SB 179

<TARGET><BILL>SB 179</BILL><SUBJECT>SB 179</SUBJECT><COMM>SHSS29</COMM></TARGET>

SB 179 - VIABLE CHILD PROTECTION ACT

An Act prohibiting abortions when the unborn child is viable outside the pregnant woman's womb with certain exceptions; providing that an infant removed from a pregnant woman's womb alive after an abortion may be surrendered and found to be a child in need of aid

Prepared by Senator John Coghill's Office, March 29, 2016

SENATE BILL NO. 179

IN THE LEGISLATURE OF THE STATE OF ALASKA

TWENTY-NINTH LEGISLATURE - SECOND SESSION

BY SENATORS COGHILL, Giessel

Introduced: 2/12/16
Referred: Health and Social Services, Judiciary

A BILL

FOR AN ACT ENTITLED

"An Act prohibiting abortions when the unborn child is viable outside the pregnant woman's womb with certain exceptions; providing that an infant removed from a pregnant woman's womb alive after an abortion may be surrendered and found to be a child in need of aid; and repealing a prohibition against partial-birth abortions."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

*** Section 1.** AS 18.16.010(a) is amended to read:

(a) **Except as provided in (k) of this section, an** [AN] abortion may **only** [NOT] be performed **or induced** in this state **if** [UNLESS]

(1) the abortion is performed by a physician licensed by the State Medical Board under AS 08.64.200;

(2) the abortion is performed in a hospital or other facility approved for the purpose by the Department of Health and Social Services or a hospital operated by the federal government or an agency of the federal government;

(3) before an abortion is knowingly performed or induced on a

pregnant, unmarried, unemancipated woman under 18 years of age, notice or consent have been given as required under AS 18.16.020 or a court has authorized the minor to proceed with the abortion without parental involvement under AS 18.16.030 and the minor consents; for purposes of enforcing this paragraph, there is a rebuttable presumption that a woman who is unmarried and under 18 years of age is unemancipated;

(4) the woman is domiciled or physically present in the state for 30 days before the abortion; [AND]

(5) the applicable requirements of AS 18.16.060 have been satisfied; **and**

(6) in the clinical judgment of the physician performing or inducing the abortion, the unborn child is not viable outside the pregnant woman's womb at the time the abortion is performed or induced.

*** Sec. 2.** AS 18.16.010 is amended by adding new subsections to read:

(k) A physician may perform or induce an abortion when, in the physician's clinical judgment, the unborn child is viable outside the pregnant woman's womb only if

(1) the pregnancy is the result of sexual assault under AS 11.41.410 - 11.41.427, sexual abuse of a minor under AS 11.41.434 - 11.41.440, incest under AS 11.41.450, or an offense under a law of another jurisdiction with elements similar to one of these offenses; or

(2) the abortion is medically necessary.

(*l*) When a physician performs or induces an abortion under (k) of this section, the physician shall use the method of terminating the pregnancy that provides the best opportunity for the unborn child to survive after the child is removed from the pregnant woman's womb if, in the physician's clinical judgment, the method of terminating the pregnancy does not present a serious risk to the life or physical health of the pregnant woman.

(m) If the unborn child is removed from the pregnant woman's womb alive under (*l*) of this section, any health care practitioner present shall exercise the same degree of professional skill, care, and diligence to preserve the life and health of the

child as a reasonably diligent and conscientious health care practitioner would render to a child born alive at the same fetal age in the course of a natural birth.

(n) In this section,

(1) "alive" means that a child, after birth or removal from a pregnant woman's womb, has spontaneous respiratory or cardiac function or pulsation of the umbilical cord, regardless of whether the umbilical cord has been cut;

(2) "clinical judgment" means a physician's or surgeon's subjective professional medical judgment exercised in good faith;

(3) "fertilization" has the meaning given in AS 18.05.032(c);

(4) "fetal age" means the age of the unborn child as calculated from the moment of fertilization;

(5) "knowingly" has the meaning given in AS 11.81.900(a);

(6) "medically necessary" has the meaning given for "medically necessary abortion" in AS 47.07.068;

(7) "serious risk to the life or physical health" has the meaning given in AS 47.07.068;

(8) "viable" means capable of surviving outside the mother's womb, with or without artificial aid.

*** Sec. 3.** AS 18.16 is amended by adding a new section to read:

Sec. 18.16.012. Surrender of child removed from womb alive. If a child is removed from a pregnant woman's womb alive under AS 18.16.010(k) - (m), the child's parent may surrender the child to the physician or an employee of the hospital or facility where the abortion is performed under AS 47.10.013(c). The person to whom the child is surrendered shall notify the Department of Health and Social Services as required under AS 47.10.013(d).

*** Sec. 4.** AS 47.10.011 is amended to read:

Sec. 47.10.011. Children in need of aid. Subject to AS 47.10.019, the court may find a child to be a child in need of aid if it finds by a preponderance of the evidence that the child has been subjected to any of the following:

(1) a parent or guardian has abandoned the child as described in AS 47.10.013, and the other parent is absent or has committed conduct or created

conditions that cause the child to be a child in need of aid under this chapter;

(2) a parent, guardian, or custodian is incarcerated, the other parent is absent or has committed conduct or created conditions that cause the child to be a child in need of aid under this chapter, and the incarcerated parent has not made adequate arrangements for the child;

(3) a custodian with whom the child has been left is unwilling or unable to provide care, supervision, or support for the child, and the whereabouts of the parent or guardian is unknown;

(4) the child is in need of medical treatment to cure, alleviate, or prevent substantial physical harm or is in need of treatment for mental injury and the child's parent, guardian, or custodian has knowingly failed to provide the treatment;

(5) the child is habitually absent from home or refuses to accept available care and the child's conduct places the child at substantial risk of physical or mental injury;

(6) the child has suffered substantial physical harm, or there is a substantial risk that the child will suffer substantial physical harm, as a result of conduct by or conditions created by the child's parent, guardian, or custodian or by the failure of the parent, guardian, or custodian to supervise the child adequately;

(7) the child has suffered sexual abuse, or there is a substantial risk that the child will suffer sexual abuse, as a result of conduct by or conditions created by the child's parent, guardian, or custodian or by the failure of the parent, guardian, or custodian to adequately supervise the child; if a parent, guardian, or custodian has actual notice that a person has been convicted of a sex offense against a minor within the past 15 years, is registered or required to register as a sex offender under AS 12.63, or is under investigation for a sex offense against a minor, and the parent, guardian, or custodian subsequently allows a child to be left with that person, this conduct constitutes prima facie evidence that the child is at substantial risk of being sexually abused;

(8) conduct by or conditions created by the parent, guardian, or custodian have

(A) resulted in mental injury to the child; or

(B) placed the child at substantial risk of mental injury as a result of

(i) a pattern of rejecting, terrorizing, ignoring, isolating, or corrupting behavior that would, if continued, result in mental injury; [OR]

(ii) exposure to conduct by a household member, as defined in AS 18.66.990, against another household member that is a crime under AS 11.41.100 - 11.41.220, 11.41.230(a)(1) or (2), or 11.41.410 - 11.41.432, an offense under a law or ordinance of another jurisdiction having elements similar to a crime under AS 11.41.100 - 11.41.220, 11.41.230(a)(1) or (2), or 11.41.410 - 11.41.432, an attempt to commit an offense that is a crime under AS 11.41.100 - 11.41.220 or 11.41.410 - 11.41.432, or an attempt to commit an offense under a law or ordinance of another jurisdiction having elements similar to a crime under AS 11.41.100 - 11.41.220 or 11.41.410 - 11.41.432; or

(iii) repeated exposure to conduct by a household member, as defined in AS 18.66.990, against another household member that is a crime under AS 11.41.230(a)(3) or 11.41.250 - 11.41.270 or an offense under a law or ordinance of another jurisdiction having elements similar to a crime under AS 11.41.230(a)(3) or 11.41.250 - 11.41.270;

(9) conduct by or conditions created by the parent, guardian, or custodian have subjected the child or another child in the same household to neglect;

(10) the parent, guardian, or custodian's ability to parent has been substantially impaired by the addictive or habitual use of an intoxicant, and the addictive or habitual use of the intoxicant has resulted in a substantial risk of harm to the child; if a court has previously found that a child is a child in need of aid under this paragraph, the resumption of use of an intoxicant by a parent, guardian, or custodian within one year after rehabilitation is prima facie evidence that the ability to parent is substantially impaired and the addictive or habitual use of the intoxicant has resulted in a substantial risk of harm to the child as described in this paragraph;

(11) the parent, guardian, or custodian has a mental illness, serious emotional disturbance, or mental deficiency of a nature and duration that places the child at substantial risk of physical harm or mental injury;

(12) the child has committed an illegal act as a result of pressure, guidance, or approval from the child's parent, guardian, or custodian;

(13) the infant was removed from the mother's womb alive during an abortion performed under AS 18.16.010(k) - (m) and a parent of the child is unwilling or unable to care for the infant.

*** Sec. 5.** AS 18.16.010(g)(1) and 18.16.050 are repealed.

*** Sec. 6.** The uncodified law of the State of Alaska is amended by adding a new section to read:

APPLICABILITY. AS 18.16.010(a), as amended by sec. 1 of this Act, AS 18.16.010(k) - (n), added by sec. 2 of this Act, AS 18.16.012, added by sec. 3 of this Act, and AS 47.10.011, as amended by sec. 4 of this Act, apply to abortions performed or induced on or after the effective date of this Act.

REPEALED LANGUAGE

AS 18.16.010 (g) It is a defense to a prosecution or claim for violation of (a)(3) of this section that, in the clinical judgment of the physician or surgeon, compliance with the requirements of (a)(3) of this section was not possible because, in the clinical judgment of the physician or surgeon, an immediate threat of serious risk to the life or physical health of the pregnant minor from the continuation of the pregnancy created a medical emergency necessitating the immediate performance or inducement of an abortion. In this subsection,

(1) "clinical judgment" means a physician's or surgeon's subjective professional medical judgment exercised in good faith;

Sec. 18.16.050. Partial-birth abortions.

(a) Notwithstanding compliance with AS 18.16.010 , a person may not knowingly perform a partial-birth abortion unless a partial-birth abortion is necessary to save the life of a mother whose life is endangered by a physical disorder, illness, or injury and no other medical procedure would suffice for that purpose. Violation of this subsection is a class C felony.

(b) A woman upon whom a partial-birth abortion is performed may not be prosecuted under this section or under any other law if the prosecution is based on this section.

(c) In this section, "partial-birth abortion" means an abortion in which the person performing the abortion partially vaginally delivers a living fetus before killing the fetus and completing the delivery.

Alaska State Legislature

Senate Majority Leader

Joint Armed Services Committee
Co-Chairman
Judiciary Committee
Vice-Chairman
Resources Committee
State Affairs Committee
Legislative Council
Rules Committee

Senator John Coghill

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SB 179 - VIABLE CHILD PROTECTION ACT
Sponsor Statement

SB 179 introduces new restrictions and principles to late-term abortions. When the baby is capable of surviving outside the mother's womb, the physician will exercise the same degree of professional skill, care, and diligence to preserve the life and health of the child as would be render to a child alive in the course of a natural birth.

If the parents do not wish to keep the child after the birth of the child, the child will be considered a child in need of aid and a loving home will be found for the child.

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SECTIONAL
SB 179 Viable Child Protection Act

Sec. 1 Amends AS 18.16.010(a), **Abortions**, to include reference to an exception to abortions in subsection (k) for the abortion of a viable baby only in the case of rape, incest or when medically necessary.

Adds a provision that provides an abortion may be performed only when in the clinical judgment of the physician performing or inducing the abortion determines the unborn child is not viable outside the pregnant woman's womb at the time the procedure is performed.

Sec. 2. Allows the physician to perform or induce an abortion when the child is viable only in the cases of incest, rape, or the abortion is medically necessary. Subsection (k).

Requires the physician to use the method of terminating the pregnancy that best provides for the unborn child to survive outside the woman's womb.

Requires any health practitioner present at the procedure to exercise the same degree of professional practice and diligence to preserve the life of the viable child born as a child born alive during the course of aa natural birth.

Provides definitions for "alive", "clinical judgment", "fertilization", "fetal age", "knowingly", "medically necessary", "serious risk to the life or physical health", and "viable".

Sec. 3. When a child is removed alive , the parents may surrender the child a physician or employee of the hospital and will be immune from prosecution under the safe surrender provisions of AS 11.81.500. The person receiving physical custody of the child will notify Office of Child's Services that he or she has physical custody of a child in need of aid (CINA).

Sec. 4. Amends the CINA provision to include as a child in need of aid a child removed from the mother's womb alive during an abortion and a parent is unwilling or unable to care for the infant.

Sec. 5. Repeals AS 18.16.010(g)(1), "clinical judgment. This language is moved to **Sec. 2**, so the definition applies to all of 18.16.010 (page 3, line 7).

Also repeals AS 18.16.050, which is a statute that was ruled unconstitutional by the Alaska Supreme Court.

Sec. 6. Applies to abortions performed or induced on or after the effective date of the Act.

