidden to clarify their viability definitions to answer any of the above questions and, instead, have been told that the standardless *Colautti* Court's definition is the only one that will be allowed.

With its holding in *Colautti*, the Court has severely crippled the State's ability to enact any laws prohibiting (or even regulating) abortions after viability in a manner that could be meaningfully enforced. The criteria for assessing viability remain both undefined and undefinable. And, the Court has determined that the purely subjective decisions that the abortion providers make may not be questioned.

B. The Court Has Tacitly Admitted That There Are No Objective Criteria or Standards Capable of Being Consistently Applied to Viability Determinations.

Having placed the determination of viability solely in the hands of abortion doctors, based entirely on their subjective judgment, the Court has granted virtual immunity to those doctors in determining whether a baby they wish to abort is viable. In so doing, the Court has ceded to third-party physicians the ability to determine both the extent of a woman's constitutional right to an abortion and the constitutional value to be accorded to the unborn child.

By abandoning the field, the Court has tacitly admitted that there are simply no standards capable of being properly applied by the courts to evaluate viability. In short, the Court has imposed upon the States a "constitutional" mandate that courts lack judicial competence to rule upon in any consistent and workable manner.

A brief examination of a hypothetical situation demonstrates just how unworkable the Court's viability rule is. Under the Court's judgments, a woman's constitutional right to terminate her pregnancy is dependent on where she lives within a State and the skill (or lack thereof) of her physician. Take two women who are 25 weeks pregnant. One seeks an abortion from a board-certified obstetrician-gynecologist who practices at a hospital with an advanced NICU where intensive care is routinely provided to newborns at this age and the survival rate is in excess of 75 percent. The other seeks to have an abortion performed at a rural outpatient clinic by a physician who is not knowledgeable about current survival rates for premature babies.

The first physician would probably judge the baby to be viable, while the second may likely judge the baby to be not viable. Thus, one woman would be unable to secure an abortion while the other would be able to obtain an abortion. Or, if a woman goes first to the skilled physician and is denied the abortion and then goes to the lesser skilled physician

later that day, her baby may be deemed both "viable" and "non-viable" on the same day.

There is no plausible reason for basing the woman's "constitutional" right to abortion or the value of the baby's life on the location or the skill level of the physician who is to perform the abortion. Nor is there any *constitutional* principle under which either of these interests should hinge on a term so indeterminate as "viability," or be decided by such haphazard means.

C. The States Cannot Meaningfully Enforce Any Law Banning Post-Viability Abortions.

The ability of the State to enforce a post-viability ban on abortion is exceedingly limited given the fact that the Court has placed the viability determination solely within the abortion provider's subjective medical judgment. For a successful prosecution to occur, the State would have to prove that the physician knew or should have known that the baby was viable (perhaps well into the third trimester) and that he performed the abortion in bad faith.[14]

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[14] Dr. Abu Hayat was convicted, in New York, of performing an illegal abortion on a young woman who was 32 weeks pregnant. However, the statute banned abortion after 24 weeks, not after "viability." Notably, the baby survived, but without her arm which was severed in the procedure. *See*, Richard Perez-Pena, "Prison Term For Doctor Convicted In

Leaving the viability determination entirely in the abortion provider's hands makes enforcement difficult enough. However, the Court's requirement that any ban on abortions after viability must also contain a "health exception" makes enforcement virtually impossible.

In *Roe*, the Court held that after viability, the State may proscribe "abortion *except* where it is necessary, in appropriate medical judgment, for the preservation of the life or *health of the mother*." 410 U.S. at 164-165 (emphasis supplied). In *Doe v. Bolton,* seemingly in *dicta*, the Court defined the scope of the mandated health exception:

> "[T]he medical judgment [as to the necessity of an abortion] may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to *health*.

410 U.S. 179, 192 (1973) (emphasis supplied).

Abortions," *The New York Times* (June 15, 1993). According to that article, the doctor was also convicted of assault upon the woman and baby for forcibly performing the abortion on her after she told him that she no longer wished to go through with it. *Id.* One wonders whether the prosecution would have been successful without these additional gruesome facts.

Given this expansive definition of "health," it is doubtful that any statute attempting to limit post-viability abortions in a meaningful way would be constitutional and enforceable. In addition, the post-*Roe* case law, which treats the *Doe dicta* as binding precedent, does nothing to dispel this doubt.

To date, every state law attempting to limit post-viability abortions to those necessary for *physical* health, that has been challenged, has been struck down.[15] The federal courts of appeals that have addressed the issue also have indicated that a post-viability ban on abortion must contain an exception for *mental* health. See, *Women's Medical Professional Corp. v. Voinovich,* 130 Fed.3d 187, 210 (6th Cir. 1997) ("health" exception must include "psychological or emotional injury"); *American College of Obstetricians and Gynecologists v. Thornburgh*, 737 F.2d 283, 298-299 (3d Cir. 1984) (noting that "no Supreme Court case has upheld a criminal statute prohibiting abortion of a viable fetus," the court opined that failure to include an exception for psychological or emotional reasons

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[15] See, e.g., *Doe v. Rampton*, 366 F. Supp. 189 (D. Utah 1973); *Margaret S. v. Edwards*, 488 F. Supp. 181 (E.D. La. 1980); *Schulte v. Douglas*, 567 F. Supp. 522 (D. Neb. 1981), *aff'd per curiam sub nom. Women's Services, P.C. v. Douglas*, 710 F.2d 465 (8th Cir. 1983). *See also*, *Stare Decisis* at 334-336 for a discussion of these and other cases striking down laws that failed to contain a mental health exception.

would violate *Doe v. Bolton*); *Women's Services, P.C. v. Douglas*, 710 F.2d 465 (8th Cir. 1983) *(affirming, per curiam, Schulte v. Douglas*).

In light of the unanimity of the foregoing authorities, it is apparent that States currently must allow post-viability abortions for *mental* health reasons. However, it is unlikely that they can impose any meaningfully enforceable limitations on such abortions, because the *Doe* health "exception" is so broad that it swallows the rule. Furthermore, this Court has repeatedly refused to grant review in cases where it could have clarified the scope of the post-viability health exception mandated by *Roe*. See, e.g., *Women's Medical Prof'l Corp. v. Voinovich*, 130 F.3d 187 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998); *Guam Soc'y of Obstetricians & Gynecologists v. Ada*, 962 F.2d 1366 (9th Cir. 1992), *cert. denied*, 506 U.S. 1011 (1992).

Under *Roe* and its progeny, then, the States have no real authority to impose any meaningful limitations on abortion even *after* viability. So, as a practical matter, it is irrelevant whether an unborn child is deemed to be viable or not.

Accordingly, *Roe's* viability rule is utterly unworkable, in part, because it lacks any principled rationale, is standardless, and cannot be reasonably enforced. But, also, because it effectively allows abortion on demand—an outcome that *Roe* repeatedly stated was not intended.

CONCLUSION

In the end, the viability rule that has been called the "essential holding" of *Roe,* boils down to an arbitrary "cut-off" which is no cut-off at all. It is an illusory distinction without legal or practical significance.

Roe has pretended to be what it is not, for long enough. It should be overturned so that States once again may provide legal protection for unborn human life.

Respectfully submitted,

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