SB 179 - VIABLE CHILD PROTECTION ACT

Baby born at 23 weeks, 4 days

Baby born at 21 weeks

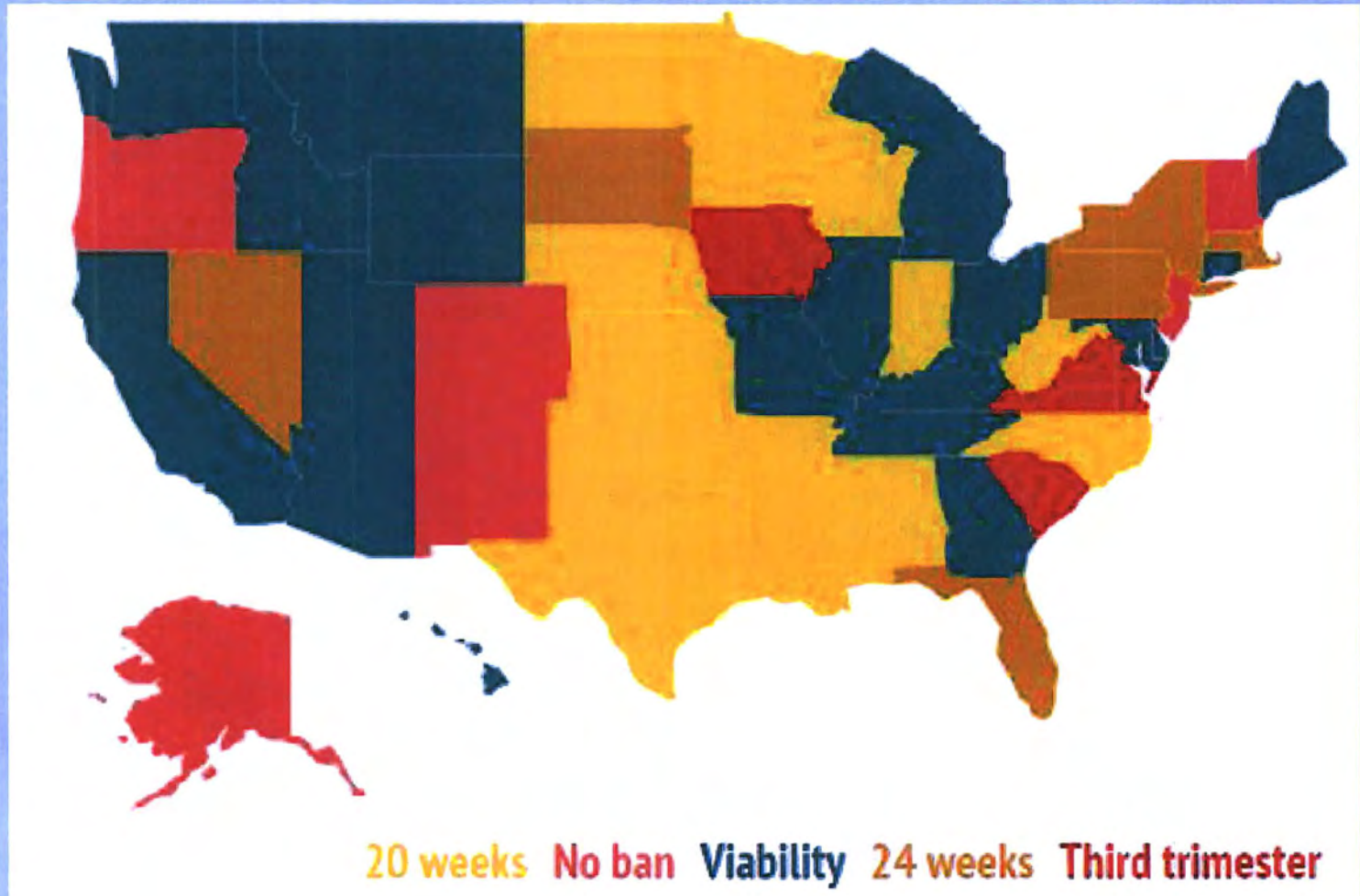
Presentation to Senate Health & Social Services Committee
By Senator John Coghill
March 30, 2016

The United States is one of only seven countries worldwide out of 198 countries analyzed that permit elective abortions past 20 weeks. This study puts the U.S. in the top 5% of the most permissive countries on abortion in the world.

Charlotte Lozier Institute report entitled *"Gestational Limits on Abortion in the United States Compared to International Norms,* Angelina Baglini, J.D., author, February, 2014

States With No Ban

Alaska
Colorado
New Hampshire
New Jersey
New Mexico
Oregon
Vermont



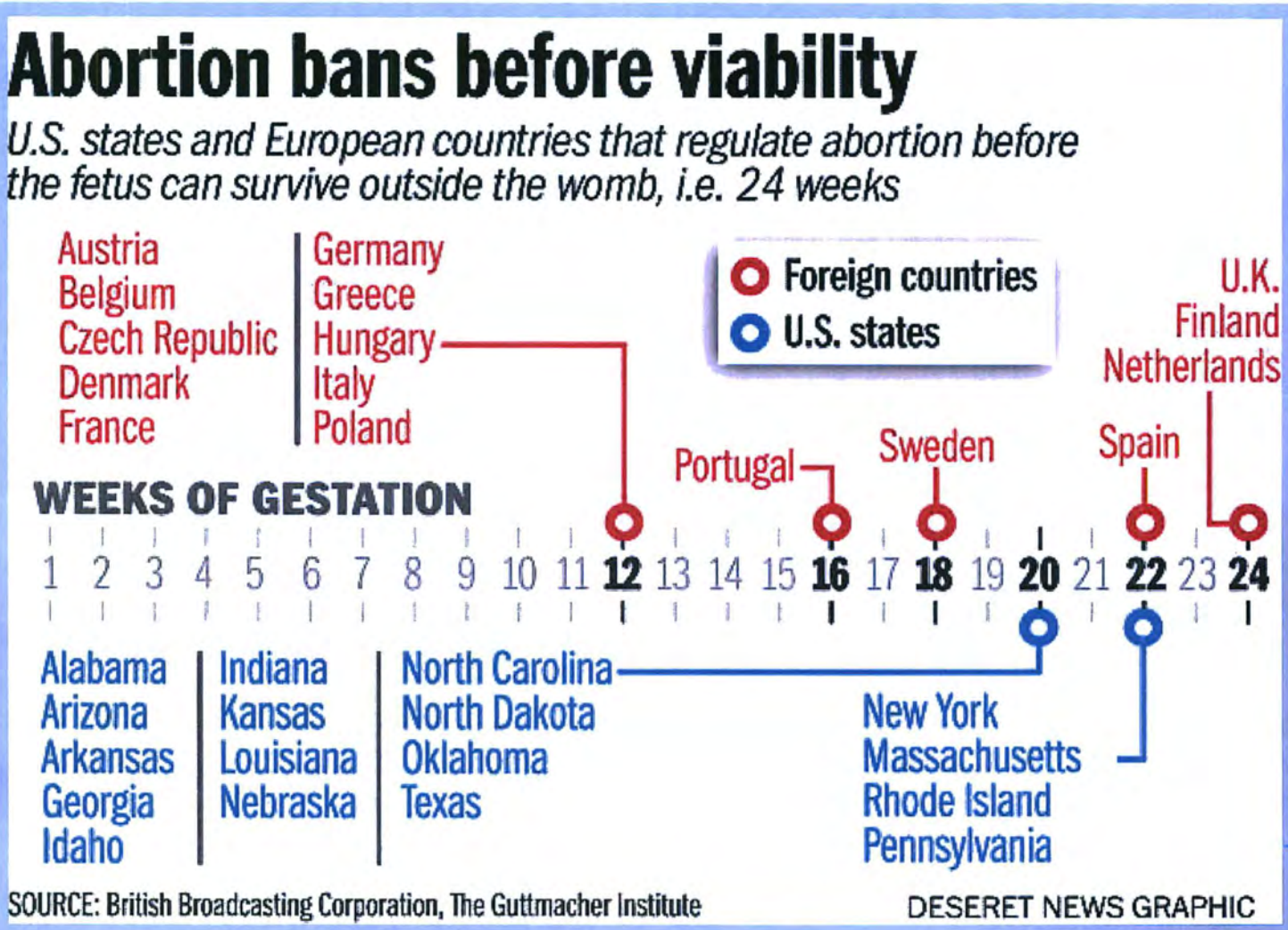
Source: Diane Rehm Show, June 11, 2015; NPR interview of Elizabeth Nash of the Guttmacher Institute.

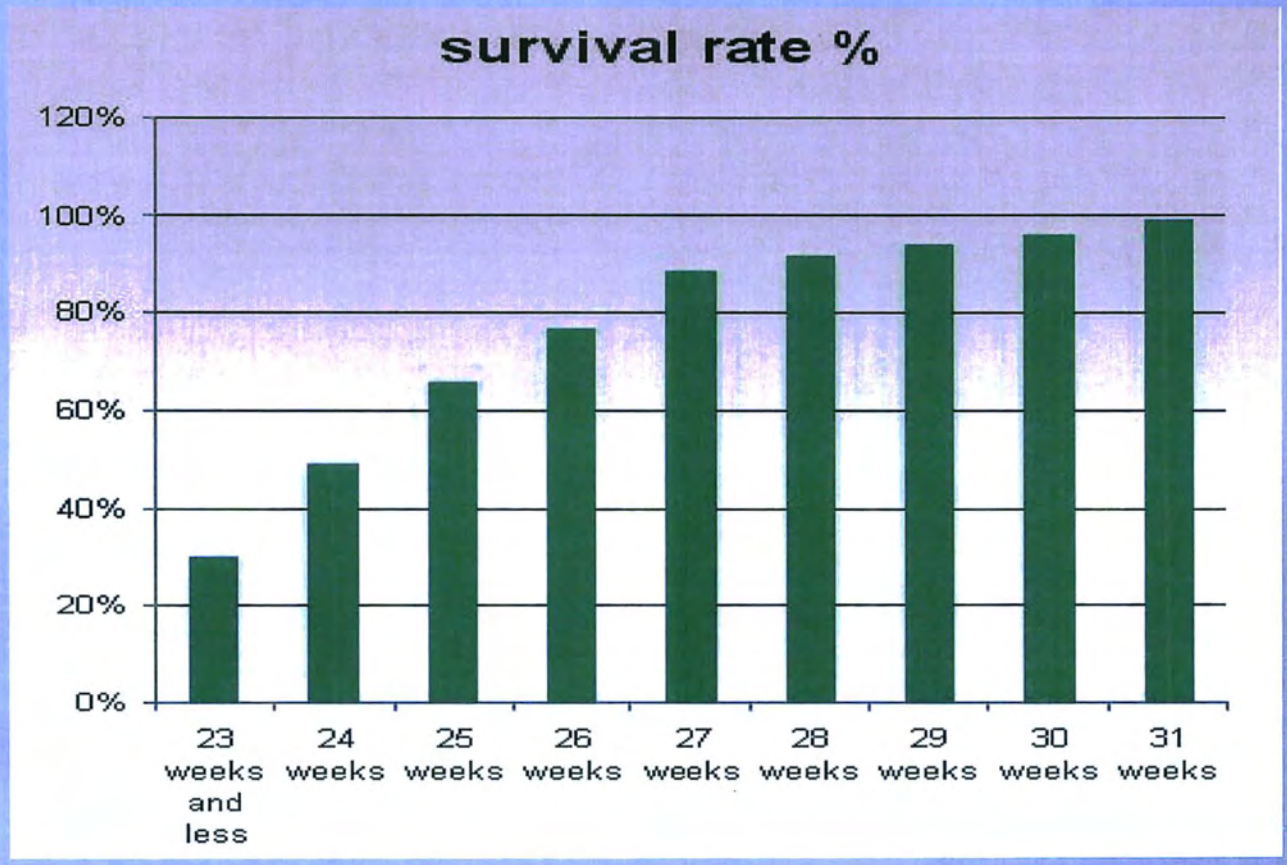
Third Trimester Ban

Iowa

South Carolina

Virginia


Abortion bans before viability
U.S. states and European countries that regulate abortion before the fetus can survive outside the womb, i.e. 24 weeks
Austria
Belgium
Czech Republic
Denmark
France
Germany
Greece
Hungary
Italy
Poland
Foreign countries
U.S. states
U.K.
Finland
Netherlands
Portugal
Sweden
Spain
WEEKS OF GESTATION
1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24
Alabama
Arizona
Arkansas
Georgia
Idaho
Indiana
Kansas
Louisiana
Nebraska
North Carolina
North Dakota
Oklahoma
Texas
New York
Massachusetts
Rhode Island
Pennsylvania
SOURCE: British Broadcasting Corporation, The Guttmacher Institute
DESERET NEWS GRAPHIC



http://www.lilaussieprems.com.au/survival-rate-for-premature-babies/

U.S. Views on Legality of Abortion by Trimester

Thinking more generally, do you think abortion should generally be legal or generally illegal during each of the following stages of pregnancy?

	Should be legal	Should be illegal	Depends (vol.)	No opinion
	%	%	%	%
First three months of pregnancy	61	31	6	3
Second three months of pregnancy	27	64	5	4
Last three months of pregnancy	14	80	4	2

(vol.) = Volunteered response

USA Today/Gallup, Dec. 27-30, 2012

GALLUP

BABY DELIVERED AT 27 WEEKS

Presentation to Senate Health & Social Services Committee by Senator John Coghill-March 30, 2016

In ***ROE V. WADE***, 410 U.S. 113 (1973) the Supreme Court maintained that the state has an interest in protecting the life of a fetus after viability—that is, after the point at which the fetus is capable of living outside the womb.

Baby delivered at 22 weeks.

Presentation to Senate Health & Social Services Committee by Senator John Coghill-March 30, 2016

Roe v. Wade 410 U.S. 113 (1973)

"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 [p164] during that period, except when it is necessary to preserve the life or health of the mother."

Forty-three other States have viability provisions to protect the child.

Nathan was delivered at 23 weeks, These are his hand prints at two day old.

Nineteen States are Time Specific

Alabama	20 wks	New York	24 wks
Arizona	20 wks	North Carolina	20 wks
Florida	24 wks	North Dakota	20 wks
Indiana	20 wks	Oklahoma	20 wks
Iowa	3rd Tri	Pennsylvania	24 wks
Kansas	20 wks	Rhode Island	24 wks
Lousiana	20 wks	South Carolina	3rd Tri
Massachusetts	24 wks	South Dakota	24 wks
Minnesota	24 wks	Texas	20 wks
Mississippi	20 wks	Virgina	3rd Tri
Nebraska	20 wks	West Virginia	20 wks
Nevada	24 wks		

Viability Provisions: Arizona, California, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Kentucky, Maine, Maryland, Mississippi, Missouri, Montana, Ohio, Tennessee, Utah, Washington, Wisconsin, and Wyoming

***Planned Parenthood of Central Missouri v. Danforth,* (74-1151), 428 U.S. 52 (1976)**

Court upholds viability definition.

In *Roe,* we used the term "viable," properly we thought, to signify the point at which the fetus is "potentially able to live outside the mother's womb, albeit with artificial aid," and presumably capable of "meaningful life outside the mother's womb," 410 U. S., at 160, 163.

Twenty-one week baby.

Planned Parenthood of Southeastern Pa. v. Casey (91-744), 505 U.S. 833 (1992)

"It must be stated at the outset and with clarity that *Roe*'s essential holding, the holding we reaffirm, has three parts.

First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure.

Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger a woman's life or health.

And third is the principle that the State has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child. These principles do not contradict one another; and we adhere to each."

Baby born at 23 weeks and four days gestation.

Gonzales v. Carhart, (05–380), 413 F. 3d 791 (2007)

Court upholds federal law restricting partial-birth abortion

"Under the principles accepted as controlling here, the Act, as we have interpreted it, would be unconstitutional "if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Casey,* 505 U. S., at 878."

Presentation to Senate Health & Social Services Committee by Senator John Coghill-March 30, 2016

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STATE POLICIES IN BRIEF

As of MARCH 1, 2016

An Overview of Abortion Laws

BACKGROUND: Since the Supreme Court handed down its 1973 decisions in *Roe v. Wade* and *Doe v. Bolton*, states have constructed a lattice work of abortion law, codifying, regulating and limiting whether, when and under what circumstances a woman may obtain an abortion. The following table highlights the major provisions of these state laws. More detailed information can be found by selecting the table column headings in blue. Except where noted, the laws are in effect, although they may not always be enforced.

HIGHLIGHTS:

- *Physician and Hospital Requirements*: 38 states require an abortion to be performed by a licensed physician. 18 states require an abortion to be performed in a hospital after a specified point in the pregnancy, and 18 states require the involvement of a second physician after a specified point.
- *Gestational Limits*: 43 states prohibit abortions, generally except when necessary to protect the woman's life or health, after a specified point in pregnancy, most often fetal viability.
- *"Partial-Birth" Abortion*: 19 states have laws in effect that prohibit "partial-birth" abortion. 3 of these laws apply only to postviability abortions.
- *Public Funding*: 17 states use their own funds to pay for all or most medically necessary abortions for Medicaid enrollees in the state. 32 states and the District of Columbia prohibit the use of state funds except in those cases when federal funds are available: where the woman's life is in danger or the pregnancy is the result of rape or incest. In defiance of federal requirements, South Dakota limits funding to cases of life endangerment only.
- *Coverage by Private Insurance*: 11 states restrict coverage of abortion in private insurance plans, most often limiting coverage only to when the woman's life would be endangered if the pregnancy were carried to term. Most states allow the purchase of additional abortion coverage at an additional cost.
- *Refusal*: 45 states allow individual health care providers to refuse to participate in an abortion. 42 states allow institutions to refuse to perform abortions, 16 of which limit refusal to private or religious institutions.
- *State-Mandated Counseling*: 17 states mandate that women be given counseling before an abortion that includes information on at least one of the following: the purported link between abortion and breast cancer (5 states), the ability of a fetus to feel pain (12 states) or long-term mental health consequences for the woman (7 states).
- *Waiting Periods*: 28 states require a woman seeking an abortion to wait a specified period of time, usually 24 hours, between when she receives counseling and the procedure is performed. 14 of these states have laws that effectively require the woman make two separate trips to the clinic to obtain the procedure.
- *Parental Involvement*: 38 states require some type of parental involvement in a minor's decision to have an abortion. 25 states require one or both parents to consent to the procedure, while 13 require that one or both parents be notified.

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CONTINUED

OVERVIEW OF STATE ABORTION LAW (PAGE 1 OF 2)

STATE	MUST BE PERFORMED BY A LICENSED PHYSICIAN	MUST BE PERFORMED IN A HOSPITAL IF AT:	SECOND PHYSICIAN MUST PARTICIPATE IF AT:	PROHIBITED EXCEPT IN CASES OF LIFE OR HEALTH ENDANGERMENT IF AT:	"PARTIAL-BIRTH" ABORTION BANNED	PUBLIC FUNDING OF ABORTION		PRIVATE INSURANCE COVERAGE LIMITED
						Funds All or Most Medically Necessary Abortions	Funds Limited to Life Endangerment, Rape and Incest	
AL	X	Viability	Viability	20 weeks*	▼		X	
AK	X				▼	X		
AZ	X	Viability	Viability	Viability	X	X		X
AR	X		Viability	20 weeks†	X		X	
CA				Viability		X		
CO							X	
CT		Viability		Viability		X		
DE	X			Viability			X	
DC							X	
FL	X	Viability	24 weeks	24 weeks	▼		X	
GA	X			Viability	Postviability		X	
HI	X			Viability		X		
ID	X	Viability	3rd trimester	Viability	▼		X	X
IL			Viability	Viability	▼	X		
IN	X	20 weeks	20 weeks	20 weeks*	X		X*	X
IA	X			3rd trimester	▼		X	
KS	X		Viability	20 weeks*	X		X	X
KY	X	2nd trimester		Viability	▼		X	X
LA	X		Viability	20 weeks*	X		X	
ME	X			Viability			X	
MD	X			Viability$^{\Omega}$		X		
MA	X			24 weeks		X		
MI	X			Viability‡	X		X	X
MN	X		20 weeks	24 weeks		X		
MS	X$^{\Phi}$			20 weeks*	X		X$^{\Omega}$	
MO	X	Viability	Viability	Viability	▼		X	X
MT			Viability	Viability*	Postviability	X		
NE	X			20 weeks*	▼		X	X
NV	X	24 weeks		24 weeks			X	
NH					X		X	
NJ	X$^{\xi}$	14 weeks			▼	X		
NM	X				Postviability	X		
NY			24 weeks	24 weeks‡		X		
NC	X	20 weeks		20 weeks			X	
ND	X			20 weeks*	X		X	X
OH	X	Viability	Viability	Viability*	X		X	
OK	X	2nd trimester	Viability	20 weeks*	X		X	X
OR						X		
PA	X	Viability	Viability	24 weeks*			X	
RI				24 weeks‡	▼		X	▼
SC	X	3rd trimester	3rd trimester	3rd trimester	X		X	
SD	X	24 weeks		24 weeks	X		Life Only	
TN	X			Viability	X		X	
TX	X			20 weeks*			X	
UT	X			Viability†,$^{\Omega}$	X		X*	X
VT						X		
VA	X	2nd trimester	Viability	3rd trimester	X		X$^{\Omega}$	
WA				Viability		X		
WV				20 weeks*	▼	X		
WI	X	Viability		Viability	▼		X*	
WY	X			Viability			X	
TOTAL	**38**	**18**	**18**	**43**	**19**	**17**	**32+DC**	**11**

▼ Permanently enjoined; law not in effect.

* Exception in case of threat to the woman's physical health.
† Exception in case of rape or incest.
‡ Exception in case of life endangerment only.
Ω Exception in case of fetal abnormality.
ξ Only applies to surgical abortion.
Φ Law limits abortion provision to OB/GYNs.

CONTINUED

OVERVIEW OF STATE ABORTION LAW (PAGE 2 OF 2)

STATE	PROVIDERS MAY REFUSE TO PARTICIPATE		MANDATED COUNSELING INCLUDES INFORMATION ON:			WAITING PERIOD (in Hours) AFTER COUNSELING	PARENTAL INVOLVEMENT REQUIRED FOR MINORS
	Individual	Institution	Breast Cancer Link	Fetal Pain	Negative Psychological Effects		
AL						48	Consent
AK	X	Private	X	X			Notice
AZ	X	X				24	Consent
AR	X	X		X[Φ]		48	Consent
CA	X	Religious					▼
CO							Notice
CT	X						
DE	X	X				▼	Notice[ξ]
DC							
FL	X	X				24	Notice
GA	X	X		X		24	Notice
HI	X	X					
ID	X	X				24	Consent
IL	X	Private					Notice
IN	X	Private		X		18	Consent
IA	X	Private					Notice
KS	X	X	X	X	X	24	Consent
KY	X	X				24	Consent
LA	X	X		X	X	24	Consent
ME	X	X					
MD	X	X					Notice
MA	X	X				▼	Consent
MI	X	X			X	24	▼
MN	X	Private		X[Φ]		24	Notice[þ]
MS	X	X	X			24	Consent[þ]
MO	X	X		X[Φ]		72	Consent
MT	X	Private				▼	Notice
NE	X	X			X	24	Consent
NV	X	Private					▼
NH							Notice
NJ	X	Private					▼
NM	X	X					▼
NY	X						
NC	X	X			X	72	Consent
ND	X	X				24	Consent[þ]
OH	X	X				24	Consent
OK	X	Private	X	X[Φ]		72	Consent and Notice
OR	X	Private					
PA	X	Private				24	Consent
RI	X						Consent
SC	X	Private				24	Consent
SD	X	X		X	X	72[◊]	Notice
TN	X	X				48	Consent
TX	X	Private	X	X	X	24	Consent and Notice
UT	X	Private		X[Φ]	X	72[◊]	Consent and Notice
VT							
VA	X	X				24	Consent and Notice
WA	X	X					
WV					X	24	Notice[ξ]
WI	X	X				24	Consent[ξ]
WY	X	Private					Consent and Notice
TOTAL	**45**	**42**	**5**	**12**	**9**	**28**	**38**

▼ Permanently enjoined; law not in effect.
§ Enforcement temporarily enjoined by court order; policy not in effect.

Φ Fetal pain information is given only to women who are at least 20 weeks gestation; in Missouri at 22 weeks gestation.
þ Both parents must consent to the abortion.
ξ Specified health professionals may waive parental involvement in certain circumstances.
◊ In South Dakota, the waiting period excludes weekends or annual holidays and in Utah the waiting period is waived in cases of rape, incest, fetal defect or if the patient is younger than 15.

FOR MORE INFORMATION:

For information on state policy activity, click on Guttmacher's Monthly State Update, for state policy information see Guttmacher's State Policies in Brief series, and for information and data on reproductive health issues, go to Guttmacher's State Center. To see state-specific reproductive health information go to Guttmacher's Data Center, and for abortion specific information click on State Facts About Abortion. To keep up with new state relevant data and analysis sign up for the State News Quarterly Listserv.

State Facts About Abortion

Alaska

National Background and Context

Abortion is a common experience: At current rates, about three in ten American women will have had an abortion by the time she reaches age 45. Moreover, a broad cross section of U.S. women have abortions. 58% of women having abortions are in their 20s; 61% have one or more children; 85% are unmarried; 69% are economically disadvantaged; and 73% report a religious affiliation. No racial or ethnic group makes up a majority: 36% of women obtaining abortions are white non-Hispanic, 30% are black non-Hispanic, 25% are Hispanic and 9% are of other racial backgrounds.

Contraceptive use is a key predictor of women's recourse to abortion. The very small group of American women who are at risk of experiencing an unintended pregnancy but are not using contraceptives account for more than half of all abortions. Many of these women did not think they would get pregnant or had concerns about contraceptive methods. The remainder of abortions occur among the much larger group of women who were using contraceptives in the month they became pregnant. Many of these women report difficulty using contraceptives consistently.

Abortion is one of the safest surgical procedures for women in the United States. Fewer than 0.5% of women obtaining abortions experience a complication, and the risk of death associated with abortion is about one-tenth that associated with childbirth.

In the 1973 *Roe v. Wade* decision, the U.S. Supreme Court ruled that a woman, in consultation with her physician, has a constitutionally protected right to choose abortion in the early stages of pregnancy-that is, before viability. In 1992, the Court upheld the basic right to abortion in *Planned Parenthood v. Casey.* However, it also expanded the ability of the states to enact all but the most extreme restrictions on women's access to abortion. The most common restrictions in effect are parental notification or consent requirements for minors, limitations on public funding, and unnecessary and overly burdensome regulations on abortion facilities.

Pregnancies and Their Outcomes

• In 2011, there were 6 million pregnancies to the 63 million women of reproductive age (15-44) in the United States. Sixty-seven percent of these pregnancies resulted in live births and 18% in abortions; the remaining 15% ended in miscarriage.

• In Alaska, 15,700 of the 146,228 women of reproductive age became pregnant in 2011. 73% of these pregnancies resulted in live births and 12% in induced abortions.

• In 2011, 1.1 million American women obtained abortions, producing a rate of 16.9 abortions per 1,000 women of reproductive age. The rate is a decrease from 2008, when the abortion rate was 19.4 abortions per 1,000 women 15-44.

• In 2011, 1,820 women obtained abortions in Alaska, producing a rate of 12.4 abortions per 1,000 women of reproductive age. Some of these women were from other states, and some Alaska residents had abortions in other states, so this rate may not reflect the abortion rate of state residents. The rate increased 3% since 2008, when it was 12.1 abortions per 1,000 women 15-44. Abortions in Alaska represent 0.2% of all abortions in the United States.

Where Do Women Obtain Abortions?

• In 2011, there were 1,720 abortion providers in the United States. This is a slight (4%) decrease from 2008, when there were 1,787 abortion providers. Thirty-five percent of these providers were hospitals, 19% were abortion clinics (clinics where more than half of all patient visits were for abortion), 30% were clinics where fewer than half of all visits were for abortion, and 17% were private physicians' offices. Sixty-three percent of all abortions were provided at abortion clinics, 31% at other clinics, 4% at hospitals and 1% at private physicians' offices.

• In 2011, there were 9 abortion providers in Alaska; 4 of those were clinics. This represents a 13% increase in overall providers and a a 33% increase in clinics from 2008, when there were 8 abortion providers overall, of which 3 were abortion clinics.

• In 2011, 89% of U.S. counties had no abortion clinic. 38% of American women lived in these counties, which meant they would have to travel outside their county to obtain an abortion. Of women obtaining abortions in 2008, one-third traveled more than 25 miles.

• In 2011, 90% of Alaska counties had no abortion clinic. 37% of Alaska women lived in these counties.

Restrictions on Abortion

• A woman must receive state-directed counseling that includes information designed to discourage her from having an abortion before the procedure is provided.

• The parent of a minor must be notified before an abortion is provided.

Definitions and Data Sources

References for information contained in this fact sheet are available at http://www.guttmacher.org/pubs/sfaa/sfaa-sources.html

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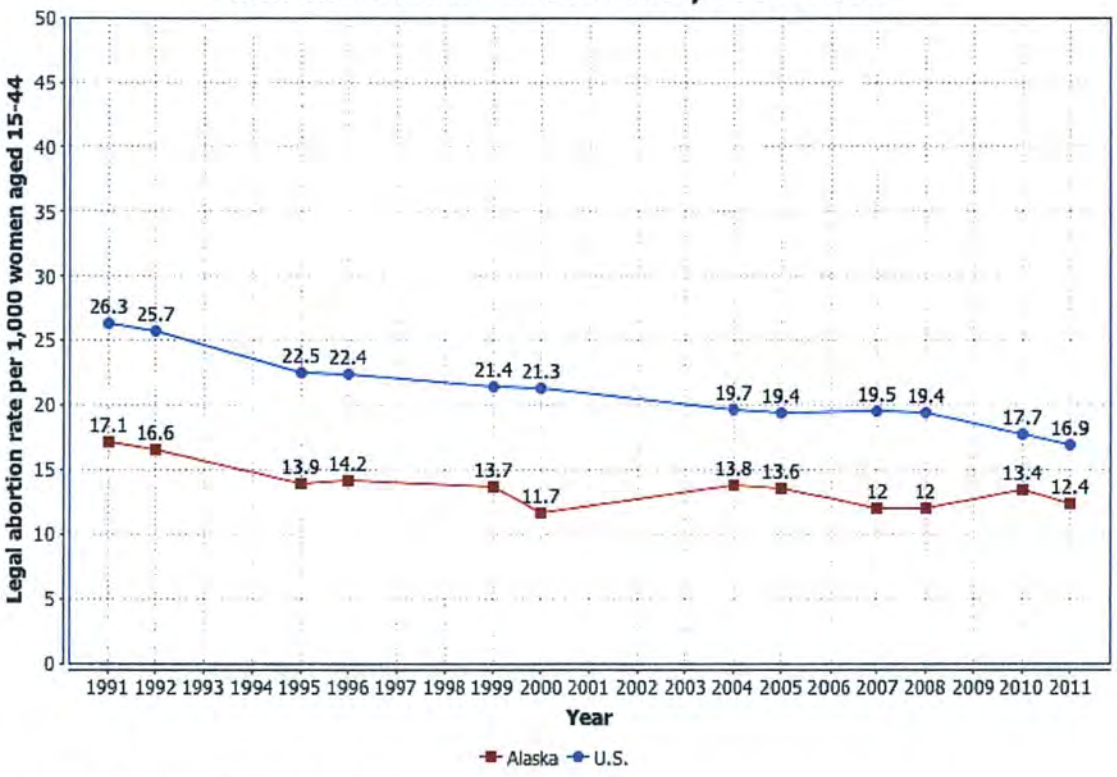
U.S. and Alaska abortion rates, 1991-2011



CHARLOTTE LOZIER INSTITUTE

American Reports Series
Issue 6 | February 2014

Gestational Limits on Abortion in the United States Compared to International Norms

Angelina Baglini, J.D.

The Charlotte Lozier Institute's American Reports Series presents analysis of issues affecting the United States at the national level. These reports are intended to provide insight into various issues concerning life, science, and bioethics.

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Charles A. Donovan, *The Adoption Tax Credit: Progress and Prospects for Expansion, American Reports Series 4.*
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Abstract: *The United States is one of only seven countries in the world that permit elective abortion past 20 weeks. Upholding laws restricting abortion on demand after 20 weeks would situate the United States closer to the international mainstream, instead of leaving it as an outlying country with ultra-permissive abortion policies.*

This report compares gestational limits in United States abortion law with gestational limits in the abortion law of the international community. The goal is to determine where the United States stands in comparison to international norms, with its federal policy enshrined in *Roe v. Wade*, which allows abortion past 20 weeks and without restriction until fetal viability.

The sample group for this project included a total of 198 countries, independent states, and semi-autonomous regions with populations exceeding 1 million. Of these 198 countries, independent states, and regions worldwide, 59 allow abortion without restriction as to reason, otherwise known as elective abortion or abortion on demand. The remaining 139 countries require *some* reason to obtain an abortion ranging from most restrictive (to save the life of the mother or completely prohibited) to least restrictive (socioeconomic grounds) with various reasons in between (e.g., physical health, mental health).[i]

Currently, the United States permits abortion on demand through viability, which is usually marked around 24 weeks. For this report, it is appropriate to compare the United States with the other 58 countries that allow abortion on demand up to some point in pregnancy. The remaining 139 countries require some reason to obtain an abortion (that is to say, they do not permit abortion on demand) and are, by definition, more restrictive than the United States on the issue of gestational limits. To require some reason before obtaining an abortion is inherently more restrictive than not requiring any reason at all.

This report finds that the United States is one of only seven countries in the world that permit elective abortion past 20 weeks. This finding suggests that current proposals in the United States to restrict elective abortions past 20 weeks would move the United States from the fringe, ultra-permissive end of the spectrum to a position closer to international norms.

Terminology and Method of Comparison

Not all countries or statutes use the same terminology when drafting restrictions on late-term elective abortion. When drafting a restriction on elective abortion past 20 weeks of pregnancy, the most common measurement of "weeks of pregnancy" is gestational age, or in short form "gestation." Gestational age marks the duration of pregnancy, which is most commonly and medically measured from the date of the

woman's last menstrual period. The woman's last menstrual period is the most identifiable date by which to measure the duration of pregnancy, and occurs approximately two weeks before conception or fertilization.

The vast majority of countries in this international survey of abortion laws use gestational age to measure duration of pregnancy. Over 80% of countries maintaining some restriction on elective abortion use gestational age as the method of calculating duration of pregnancy. However, a minority of countries measures duration of pregnancy from "conception" or "fertilization." One country measures from the time of "implantation," which occurs approximately one week after conception or fertilization. Some statutes do not even specify a method of measurement, simply using the vague term "weeks of pregnancy" without indicating a precise method measuring the duration of pregnancy.

Conception or fertilization is the moment when an ovum and sperm unite, which creates a unique human organism. The date of conception or fertilization is often difficult to determine, as few women know the exact date they conceived. Because the last menstrual period is a more ascertainable date, in many cases doctors add two weeks to the woman's last menstrual period to approximate the date of conception or fertilization.

Using Gestational Age to Produce the Best International Comparison

This report uses gestation to compare restrictions on elective abortion that are based on duration of pregnancy. More than 80% of countries already use gestation in establishing duration of pregnancy restrictions on elective abortion and measuring the age of the unborn child using gestation is in line with common medical practice.

For those countries that use a different measurement of age, such as conception or fertilization or pregnancy, this study converts the measurement of age into gestation by adding two weeks to date back to the woman's last menstrual period. Using gestation as a common method of measuring duration of pregnancy restrictions on elective abortion produces a more meaningful comparison.

International Gestational Limitations on Elective Abortion

The sample group of countries for this project included a total of 198 countries, independent states, and semi-autonomous regions with populations exceeding 1 million.[1]

Of these 198 countries, independent states, and regions worldwide, 59 allow abortion without restriction as to reason, otherwise known as elective abortion or abortion on demand.[2] [ii]

The remaining 139 countries require some reason to obtain an abortion ranging from most restrictive (to save the life of the mother or completely prohibited) to least restrictive (socioeconomic grounds) with various reasons in between (e.g., physical health, mental health).[iii] [iv] [v] [vi]

Of the 59 countries permitting elective abortion[vii]:

- 9 countries limit elective abortion before the 12th week of gestation[3],
- 36 countries limit elective abortion at 12 weeks gestation[4] [5] [6],

[1] For purposes of this study, Puerto Rico is not included as a separate "country, independent state, or semi-autonomous region with population exceeding 1 million" as it follows the elective abortion policy of the United States and is subject to the constitutional determination of *Roe v. Wade* on elective abortion permissiveness. Center for Reproductive Rights, "The Legal Right to Abortion in Puerto Rico," July 2009

[2] Other studies have counted 60 countries in the category of abortion without restriction as to reason. This study discovered that Bahrain could not be considered a country allowing elective abortion, as it permits abortion only to save the life of the mother in practice, although the country's statutory language is vague.

[3] Three countries (Croatia, Macedonia, Montenegro) limit elective abortion past 10 weeks from conception. Converting this statutory language to gestational age, Croatia, Macedonia, and Montenegro limit elective abortion past 12 weeks gestational age. Using gestational age, Croatia, Macedonia, and Montenegro belong in the category of limiting abortion "at 12 weeks."

[4] Two countries (Belgium, Germany) limit elective abortion past 12 weeks from conception. Converting this statutory language to gestational age, Belgium and Germany limit elective abortion past 14 weeks gestational age. Using gestational age, Belgium and Germany belong in the category of limiting abortion "between 12 and 20 weeks."

[5] Two countries (Mongolia, Tunisia) limit elective abortion past 12 weeks of "pregnancy" without defining how pregnancy duration is measured. This study measures 12 weeks of "pregnancy" as 12 weeks gestational age, therefore Mongolia and Tunisia are included in the category limited "at 12 weeks." However, if Mongolia and Tunisia measure "pregnancy" from the date of conception or fertilization, then they would belong in the category "between 12 and 20 weeks."

[6] Luxembourg recently broadened its abortion policy in 2013 to allow women to decide if they are "in distress" for purposes of obtaining an abortion within the first 12 weeks of pregnancy. This broadening of the law effectively allows elective abortion in the first 12 weeks of pregnancy. Luxembourg does not specify whether "weeks of pregnancy" are measured by gestational age or from conception or fertilization. "Restrictions on abortion in Luxembourg to be relaxed," November 2013, http://www.wort.lu/en/view/restrictions-on-abortion-in-luxembourg-to-be-relaxed-

- 6 countries limit elective abortion between 12 and 20 weeks gestation[7] [8],
- 7 countries permit elective abortion past 20 weeks or have no gestational limit.
- 1 country maintains a federal system where abortion policy is determined at the state/territory level, and at least two of those states permit elective abortion past 20 weeks.

Australia is the one country where a federal system is in place, but abortion policy is determined on the state or territory level. Three states or territories within Australia permit elective abortion, and two allow elective abortion past 20 weeks. However, other states and territories of Australia maintain more restrictive abortion policies and some do not permit elective abortion at all.[viii] Due to the diverse range of abortion policy in Australia, from restrictive to ultra-permissive, this study does not include Australia, as a whole, as a country that permits elective abortion past 20 weeks.

More than 75% of the countries permitting abortion without restriction as to reason do not permit elective abortions past 12 weeks gestation.[ix] [x]

Only 12% (7 out of 59) of the countries permitting abortion without restriction as to reason permit elective abortion past 20 weeks gestation.

The U.S. is among these 7 countries that permit elective abortion past 20 weeks.[xi] This is true whether 20 weeks is measured from the last menstrual period (gestational age), conception, or implantation. No matter how duration of pregnancy is measured, whether by gestational age or conception or fertilization, or implantation, all countries in this category pass the 20-week threshold. These countries/territories are:

50af1938e4b0246412999677. Luxembourg Penal Code, L. Nov. 15, 1978, Art. 353. This study measures 12 weeks of "pregnancy" as 12 weeks gestational age; therefore, Luxembourg is included in the category limited "at 12 weeks." However, if Luxembourg measures "pregnancy" from the date of conception or fertilization, then it would belong in the category "between 12 and 20 weeks."

[7] Sweden limits elective abortion past 18 weeks of "pregnancy" without defining how pregnancy duration is measured. However, whether Sweden measures 18 weeks from conception or fertilization (20 weeks gestational age) or measures 18 weeks gestational age, Sweden's law still falls in the category "between 12 and 20 weeks."

[8] Austria is the only country permitting elective abortion that measures duration of pregnancy from the date of "implantation." Austria restricts elective abortion past the first 3 months of pregnancy measured from implantation. In terms of gestational age this would convert to approximately 15 weeks. Using gestational age, Austria falls in the category of "between 12 and 20 weeks."

- Canada (no restriction in law)[xii]
- China (no restriction in law)[xiii]
- Netherlands (24 weeks)
- North Korea (no restriction in law)
- Singapore (24 weeks)
- United States (viability)[9]
- Vietnam (no restriction in law)[xiv]

The United States is within the top 4% of most permissive abortion policies in the world (7 out of 198) when analyzing restrictions on elective abortion based on duration of pregnancy.

Implications for Current Policy in the United States

Under U.S. law, abortion on demand is permitted without restriction through viability. Viability can vary, and is decreasing in terms of weeks of gestation as perinatal medicine advances, but normally occurs no earlier than 24 weeks.

Recently, in the United States, there has been great interest in restricting abortion on demand after 20 weeks.[xv] [xvi] Two states have had 20-week laws on the books since before *Roe v. Wade*. Eleven more states have enacted 20-week laws in recent years.[10] A proposed 20-week law in Albuquerque, New Mexico failed to gain majority support in 2013 but was notable for the engaged citizen activism that resulted in the proposal being put on a municipal ballot for a direct vote.[xvii]

There is also interest at the federal level in restricting elective abortion after 20 weeks. In 2013, the U.S. House of Representatives passed a 20-week law.[xviii] A similar law has been introduced in the U.S. Senate.[11] [xix]

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[9] Puerto Rico is not considered a separate country for purposes of this study, as it follows U.S. elective abortion policy, permitting abortion on demand through fetal viability without restriction. Puerto Rico is included under the United States as a special jurisdiction that allows elective abortion past 20 weeks. Center for Reproductive Rights, "The Legal Right to Abortion in Puerto Rico," July 2009

[10] Twenty-week laws have been challenged in court. To date, Arizona, Georgia, and Idaho have been involved in litigation defending their 20-week restrictions on elective abortion. Although the U.S. Supreme Court recently declined to hear a case involving a 20-week law, it will likely consider the issue at some point.

[11] Five states have enacted or attempted to enact 20-week laws using gestational age. Nine states have enacted or attempted to enact 20-week laws using conception or fertilization. One state has enacted a 20-week law using pregnancy. The federal House bill, the Pain- Capable Unborn Child Act, and the similar law introduced in the U.S. Senate, measure the 20-week restriction using fertilization.

Permitting abortion on demand past 20 weeks places the United States among the top 4% of most-permissive countries in the world based on duration of pregnancy restrictions on abortion. If the United States adopts a federal policy restricting elective abortion past 20 weeks, or if more states adopt such policies, the U.S. will more closely align itself with the international norm that limits elective abortion past 12 weeks. Policies imposing gestational limits on elective abortion have been overwhelmingly adopted by countries permitting abortion on demand, indicating policies that encourage woman's safety in limiting abortion to early pregnancy and policies that protect unborn children from pain and prolonged exposure to the risk of abortion.

Conclusions

In terms of gestational limits, the United States ranks among 7 countries with the most permissive abortion policies. The clear norm among countries that permit elective abortion is to limit abortion to before 20 weeks gestation, and elective abortion is more commonly limited to 12 weeks (the first trimester).

Twenty-week abortion laws in the United States are neither extreme nor unreasonable. Rather, they move the United States closer to international norms of legislating what is safe and healthy for the mother and what grants unborn children more protection in the womb.

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[i] Sam Rowlands, "Abortion Law of Jurisdictions Around the World," Aug 2012, http://www.fiapac.org/media/Divers/ABORTION%20LAW%20OF%20EACH%20NATION%20STAT E%20Sam%20Rowlands%20rev%202012.pdf

[ii] Bahrain, Penal Code of 20 March 1976. Social Institutions & Gender Index, "Bahrain," http://genderindex.org/country/bahrain#_ftnref69. Committee on the Elimination of All Forms of Discrimination Against Women (CEDAW) (2007) 'Consideration of reports submitted by States Parties under article 18 of the Convention on the Elimination of All Forms of Discrimination against Women Combined initial and second periodic reports of States Parties Bahrain', CEDAW/C/BHR/2, CEDAW, New York

[iii] Center for Reproductive Rights, "The World's Abortion Laws Map 2013 Update," June 2013, and "Abortion Worldwide: Seventeen Years of Reform" October 2011

[iv] Pew Research, Religion & Public Life Project, "Abortion Laws Around the World," September 2008, http://www.pewforum.org/2008/09/30/abortion-laws-around-the-world/

[v] United Nations, Department of Economic and Social Affairs Population Division, "Population Policy Data," 2007

[vi] United Nations, Department of Economic and Social Affairs Population Division, "World Abortion Policies 2013"

[vii] Harvard School of Public Health, "Abortion Laws of the World" Database, http://www.hsph.harvard.edu/population/abortion/abortionlaws.htm

[viii] Children by Choice, "Australian abortion law and practice," http://www.childrenbychoice.org.au/info-a-resources/facts-and-figures/australian-abortion-law-and-practice#VIC

[ix] BBC, "Europe's abortion rules," February 2007

[x] International Planned Parenthood Federation, "Abortion Legislation in Europe," January 2009, Updated May 2012

[xi] Americans United for Life, "United States Abortion Policy in the International Context," August 2012, http://www.aul.org/united-states-abortion-policy-in-the-international-context/

[xii] "Abortions by Gestational Age," Abortion in Canada, http://abortionincanada.ca/stats/abortions-by-gestational-age/

[xiii] Elina Hemminki, Zhuochun Wu, Guiyung Cao, and Kirsi Viisainen, "Illegal births and legal abortions - the case of China," Reproductive Health, 2005; 2:5

[xiv] Nguyen Thanh Binh, "Abortion in Present Day Vietnam," International Journal of Academic Research in Business and Social Sciences, January 2012, Vol. 2, No. 1

[xv] Betsy Johnson, "Momentum for Late-Term Abortion Limits," Charlotte Lozier Institute, August 2013, http://www.lozierinstitute.org/momentum-for-late-term-abortion-limits/

[xvi] Guttmacher Institute, "State Legislation and Policies Enacted in 2013 Related to Reproductive Health," "An Overview of Abortion Laws," and "State Policies on Later Abortions," October 2013

[xvii] Juliet Lapidos, "Albuquerque Rejects 20-Week Abortion Ban," New York Times, November 2013

[xviii] House Bill H.R. 1797, Pain-Capable Unborn Child Protection Act, 113th Congress (2013-2014)

[xix] Senator Graham Press Releases, "Graham Introduces Pain Capable Unborn Child Protection Act," November 2013

St. John's Law Review

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Article 5

March 2012

Extending Child Abuse Protection to the Viable Fetus: Whitner v. State of South Carolina

Regina M. Coady

COMMENTS

EXTENDING CHILD ABUSE PROTECTION TO THE VIABLE FETUS: *WHITNER v. STATE OF SOUTH CAROLINA*

INTRODUCTION

Systems of law serve to protect individual rights from unlawful intrusions by the state. Arguably, the most fundamental aspect of such legal regimes is the protection from physical harm. As the most vulnerable members of society, children are guaranteed protection from child abuse inflicted upon them by all adults, including their own parents. The only entity more vulnerable than a child is a fetus. Although an entirely separate being, the fetus is completely dependent upon the woman who conceived it.[1] The fetus' inability to protect itself from any type of harm raises the issue of whether those fundamental protections afforded to a child under existing laws should originate before birth. Recently, in *Whitner v. State of South Carolina*,[2] the South Carolina Supreme Court held that a viable fetus was a "person" within the meaning of the Children's Code and could be the victim of criminal child neglect just as any child could after birth.[3] It is the scope of such child abuse protection that is presently in dispute.

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[1] *See* Ariela R. Dubler, *Monitoring Motherhood*, 106 YALE L.J. 935, 939 (1996). While a fetus may, with medical assistance, survive outside the womb as early as the end of the second trimester, fetal viability prior to this point is highly doubtful. DAVID F. MOFFETT, ET AL., HUMAN PHYSIOLOGY 736 (1993).

[2] No. 24468, 1996 S.C. LEXIS 120 (S.C. July 15, 1996).

[3] *Whitner*, 1996 S.C. LEXIS 120, at *21.

Cornelia Whitner was a 28-year old woman from Pickens County, South Carolina with a minimal education and a serious drug addiction.[4] In 1992, Whitner continued abusing crack cocaine during her third trimester of pregnancy and subsequently gave birth to a child with cocaine residue in his system.[5] Whitner, who had prior convictions for theft and cocaine possession,[6] was charged with criminal child neglect for using an illicit drug during the later stages of her pregnancy.[7] Whitner was sentenced to eight years in prison after her guilty plea, but gained release just nineteen months later when the ACLU learned of her case.[8] At that time, a state court judge ruled that the child neglect law did not apply to prenatal drug use and issued an order for Post Conviction Relief for Whitner.[9] The South Carolina Supreme Court, however, reinstated Whitner's conviction for criminal child neglect in July of 1996, reversing the prior decision for Post Conviction Relief.[10]

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[4] Lyle Denniston, *Abortion, Fetus Rights on Legal Collision Course, Protections for Unborn Head for Test in Fla.*, BALTIMORE SUN, Nov. 4, 1996, at 1A.

[5] *Id.*; John Carlson, *State Law Fails to Protect Fetus from Chemical Abusing Mother*, NEWS TRIB., July 24, 1996, at A9; Stephanie Stone, *Conduct During Pregnancy Harming Fetus May Be Prosecuted, South Carolina High Court Holds*, WEST'S LEGAL NEWS, July 22, 1996, *available in* 1996 WL 405681.

[6] Carlson, *supra* note 5, at A9.

[7] *Whitner*, 1996 S.C. LEXIS 120, at *3; *see also* Carlson, *supra* note 5, at A9; Marilyn Kaufus, *Pregnancy Negligence Not Prosecuted/Law: Taking Speed and Other Drugs Might Be Bad for the Body, but in California It's Typically Not Treated As a Crime*, ORANGE COUNTY REG., Aug. 11, 1996, at B7.

[8] *Whitner*, 1996 S.C. LEXIS 120, at *3; *see also* Carlson, *supra* note 5, at A9. The ACLU challenges these types of prosecutions under the theory that child abuse statutes were meant to include children and not fetuses. Brian Maffly, *Prosecuting Fetal Abuse Isn't Easy, County is Bucking Odds Prosecuting Fetal Abuse*, SALT LAKE TRIB., May 7, 1996, at A1. The ACLU contends that prosecutions have decreased because cases usually end with acquittals or reversals on appeal. *Id.* Prosecutors have a lesser burden when proving criminal child abuse than when proving a homicide. *Id.* In a child abuse case, the state need only prove that the pregnant mother knew that her conduct could be harmful; in a homicide prosecution, however, the state must show that the baby's death was a direct result of exposure to drugs. *Id.*

[9] *Whitner*, 1996 S.C. LEXIS 120, at *3.

[10] *Id.* at *2. The statute at issue prescribes the legal obligation of an individual.

> Any person having the legal custody of any child or helpless person, who shall, without lawful excuse, refuse or neglect to provide, as defined in § 20-7-490, the proper care and attention for such child or helpless person, so that the life, health or comfort of such child or helpless person is endangered or is likely to be endangered, shall be guilty of a misdemeanor and shall be punished within the discretion of the circuit court.

Id. at *5 (citing S.C. CODE ANN. § 20-7-50 (1985)). The South Carolina statute

The *Whitner* court held, in a 3-2 decision, that Cornelia Whitner's prenatal drug use constituted criminal child neglect.[11] Facing the issue of when a fetus is entitled to protection, the court held that a viable fetus was a "person" for purposes of the Children's Code.[12] It is submitted that the Supreme Court of South Carolina correctly decided that a viable fetus was a "person" entitled to protection from criminal child neglect.

The South Carolina Supreme Court rested its position, in large part, upon existing medical information regarding fetal development.[13] It is well documented that maternal cocaine use during pregnancy can cause serious harm to the viable fetus.[14] The causal connection between Cornelia Whitner's drug use and the injury to her child was not in dispute. The court reasoned that injuries sustained while a fetus is in its mother's womb can often be far more serious than those sustained after birth.[15] The Supreme Court of South Carolina interpreted the statute very broadly to encompass all those children, born and unborn, in need of protection.[16]

Originally, fetal rights were interpreted as merely protecting unborn children from third parties; the legislatures and the courts did not initially imagine the mother as a potential offender.[17] The *Whitner* court boldly defied this an-

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wielded a maximum penalty of ten years in prison for abuse to a fetus. This provision has been amended twice since Ms. Whitner's 1993 conviction. *See* S.C. CODE ANN. § 20-7-50 (Law Co-op. 1996 Supp.).

[11] *Whitner*, 1996 S.C. LEXIS 120, at *25; *see also* Stone, *supra* note 5.

[12] *Whitner*, 1996 S.C. LEXIS 120, at *9; *see also* Stone, *supra* note 5.

[13] *Whitner*, 1996 S.C. LEXIS 120, at *9; *see also* Joseph Wharton, *Drugs in Pregnancy Amount to Abuse*, 82 A.B.A. J., Nov. 1996, at 43 (stating that *Whitner* court's reasoning was based mainly on existing medical knowledge instead of on relationship between mother and child).

[14] *See infra* notes 54-58; *See generally* Joseph J. Volpe, M.D., *Effect of Cocaine Use on the Fetus*, 327 NEW ENG. J. MED. 666 (1985).

[15] *Whitner*, 1996 S.C. LEXIS 120, at *10.

[16] *Id.*

[17] A precedent case in the area of fetal rights was *Smith v. Brennan*, 157 A.2d 497 (N.J. 1960), which declared that a child had the right to be protected in utero from negligence or harm. This court, however, only intended liability to extend to third parties. CYNTHIA R. DANIELS, AT WOMEN'S EXPENSE 12 (1993). The most difficult cases arise when the mother, not a third party, has injured the fetus because the courts must balance the privacy interests of women and the state's interest in protecting life. Tony Mauro, *Rights of the Unborn Abortion Battle, Medical Gains Cloud Legal Landscape*, USA TODAY, Dec. 12, 1996, at 1A. Today, it is recognized

tiquated notion, however, to achieve justice for the woman's neglected newborn. Accordingly, the court concluded that Cornelia Whitner was guilty of criminal child neglect.[18]

While the use of certain drugs by any person has been criminally actionable throughout the twentieth century,[19] accountability for such illicit substances' effects on one's child treads a historically less traveled path but elevates the status of the child inside the womb to that of a child outside the womb. *Whitner* was a "landmark decision for protecting children,"[20] in which the South Carolina Supreme Court became the first state high court in the nation to uphold a conviction of a mother for endangering the life of her fetus through her prenatal conduct.[21] Jurisdictions are split regarding the issue of whether viable fetuses are persons entitled to legal protection under child abuse statutes. The critical inquiry has been the status of fetal rights, specifically in relation to the rights of the mother.[22] Criminal

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that a woman who injures her own viable fetus should receive the same penalty as a third party inflicting the same damage and that legislative bills must not exempt the mother from liability. *See* Philip C. Thornberg, Letter to the Editor, *Woman Abusing Fetus Ought to be Penalized,* COLUMBUS DISPATCH, May 11, 1996, at 13A (writing in response to Ohio "feticide" legislation, Senate Bill 239, which allows prosecution of third parties but exempts abusive behavior by mothers).

[18] *Whitner*, 1996 S.C. LEXIS 120, at *25.

[19] KENNETH J. MEIER, THE POLITICS OF SIN: DRUGS, ALCOHOL, AND PUBLIC POLICY 22 (1994).

[20] *Abuse of Viable Fetus Ruled a Crime*, NAT'L L.J., July 29, 1996, at A8 (quoting South Carolina State Attorney General, Charlie Condon).

[21] Stone, *supra* note 5. Stone explains that, in recent years, prosecutions for a mother's prenatal conduct have become more common but most appellate courts have dismissed such charges. *Id.* Criminal charges are usually brought under statutes prohibiting child abuse or distribution of drugs to a minor. *Id.* Stone states that only four other high courts in the nation have considered this question (Nevada, Florida, Kentucky, and Ohio) and all have ruled against criminalizing maternal conduct before the birth of a child. *Id.* A total of 200 women in 30 different states have been prosecuted for such prenatal conduct but only Cornelia Whitner's conviction has been upheld. Kaufus, *supra* note 7, at B7. Despite strong opposition, the South Carolina Supreme Court believed case law and the plain language of the child neglect statute supported its landmark decision. *See Whitner*, 1996 S.C. LEXIS 120, at *9 (holding plain meaning of "person" as set forth in prior decisions includes viable fetus).

[22] *See generally* DANIELS, *supra* note 17, at 3-4 (describing fetus "as the newest 'social actor' in the American conservative imagination"); Robin Blumner, *Drunk Fetus Cases Endanger Abortion Choice*, MILWAUKEE J. SENTINEL, Sept. 22, 1996, *available in* 1996 WL 11293503 (analyzing impact of extension of fetal rights on abortion debate). The debate over the existence of fetal rights involves questions about the maternal-fetal relationship, moral obligations owed to the fetus, and a pregnant woman's right to privacy. *See* DANIELS, *supra* note 17, at 3-7; BONNIE

courts have struggled with the question of whether the fetus should be considered an independent legal entity or simply an appendage of its mother.[23]

Part One of this Comment traces the evolution of a fetus' legal status throughout history, focusing on the development in South Carolina's jurisprudence. Part Two asserts that viability is the birthplace of fetal rights. Part Three posits that a woman's freedom of choice concerning abortion is preserved and can exist alongside fetal rights under the *Whitner* analysis. Part Four establishes limits on the extent of a pregnant mother's criminal liability, confining liability to illegal activities undertaken during pregnancy. Ultimately, this Comment concludes that child abuse protection must be extended to all viable "persons" whether their physical locations are inside or outside of the womb.

I. *WHITNER* MARKS NEXT STAGE IN EVOLUTION OF FETAL RIGHTS

Historically, birth, when the child became physically separate from its mother, was the origin of legal rights.[24] Over time, however, courts began recognizing that legal rights precede one's debut into the external environment. Nineteenth-century property law concerning inheritance marked the earliest recognition of fetal rights. Under such law, a fetus existing at the time of the testator's death was entitled to receive an inheritance.[25] The fetus was granted the status of a person for this limited purpose, provided that the fetus was born alive.[26]

STEINBECK, LIFE BEFORE BIRTH 128-163 (1992) (concerning maternal-fetal conflict).

[23] *See* VALERIE GREEN, DOPED UP, KNOCKED UP, AND ... LOCKED UP? 37-60 (1993) (tracing trend extending criminal laws to protect fetus); *see also* Blumner, *supra* note 22 (citing examples from Florida, South Carolina, and Wisconsin where states determined that criminal and civil laws applied to viable fetus).

[24] *See* Patricia A. Sexton, *Imposing Criminal Sanctions on Pregnant Drug Users: Throwing the Baby Out With the Bath Water*, 32 WASHBURN L.J. 410, 414 (1993) ("Historically, the legal system treated the fetus as part of the woman.").

[25] *See, e.g.*, Cowles v. Cowles, 13 A. 414, 417 (Conn. 1887) (holding that child will be considered "in being" from conception when it benefits child). The right of inheritance vested with the fetus in recognition of parent's presumed desire to provide for children conceived but not yet born at the time of their death. *See* Christian v. Carter, 137 S.E. 596, 597 (N.C. 1927).

[26] *See* Medlock v. Brown, 136 S.E. 551, 553 (Ga. 1927) ("A child en ventre sa mere, after it becomes quick, is to be regarded as a child in esse, or a child then liv-

Tort law was the next legal arena to afford rights to the fetus. After the 1946 decision in *Bonbrest v. Kotz*,[27] fetuses gained the right to recover for tortious injuries inflicted upon them in utero.[28] The *Bonbrest* decision marked a major advance in the development of fetal rights; the fetus was no longer merely afforded protection from the opportunistic conduct of others but it was also given standing to seek redress for its injuries in court.[29]

While case law continued to expand notions of fetal rights in the civil law context, criminal statutes have not displayed the same flexibility.[30] A fetus was first declared a person for purposes of criminal liability in the landmark decision *Commonwealth v. Cass*.[31] In *Cass*, the Massachusetts court concluded that a fetus, who died as a result of a car accident, constituted a "person" within the meaning of the state's vehicular homicide statute.[32] This pronouncement afforded fetuses relief in the criminal realm as well as the civil one.

While individual states have struggled with the issue of whether a fetus is a "person" under the criminal law, courts such as *Cass* and *Whitner* represent the gradual erosion of narrowly construed and outdated criminal statutes and seek to include fetal rights within the scope of such criminal laws.[33]

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ing.").

[27] 65 F. Supp. 138 (D.C. Cir. 1946).

[28] *Id.* at 142 (allowing recovery when child was injured through professional malpractice during delivery). "The absence of precedent should afford no refuge to those who by their wrongful act ... have invaded the right of an individual ... in their professional capacities." *Id.* While the *Bonbrest* decision did establish fetal rights under tort law, the court maintained that a fetus did not receive separate recognition until it passed the point of viability. DANIELS, *supra* note 17, at 11. Furthermore, the court held that such rights were not conferred until the fetus was born alive. *Id.*

[29] *See* James Andrew Freeman, Comment, *Prenatal Substance Abuse: Texas, Texans and Future Texans Can't Afford It*, 37 S. TEX. L. REV. 539, 567-68 (1996) (noting that court recognized fetus as separate legal entity having right of action).

[30] Many states follow the Model Penal Code which defines a "human being" as "a person who has been born and is alive." MODEL PENAL CODE § 210.0 (1) (1985).

[31] 467 N.E.2d 1324 (Mass. 1984).

[32] *Id.* at 1325, 1329.

[33] While *Cass*, *Whitner*, and other recent cases represent judicial activism on behalf of the expansion of fetal rights under criminal law, a number of state legislatures have also adopted new criminal statutes expressly imposing liability for fetal harms. *See* Sexton, *supra* note 24, at 415.

South Carolina's legal protection of viable fetuses as persons holding certain legal rights and privileges began in the 1960's when the state Supreme Court first declared that a fetus was a person for the purposes of civil actions under the state's wrongful death statute.[34] Several years later, South Carolina extended protection to viable fetuses in the criminal context by recognizing that homicide laws afford protection to the unborn child in *State v. Horne*.[35]

In *Horne*, the defendant stabbed his wife in the abdomen when she was nine months pregnant.[36] He was charged and convicted of assault and battery and voluntary manslaughter in connection with the stabbing of his wife and the resulting death of the full-term viable fetus.[37] The South Carolina Supreme Court unanimously held that a viable fetus was a "person" within the meaning of the state's murder statute.[38] Through the application of tort-based fetal rights in this criminal context, as well as the finding of fetuses as persons in the civil realm, the court laid the groundwork for the state's further extension of fetal rights in *Whitner*.

Several other states have joined the fetal rights movement, supporting South Carolina's belief that the fetus is an independent legal entity entitled to protection under criminal statutes.[39] Other states, however, have held that a

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[34] *See* Fowler v. Woodward, 138 S.E.2d 42, 44 (S.C. 1964) (determining that viable fetus need not be born alive because administrator can maintain action for wrongful death of fetus). The *Fowler* court said that a viable child constituted a "person" even before it left the womb. *Id.* at 43; *see also* Hall v. Murphy, 113 S.E.2d 790, 793 (S.C. 1960) (holding that fetus capable of life apart from its mother is person).

[35] 319 S.E.2d 703, 704 (S.C. 1984) ("From the date of this decision henceforth, the law of feticide shall apply in this state.").

[36] *Id.*

[37] *Id.*

[38] *Id.* at 704. "It would be grossly inconsistent for us to construe a viable fetus as a 'person' for the purposes of imposing civil liability while refusing to give it a similar classification in the criminal context." *Id.* Despite its holding that a fetus would be considered a person, the *Horne* court reversed defendant's conviction for voluntary manslaughter based on the absence of such criminal law at the time of defendant's action. *Id.* The court firmly held, however, that the law of feticide would apply henceforth in South Carolina. *Id.*

[39] *See* Commonwealth v. Cass, 467 N.E.2d 1324, 1325 (Mass. 1984); Mone v. Superior Judicial Ct. of Mass., 331 N.E.2d 916, 920 (Mass. 1975) (holding that viable fetus was "person" under state wrongful death statute); State v. Knapp, No. WD 44098, 1991 Mo. App. LEXIS 1883 (Mo. Ct. App. Dec. 3, 1991) (declaring that fetus

fetus is not a "person" within their criminal statutes.[40] Opponents argue for strict construction of child abuse statutes asserting that a fetus is fundamentally different from a child and, therefore, a statute must have a specific reference to the protection of "fetuses" for it to apply to the unborn.[41] The *Whitner* court, however, believed that an ex-

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is "person" under involuntary manslaughter statute); *In re* Ruiz, 500 N.E.2d 935, 939 (Ohio Ct. C.P. 1986) (stating that fetus was "abused child" when mother used heroin dangerously close to child's birth); Hughes v. State, 868 P.2d 730, 734 (Okla. Ct. Crim. App. 1994) (stating that "[a] viable human fetus is nothing less than human life").

Since fetal rights are established in civil law allowing unborns to inherit and in criminal law allowing third parties to be prosecuted for harming a fetus, holding mothers accountable for harming a fetus is a logical extension of this evolution. Jean Davidson, *Pregnant Addicts Drug Babies Push Issue of Fetal Rights*, L.A. TIMES, Apr. 25, 1989, at 1.

[40] "Nearly half the states still don't recognize the killing of a fetus as murder unless the child is born alive and then dies." Mauro, *supra* note 17, at 1A. This illustrates the traditional "born alive" rule. Historically, many homicide statutes did not cover feticide cases. *See* State v. McCall, 458 So. 2d 875, 877 (Fla. Ct. App. 1984) (declaring that individual cannot be convicted of murder or manslaughter of viable fetus); Billingsley v. State, 360 S.E.2d 451, 452 (Ga. Ct. App. 1987) (holding that "person" does not include fetus within vehicular homicide statute); State v. Trudell, 755 P.2d 511, 517 (Kan. 1988) (holding that "person" does not include fetus within vehicular homicide statute); State v. Gyles, 313 So. 2d 799, 802 (La. 1975) (refusing to include fetus as "person" under murder statute); State v. Beale, 376 S.E.2d 1, 4 (N.C. 1989) (refusing to include fetus as "person" under murder statute).

[41] *See Whitner*, 1996 S.C. LEXIS 120, at *30 (Finney, C.J., and Moore, A.J., dissenting) (stating that "it is for the General Assembly, and not this court" to criminalize such conduct and craft legislation to specifically target fetuses); *see also* Vo v. Superior Ct. of Ariz., 836 P.2d 408, 419 (Ariz. Ct. App. 1992) (refusing to extend common law rule that viable fetus can recover in wrongful death action to justify including feticide under murder statute). The *Vo* court believed that common law authority was not sufficient; only the legislature could define criminal penalties. *Id.*; *see also* Carlson, *supra* note 5, at A9 (discussing dismissal of criminal case where pregnant woman used cocaine and heroin and stating that "if Washington state legislators wanted viable fetuses protected by child abuse laws they should've written that protection specifically into the statute"). In a criminal context, courts tread very carefully because an individual's liberty and constitutional rights are at stake. *See, e.g.*, *McCall*, 458 So. 2d at 877 (citations omitted) ("Penal statutes must be strictly construed. In most circumstances, substantive changes in long-standing common law rules are best left to the legislature."); *see also* Timothy Lynch, *At Issue: Is the Prosecution of 'Fetal Endangerment' Legitimate?*, A.B.A. J., Dec. 1996, at 72 (arguing that prosecutorial and judicial lawmaking infringes upon constitutional rights); *see* Murphy S. Klasing, *The Death of an Unborn Child: Jurisprudential Inconsistencies in Wrongful Death, Criminal Homicide, and Abortion Cases*, 22 PEPP. L. REV. 933, 952 (1995).

As a consequence, there are often inconsistencies in court decisions; a court may deem a viable fetus a "person" within the civil context but not within the criminal context. *Id.* at 959. The Arizona Supreme Court, for example, determined that a viable fetus was a person under the wrongful death statute, but not under the mur-

pansive interpretation of "person" to include fetuses was necessary to appropriately effectuate the legislature's intent.[42] Moreover, it is unrealistic to expect legislatures to change laws to specifically include fetuses, especially in an area as controversial as that of reproductive rights.[43] Until legislators consider such fetal rights issues, it is the role of prosecutors to test the limits of state criminal statutes.[44] A rigid construction of such statutes denies a court the flexi-

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der statute. *Compare* Summerfield v. Superior Ct., 698 P.2d 712, 724 (Ariz. 1985), *with Vo*, 836 P.2d at 419 (explaining that Arizona became code state and thus court did not have power to expand criminal law through changing common law principles as in *Summerfield*). North Carolina has exhibited the same inconsistency. *Compare Beale*, 376 S.E.2d at 4 (holding fetus was not "person" under murder statute), *with* DiDonato v. Wortman, 358 S.E.2d 489, 495 (N.C. 1987) (stating that viable fetus was "person" under wrongful death statute). To ensure fairness, there must be uniformity of interpretation among the courts.

[42] *See supra* note 16 and accompanying text. The intent of the legislature is often determinative in a court's ruling. *See, e.g.*, California v. Stewart, No. M508197, slip. op. at 1-11 (Cal. Mun. Ct. 1987) (stating that intent of child abuse statute was to ensure financial support of children by their fathers).

[43] *See* Mauro, *supra* note 17, at 1A. Opponents fear that "expansion of fetal rights may deny fundamental right of reproduction to a particular class of sick women [drug addicts] whose symptoms [compulsive drug use] may injure their fetuses." Doretta Massardo McGinnis, *Prosecution of Mothers of Drug Exposed Babies: Constitutional and Criminal Theory*, 139 U. PA. L. REV. 505, 520 (1990). McGinnis argues that pregnant women with cancer require drugs that harm fetuses and such right to procreate must extend to drug users. *Id.* The distinct difference, however, is that cancer drugs are legal and serve a valuable societal purpose, unlike the drug cocaine. Therefore, distinctions should be made so that a pregnant woman indulging in otherwise legal activities, such as smoking, drinking alcohol, or taking prescription drugs, would not be subject to criminal liability for any potential harms such legal acts cause to the fetus. *But see, e.g.*, *Drunken Fetus Charges Stay*, NAT'L L.J., Sept. 30, 1996, at A8 (highlighting pending Wisconsin case of *People v. Zimmerman* where mother was charged with intentional homicide and reckless conduct after giving birth to child with blood-alcohol content of 0.199%).

[44] *But see* McGinnis, *supra* note 43, at 513 (asserting that legislatures, not courts, must define criminal offenses because it is unconstitutional to ignore legislative intent and create new crimes). To date, no state has specifically criminalized a mother's prenatal drug use. As a result, prosecutors must "creatively manipulate statutes that do not expressly address the issue in order to charge mothers whose drug addiction harms the fetus." Lisa M. Noller, *Taking Care of Two: Criminalizing the Ingestion of Controlled Substances During Pregnancy*, 2 U. CHI. L. SCH. ROUNDTABLE 367, 376 (1995). The result is inconsistent precedents on which to rely. Prosecutors try to "find" or "manufacture" liability and women may claim lack of notice because the statutes do not clearly proscribe their ingestion of drugs while pregnant. *Id.* Punishment under such a system is too discretionary and based on the subjective and discriminatory leanings of public officials rather than firm statutory language. Louise Marlane Chan, *S.O.S. from the Womb: A Call for New York Legislation Criminalizing Drug Use During Pregnancy*, 21 FORDHAM URB. L.J. 199, 213 (1993).

bility to modify traditional rules in order to accommodate the changing times.[45] While a statute well crafted by the legislature would be the ideal solution, viable fetuses may only have the judiciary on which to rely for protection. Justice demands judicial activism in this area.

A corollary to a fetus' legal standing as a "person" in the criminal law is the implication on the mother's legal rights. Opponents argue that maternal conduct before the birth of a child does not give rise to criminal responsibility.[46] Since no statute specifically proscribes maternal drug use, states have attempted to prosecute such cases under many different statutes, including those for child abuse and neglect, drug delivery and distribution to minors, involuntary manslaughter, and pure drug use.[47]

South Carolina's historic decision resurrected the balancing of a woman's rights with those of her fetus. With the advance of technology, there has been increasing support for a fetus' legal rights.[48] By necessity, however, ex-

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[45] *See* K. Christopher Shen, *The Lack of a Judicial Policy Addressing Maternal Substance Abuse Cases*: Commonwealth v. Welch, 864 S.W.2d 280 (Ky. 1993), 17 HARV. J. L. & PUB. POLICY 929, 937 (1994).

[46] Critics of *Whitner* have extensive case law to support their position. *See* Johnson v. State, 602 So. 2d 1288, 1296 (Fla. 1992) (reversing mother's conviction for child abuse for ingesting cocaine while pregnant); State v. Gethers, 585 So. 2d 1140, 1140 (Fla. Ct. App. 1991) (explaining that introduction of cocaine into woman's own body did not amount to child abuse); Commonwealth v. Welch, 864 S.W.2d 280, 283 (Ky. 1993) (holding that drug abuse by mother when she injected oxycodone into her jugular vein while pregnant cannot be included within criminal child abuse statute). The *Welch* court drew a distinction between protecting a child from abuse and from death when it stated that "common law intended definition of 'person' to vary depending on [the] type of crime committed." Shen, *supra note* 45, at 935. The difference is that criminal child abuse, unlike homicide, is not a common law crime; so, legislative intent (not common law) is binding and demands that the court not apply such statutes to prenatal injuries inflicted by the mother. *Welch*, 864 S.W.2d at 282-83. The *Welch* analysis incorrectly focused on the particular consequences and not the act itself.

[47] *See* Shona B. Glink, *The Prosecution of Maternal Fetal Abuse: Is This the Answer?*, 1991 U. ILL. L. REV. 533, 546 (1991).

[48] Sheilah Martin & Murray Coleman, *Judicial Intervention in Pregnancy*, 40 MCGILL L.J. 947 (1995) (relating both sides of struggle for superiority of interests between mother and child). Additionally, with a growing number of infants injured by prenatal drug addiction each year, both sides agree that prosecutions based on old laws will increase. Jean Davidson, *Newborn Drug Exposure Conviction a Drastic First*, L.A. TIMES, July 31, 1989, at 1 (reporting on *Johnson v. State*, first U.S. conviction of pregnant woman who gave birth to drug exposed newborn in Florida (later reversed by Florida Supreme Court) on "delivery" theory that woman passed drugs to infant in one minute time period between birth and cutting of umbilical cord). "As

tensions of fetal rights compromise the freedoms of pregnant women.[49]

Past recognition of the legal rights of unborn viable fetuses in South Carolina has facilitated the court's extension of fetal protection from wrongful death and murder statutes to this criminal child neglect statute. *Whitner* establishes a significant turning point in the direction of greater fetal rights and serves as a model to which courts may look in justifying future convictions.[50]

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many as 15% of all pregnant women ingest illegal drugs during their pregnancies." Margaret P. Spencer, *Prosecutorial Immunity: The Response to Prenatal Drug Use*, 25 CONN. L. REV. 393, 393 (1993). Recognition of fetal rights simply illustrates that the law is keeping pace with medical science; the evolving protections afforded the unborn have paralleled scientific knowledge about the fetus. Scot Lehigh, *Court Cases Pit Fetus' Rights Against Abortion Rights, The Issue: When Does it Become a Living Person?*, PLAIN DEALER, Sept. 22, 1996, at 31A.

Birth was formerly the dividing line between rights recognized by the law and those not recognized. *See* Mauro, *supra* note 17, at 1A. With advances in technology, however, legally recognized life begins inside the mother's womb at some point between conception and birth. *Id.* Fetal monitoring and surgery, even fetal autopsies, have given prosecutors the tools they need to prove the elements of a crime. *Id.* It is possible to see that the fetus was alive and healthy when the injuries from drug ingestion took place; in comparison, under the early common law standards, it was difficult to tell if a woman was even pregnant and more difficult to tell if the child was healthy. *Id.*

[49] Mauro, *supra* note 17, at 1A. "A woman's freedom to control her body is circumscribed by the obligation she incurs to her fetus." DANIELS, *supra* note 17, at 25. "A pregnant woman represents the interdependence of life." *Id.* at 139. *But see* Margaret Phillips, *Umbilical Cords: The New Drug Connection*, 40 BUFF. L. REV. 525, 527, 553 (1992) (arguing that prosecuting pregnant drug addicts is merely mechanism to subjugate women and that their biological connection to fetuses subjects their actions to far greater punishment than actions of men).

Phillips claims that the criminal prosecution of pregnant addicts will reinforce the gender hierarchy in which women do not have their own identity but rather, are viewed in relation to their fetuses. *Id.* at 557. Prosecutors, she argues, are just inventing crimes of which only women can be guilty. *Id.* at 562. This argument raises a possible Equal Protection question. The *Whitner* prosecution, however, survives the equal protection challenge. Because women are found in both the deprived class (drug abusing women) and the class receiving benefits (all other pregnant women), the law does not discriminate based on gender. James Denison, *The Efficacy and Constitutionality of Criminal Punishment for Maternal Substance Abuse*, 64 S. CAL. L. REV. 1103, 1133 (1991). Even if the law was gender specific, it would pass the applicable constitutional test, intermediate scrutiny, because protecting fetuses from drug addiction serves an important state interest. *Id.*; *cf.* Michael M. v. Superior Ct., 450 U.S. 464, 469 (1987) (upholding statutory rape law which held only men liable in interests of preventing teen pregnancy).

[50] The landmark decision in *Whitner* will have an effect on pending cases involving a mother's substance abuse that has injured her fetus.

In Wisconsin, a state appeals court, in *State ex rel. Angela M.W. v. Kruzicki*, 541 N.W.2d 482 (Wis. Ct. App. 1995), stated that a pregnant woman's rights were

II. VIABILITY: THE BIRTHPLACE OF FETAL RIGHTS

The viability stage, defined as the time when the fetus can live apart from its mother, has been designated as the "birth" of fetal rights entitled to constitutional protection.[51] The court, in *Bonbrest v. Kotz*,[52] declared that viability was the decisive factor in determining when protection from various harms begins.[53] It is submitted that the devastating physiological effects of cocaine[54] upon the viable fetus

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not violated by a "protective custody" order, which detained her for three weeks in a drug treatment center, because only the fetus was ordered detained. Denniston, *supra* note 4, at 1A. In this case, the court construed the child welfare statute to include "fetus" within statutory definition of "child" and issued the order for the viable fetus, citing *Roe's* holding that the state's interest in potential life becomes compelling at viability. This was the first appellate court in the nation to make such a ruling, evidencing the march toward greater fetal rights. *See* A. Michael Lee, *State ex. rel.* Angela M.W. v. Kruzicki: *the Wisconsin Court of Appeals Introduces a Dangerous New Weapon in Battle over "Fetal Rights,"* 30 GA. L. REV. 1183 (1996). This case has been appealed to the Wisconsin Supreme Court on the issue of the constitutionality of such state detention. Even though the custody order was for the fetus, the mother, being physically attached to the fetus, was also detained. Cary Segall, *Court to Hear Case of Woman Held to Protect Fetus, the Wisconsin Supreme Court Will Decide Whether the State Had the Right to Detain a Waukesha Woman Who Used Drugs While Pregnant*, WIS. ST. J., Oct. 27, 1996, at 1A.

Another case is that of Kawana Ashley, a 19-year old girl in Florida who shot herself in the stomach resulting in the death of her infant. *Florida: Manslaughter Trial Goes before State Supreme Court*, AM. POL. NETWORK, Nov. 7, 1996. The infant died of organ failure after an emergency cesarean section after the gunshot wound. *Id.* Ashley was originally charged with third-degree felony murder and manslaughter, but the courts dismissed the manslaughter charge. *Id.* Both sides have appealed to the Florida Supreme Court. *Id.*

The timing of the *Whitner* decision was critical; as the first state high court to criminalize maternal drug use, it sent a prominent message that abuse to the unborn child will not be tolerated.

[51] Viability is "that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb by natural or artificial life supportive systems." BLACK'S LAW DICTIONARY 1565 (6th ed. 1990); *see, e.g.*, Roe v. Wade, 410 U.S. 113, 162 (1973) (declaring that women have constitutional right to abortion under Fourteenth Amendment up to point of fetus' viability after which time state has compelling interest in life of fetus); *see also* DANIELS, *supra* note 17, at 17-18. In the medical community, the third trimester fetus is called the "unborn patient" upon whom surgical and therapeutic procedures can be performed. KEITH L. MOORE & TVN PERSAUD, THE DEVELOPING HUMAN 105 (1993). On a practical level, viability is a workable demarcation because it is often difficult to prove causation in early stages of pregnancy. *See* Kaufus, *supra* note 7, at B7.

[52] 65 F. Supp. 138 (D.C. Cir. 1946).

[53] *Id.* at 140; *cf.* Kelly v. Gregory, 125 N.Y.S.2d 696, 698 (1953) (stating that legal entity begins at conception and can recover for tortious injury occurring anytime after then). The *Kelly* court posited that viability is immaterial and focus should be solely on child's survival after birth. *Id.*

[54] Cocaine is one of the most commonly used drugs among women of childbear-

qualify as child abuse.[55] Civil statutes have already acknowledged this reality.[56] Child abuse does have criminal sanctions; if child abuse includes drug dependent children, as specifically enumerated in the civil law, then such criminal sanctions should also be imposed upon mothers.

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ing age. Dr. Claudia A. Chiriboga, *Fetal Effects*, 11 NEUROLOGIC CLINICS 3, 707-22 (Aug. 1993). It is a teratogen, an "agent that can produce a congenital anomaly or raise the incidence of an anomaly in the population." MOORE & PERSUAD, *supra* note 51, at 153. Crack is an alkaline form of cocaine that can be 95% pure. Zeev N. Kain, et al., *Cocaine Abuse in the Parturient and Effects on the Fetus and Neonate*, 77 ANESTHESIA & ANALGESIA 4, 835-42 (Oct. 1993). It is a relatively inexpensive drug and a "hit" takes under one minute and lasts five to ten minutes. *Id.* The drug then enters the fetus' system where it is converted into the more potent substance, narcocaine. Julie J. Zitella, *Protecting our Children: A Call to Reform State Policies to Hold Pregnant Drug Addicts Accountable*, 29 J. MARSHALL L. REV. 765, 767 (1996). The fetus experiences a "rush" when the drug is transferred by enzymes through the umbilical cord. Freeman, *supra* note 29, at 546. The drug is not immediately recirculated to the mother's bloodstream; it is absorbed in the fetal tissue where its deadly effects are compounded. *Id.* After birth, the child actually suffers physical withdrawal from the drug and its brain "never forgets cocaine," increasing the likelihood that the child will become an addict in later life. *Id.* at 550. The effects of cocaine follow a child through his/her early development as well. Physically, infants exposed to cocaine while in the womb may have deformities; physiologically, they may have different organizational responses and different interactive behavior. Chiriboga, *supra*, at 716-17. They often experience difficulty feeding and sleeping. *Id.* "[C]ocaine affects the excitability and central pathways of the developing brain, especially of the brain stem." *Id.* at 718. Women who use cocaine are more likely to give birth prematurely, thereby increasing the chances that the child will suffer respiratory and developmental problems. Davidson, *supra* note 39, at 1. Even if these babies are carried to full term, there is still a greater risk of physical and neurological defects. *Id.* They are also more prone to sudden infant death syndrome. *Id.*

[55] "[W]hen a mother feeds her fetus crack cocaine through its umbilical cord just hours before it is born, and it is born as a crack addicted child, it is clearly an abused child." Thornberg, *supra* note 17, at 13A. A woman does not have the right to "inflict a lifetime of suffering on her future child, simply in order to satisfy a momentary whim for a quick fix .... [The] right to abuse [her] own body stops at the border of [her] womb." DANIELS, *supra* note 17, at 26. (quoting Alan Dershowitz). "We must now have a presumption that a child [born with drugs in his or her system] is the victim of abuse." Alex Adwan, *Coke Babies and Their Mothers*, TULSA WORLD, Jan. 21, 1996, at G1 (quoting New York City Mayor Rudolph Guiliani, regarding proposal making it easier to take crack addicted babies away from their drug addicted mothers). In New York, as Oklahoma, the law does not specifically include drug exposure to a fetus as child abuse. *Id.* Oklahoma, however, does allow the state to take custody, an alternative to prosecution of the mother, when it is for the safety of the newborn. *Id.*

[56] Some states have enacted civil laws that clearly define prenatal drug use as evidence of child abuse or neglect. MINN. STAT. ANN. § 626.556(2)(c) (West 1995) (stating that "prenatal exposure to a controlled substance" constitutes "neglect"); NEV. REV. STAT. § 432.330(1)(b) (1991) (declaring that drug addicted child is in need of protection); OKLA. STAT. tit. 10, § 7001-1.34(a)(3) (1995) (stating that child born drug dependent is "deprived" and in need of treatment).

The fetus sustains varying degrees of damage, depending upon the extent of the mother's drug use.[57] Critics of fetal rights claim that most of this damage takes place during the early stages of pregnancy when the fetus is developing its organ systems.[58] Insulating mothers from liability during this pre-viability period, they posit, fails to prevent the fetal harm.[59] This simplistic view of fetal development, however, ignores the continuing biological development and tremendous growth that takes place in the third trimester, after the point of viability. For example, beginning in the sixth month of pregnancy there is substantial weight gain.[60] The fetus accumulates a store of fat, up to fourteen grams a

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[57] A medical analysis reinforces viability as the origin of a mother's liability. Studies indicate that the timing of the cocaine ingestion is important. *See* Kain, et al., *supra* note 54, at 835-42. Cocaine ingestion during later stages of pregnancy causes lower birth weight and retarded intrauterine growth. *Id.* at 840. One study found that exposure to cocaine in the first trimester had no effect. *Id.* The pattern of cocaine use - the frequency as well as the timing - is critical in assessing the danger to the fetus. D.W. Rurak, *Fetal Behavioral States: Pathological Alterations with Drug/Alcohol Abuse*, 16 SEMINARS IN PERINATOLOGY 4, 239-51 (Aug. 1992). A child has time to recover if cocaine is taken in early pregnancy but severe, permanent damage is often done after the point of viability. Third trimester cocaine use may cause immediate contractions, heightened fetal activity, and premature labor. Kain, et al., *supra* note 54, at 838. A dangerous consequence can be abruptio placentae, "the vasoconstrictive effect of cocaine caus[ing] disruption in placental adherence to the uterine wall." *Id.* This condition could be fatal for both mother and child. *Id.* In addition, there is a greater chance of a fetal stroke resulting from an intracranial hemorrhage from late cocaine use; this is evidenced by findings that newborns had increased cerebral blood flow from "recent cocaine exposure." Chiriboga, *supra* note 54, at 717.

[58] *See* Denison, *supra* note 49, at 1112; Glink, *supra* note 47, at 564 (claiming that fetus is most susceptible to harm by drug use during first trimester); Kristen Rachelle Lichtenberg, *Gestational Substance Abuse: A Call for a Thoughtful Legislative Response*, 65 WASH. L. REV. 377, 380 (1990) (asserting that majority of fetal damage from cocaine use occurs during first trimester and cannot be reversed by ceasing to use drug). The author explains that urogenital malformations are also associated with first trimester drug usage. *Id.* at 379 n.25.

[59] Critics argue that a "maternal duty model," allowing for state intervention in the first trimester would be most sensible, because this is when most of the damage to the fetus occurs. Lichtenberg, *supra* note 58, at 389. It is conceded, however, that a policy of prosecuting a woman for acts which harm her fetus but allowing her to end her pregnancy at the same stage would clash with *Roe v. Wade*. *Id.* A conflict arises when abortion law overlaps with child abuse law.

[60] MOORE & PERSUAD, *supra* note 51, at 96. Because of the rapid growth during this time, fetal demands for proper and sufficient nutrition are enormous. MOFFETT, ET AL., *supra* note 1, at 738. Doctors advise pregnant women to consume an excessive amount of calories during the first trimester to have a supply for this growth spurt. *Id.*

day in the last weeks of gestation, that is critical to survival after delivery.[61] Additionally, this period is vital for proper organ development that continues throughout pregnancy, such as the development of the fetal brain and nervous system.[62] Furthermore, in the later stages of gestation, the fetus builds up the necessary tissue and prepares its organ systems to facilitate the transition from the inside of the mother's womb to the outside environment.[63]

The period after viability is a critical stage during which serious damage may be prevented. Thus, state intervention after viability would prevent substantial harm to the fetus and long term effects upon the child.[64] Cocaine's long-term effects, including fine and gross motor skill delay and retarded physiological maturity,[65] are no less brutal than the effects of starving or beating a child. Child abuse must not be distinguished based upon when or where it takes place; it is the nature and effects of the abusive treatment that must be examined when assessing criminal

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[61] Fat develops rapidly during the last six to eight weeks of development, giving the fetus a smooth, plump appearance which transforms the wrinkled form characteristic of early gestation. MOORE & PERSUAD, *supra* note 51, at 109. Low birthweight is the classic result of cocaine use. *See* Kain, et al., *supra* note 54, at 840.

[62] MOFFETT, ET AL., *supra* note 1, at 738. "The development of each individual organ system can be thought of as a thread that is woven together with other threads to generate an organism that, as development goes forward, is increasingly capable of independent life." *Id.* at 736. The sixth month also marks the beginning of rapid eye movements and blink startle responses by the fetus. MOORE & PERSUAD, *supra* note 51, at 96. The fetal nervous system develops continuously throughout gestation and is not complete even at birth. MOFFETT, ET. AL., *supra* note 1, at 738. Substance abuse by pregnant women, therefore, can have a devastating effect on the fetus' nervous system at any time during pregnancy. *Id.* In addition, while the brain endures its most intensive development in the first 3-16 weeks, it continues to develop throughout pregnancy and the first two years after birth. MOORE & PERSUAD, *supra* note 51, at 154.

[63] MOORE & PERSUAD, *supra* note 51, at 109.

[64] *See, e.g.*, Glink, *supra* note 47, at 572 (explaining that "[b]y criminalizing illegal substance abuse during pregnancy, society would seek to prevent the resulting injury that such conduct inflicts on the fetus and to place a value on society's interest in condemning maternal substance abuse").

[65] *See supra* notes 54-58. These children also become a great economic burden on society. When drug addicted children are separated into special classrooms, it costs approximately $15,000 a year to educate them compared to about $3,500 a year for a normal child. Thornberg, *supra* note 17, at 13A. Cocaine causes children to be rowdy, disorganized, and violent in school and also affects language production and comprehension, necessitating the separation. Zitella, *supra* note 54, at 768.

liability. The child's physical location is irrelevant.[66] A mother must not evade responsibility for abusing her child at the child's most vulnerable stage, its fetal stage.

III. ABORTION RIGHTS SURVIVE

Opponents seek an answer to a seemingly illogical implication of *Whitner*: if abortion, the killing of a fetus, is legal, then how can abusing or neglecting a fetus be illegal?[67] The fear is that *Whitner's* extension of fetal rights will endanger the abortion rights guaranteed to women under *Roe v. Wade*.[68] Critics of fetal rights believe that fetuses are not children in need of protection and that a mother's conduct before the birth of her child is protected under a constitu-

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[66] Mary E. Roper, *Reaching the Babies Through the Mothers: The Effects of Prosecution on Pregnant Substance Abusers*, 16 LAW & PSYCHOL. REV. 171, 220 (1992); *see, e.g.*, Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457, 458 (Ga. 1981) (declaring that viable fetus survival rights must be placed ahead of mother's privacy rights). This reflects the "parent-child" test which asks whether the conduct of pregnant women would be "wanton" in the context of parent and child instead of mother and fetus; if the conduct fails to meet this test, it is not punishable. Shen, *supra* note 45, at 940. It is asserted that, ultimately, there is no difference between transferring cocaine via the umbilical cord and injecting a young child with cocaine. *But see* Michael A. Shekey, Note and Comment, *Criminal Liability of a Prospective Mother for Prenatal Neglect of a Viable Fetus*, 9 WHITTIER L. REV. 363, 388 n.220-21 (1987) (positing "geography" argument: mother and fetus are social unit and, while baby is in womb, mother cannot be prosecuted for actions that harm fetus). The author posits that pregnant mothers are held to a lower standard than parents of children already born. *Id.* at 363 n.1 (citing California v. Stewart, No. M508197 (San Diego Mun. Ct. 1987))(stating that pregnant women cannot be equated with parents of children). Just moments, however, separate the two statuses and the liability line must be drawn at viability. Child abuse law ought to conform to other systems of law where the line is drawn at viability, a marker that has both logical and biological justifications. *See* Roe v. Wade, 410 U.S. 113, 163 (1973).

[67] *See* Blumner, *supra* note 22. Opponents to maternal criminalization for drug use during pregnancy claim that part of the pro-life agenda is to put the fetus on an equal plane with its mother. Lehigh, *supra* note 48, at 31A. Abortion foes, however, are also opposed to such criminalization for the very reason that it will give women greater incentive to have an abortion. *See Whitner*, 1996 S.C. LEXIS 120, at *33 (Finney, C.J., and Moore, A.J., dissenting) (stating that, from a liability standpoint, woman would be better off illegally aborting third trimester fetus and facing two-year sentence rather than giving birth to baby after ingesting cocaine and facing 10-year sentence).

[68] 410 U.S. 113 (1973). Before 1973, courts seemed willing to grant protection to the viable fetus. *See* GREEN, *supra* note 23, at 8. Courts also made clear, however, that an unviable fetus could never achieve rights greater than the mother's right to privacy. *Id.* A pregnant woman can even have an abortion in the third trimester if it is performed to save her life. *Id.* at 12; *Roe*, 410 U.S. at 163.

tional right to privacy.[69] They argue further that drug addiction during pregnancy is a health problem, not a legal one.[70]

Whitner is consistent with *Roe v. Wade* and its progeny. Both areas of law, fetal and reproductive rights, address the interests of women, fetuses, and the State. The constitutional right to privacy under the Due Process Clause of the Fourteenth Amendment includes a woman's right to have an abortion.[71] This right is not absolute, however, and the State may infringe upon it in the interests of safeguarding health and protecting potential life.[72] When state interests are triggered, an abortion is no longer available to a

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[69] *See, e.g.*, Kaufus, *supra* note 7, at B7 (stating that, in California, criminal laws do not protect fetuses and women are generally not prosecuted for taking drugs while pregnant); *see also* Davidson, *supra* note 39, at 1 (noting that, although great number of children are taken into custody in California because of abuse or neglect due to mothers' drug ingestion, state has not further criminalized taking drugs while pregnant because fetus is not legally recognized as person). *But see* Glink, *supra* note 47, at 568 (asserting that statute prosecuting maternal drug use would be justifiable because drug dependent babies are serious problem and criminalizing already illegal conduct is minimal intrusion upon woman's right to privacy).

[70] Roper, *supra* note 66, at 187; Kaufus, *supra* note 7, at B7.

[71] *Roe*, 410 U.S. at 153. "A fundamental right to privacy protects a decision to abort, but not a decision to abuse drugs or alcohol." Lichtenberg, *supra* note 58, at 388. Abortion rights have evolved through the *Roe* line of cases. The *Roe* Court stated that a fetus was not a "person." While the Court would not explicitly address the issue of when life begins, it indirectly determined that life begins at viability. *See* Klasing, *supra* note 41, at 966. After the point of viability, the state can intervene and regulate abortion. *Id.* at 967. Abortion was declared a fundamental right requiring "strict scrutiny" to infringe upon it. *Id.* at 966-70. "Strict scrutiny" demands a "compelling state interest" to regulate an activity, and this regulation must be "closely tailored" to achieve that interest through the least restrictive means possible. *Id.* The term "viability" came alive in the legal field following the *Roe* decision. *Id.* The line of viability was moved back from 28 weeks to 20 weeks in *Webster v. Reproductive Health Services*, 492 U.S. 490, 515-16 (1989), marking a move towards greater fetal rights as modernized medicine enabled a fetus to survive at an earlier stage. *See* Klasing, *supra* note 41, at 968. The Supreme Court, in *Planned Parenthood v. Casey*, 505 U.S. 833 (1992), declared that abortion is no longer a fundamental right, replaced "strict scrutiny" with an "undue burden" test, and rejected the three trimester approach. *Id.* at 836. This approach effectively allows state regulation of abortion throughout pregnancy as long as it does not create an "undue burden" on a woman. *Id.* Although Court decisions evolved to keep pace with modern science, leading to an increase in fetal rights, the Supreme Court continues to maintain the core holding of *Roe* which established the viability line. In doing so, the Court maintains a consistent line of demarcation in circumscribing criminal liability. It is the mother, not the fetus, who is protected under the Fourteenth Amendment right to privacy. Glink, *supra* note 47, at 562; Noller, *supra* note 44, at 386.

[72] Glink, *supra* note 47, at 563-66.

woman. While the historic decision by the Justices in *Roe* protect a woman's freedom of choice in the initial stages of her pregnancy, it also permits state intervention in the pregnancy's final stages.[73] In the past, states have even ordered invasive medical procedures during late pregnancy, such as cesarean sections and blood transfusions, over the objections of women in order to protect a fetus.[74] Such cases evidence the drive toward greater fetal rights, illustrating that the health of the fetus often takes precedence over a woman's right to bodily autonomy.[75] Compared to such invasive surgical procedures, proscribing maternal drug use during pregnancy is a minimal intrusion upon a woman's rights.

Cornelia Whitner could have exercised her constitutional right to have an abortion, but she did not. By deciding to carry her fetus to term, Whitner accepted the greater duty imposed upon her by law to ensure the delivery of a healthy child.[76] A viable fetus is a "presently existing per-

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[73] Nancy Grace, *Individual Rights: Is the Prosecution of "Fetal Endangerment" Illegitimate?*, A.B.A. J., Dec. 1996, at 72-73; *see also* Davidson, *supra* note 39, at 1 (explaining that *Roe* ruling permits state intervention after first trimester, making restrictions after this time constitutional).

[74] *See In re* A.C., 533 A.2d 611, 617 (D.C. 1987) (ordering cesarean section against wishes of terminally ill mother); Jefferson v. Griffin Spalding County Hosp. Auth., 274 S.E.2d 457, 459-60 (Ga. 1981) (ordering cesarean section over mother's religious objection); Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537, 538 (N.J. 1964) (ordering that woman receive blood transfusions despite religious beliefs); *In re* Jamaica Hosp., 491 N.Y.S.2d 898, 900 (N.Y. Sup. Ct. 1985) (same). The *Jefferson* court declared that the "state's interest in protecting potential life outweighed mother's right to bodily integrity and to practice her religion." *Id.* States have also ordered such procedures to protect individual and public health. *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11, 38-39 (1905) (weighing individual's right to refuse vaccinations against state interest in public health).

[75] *See* Timothy Sean McBride, *Criminal Law - Should States Criminally Prosecute Mothers for Delivering Drugs to Their Newborns During the Birthing Process?: Johnson v. State*, 602 So. 2d 1288 (Fla. 1992), 27 SUFFOLK U. L. REV. 251, 253 (1993).

[76] *See* Greater S.E. Community Hosp. v. Williams, 482 A.2d 394, 398 (D.C. 1984) (stating that every child has right to be born healthy); Jarvis v. Providence Hosp., 444 N.W.2d 236, 238-39 (Mich. Ct. App. 1989) (declaring that every child has right to be born with healthy mind and body); *In re* Baby X, 293 N.W.2d 736, 739 (Mich. Ct. App. 1980) (same); Department of Social Servs. v. Felicia B., 543 N.Y.S.2d 637, 638 (N.Y. Fam. Ct. 1989) (holding mother liable for ingesting cocaine during pregnancy because of "the legal right of every human being to begin life unimpaired by physical, mental, or emotional defects resulting from the neglectful acts of the parent"); McBride, *supra* note 75, at 253; Carlson, *supra* note 5, at A9 (implying that carrying pregnancy to term entails responsibilities); *see also* Denniston, *supra* note

son" and thereby entitled to legal protection.[77] Public policy considerations dictate that courts treat prenatal substance abuse consistently with abortion law by only allowing state intervention after the first trimester.[78] While the Constitution does not prohibit first trimester intervention in drug abuse, it is logically consistent for states to follow *Roe* and not intervene until the point of viability.[79] The viability line maintains the separateness of the two areas of law; otherwise, "the ostensibly culpable conduct of abuse would go unpunished if a woman exercised her right to abortion during the same time period."[80] Thus, adhering to the constitutional dividing line of viability allows the *Whitner* and *Roe* line of cases to peacefully coexist.

IV. CRIMINAL LIABILITY CONFINED TO ILLEGAL ACTIVITIES

A recurring argument posited by *Whitner* opponents is that liability for cocaine ingestion during pregnancy would then extend to liability for smoking or drinking during pregnancy or even failing to seek proper medical care.[81] A

4, at 1A (stating that "[w]hen there is a child who is to be born and is not going to be aborted, and when there is a direct and severe threat to the health or life of the child, the state can intervene to protect the child") (quoting Clarke Forsythe, president of the Chicago-based Americans United for Life). Once a woman chooses to continue a pregnancy she is charged with a "duty to care" for the fetus in her womb to ensure that it is born with a "sound mind and body." DANIELS, *supra* note 17, at 3 (citing Smith v. Brennan, 157 A.2d 497 (N.J. 1960)); Noller, *supra* note 44, at 387. An analogy can be made to the Good Samaritan rule in tort law: there is no obligation to help but once you begin assisting, you have a duty to continue. Denison, *supra* note 49, at 1127.

[77] Shekey, *supra* note 66, at 368 (citing Vaillancourt v. Medical Ctr. Hosp. of Vt., Inc., 425 A.2d 92 (Vt. 1980)).

[78] *See, e.g.*, Lichtenberg, *supra* note 58, at 377. *But see* Glink, *supra* note 47, at 564 (declaring that state has greater interest in preventing future suffering of those who will be born than it does in deciding whether baby will be born so state should have power to regulate maternal conduct through entire term of pregnancy). Glink asserts that, while *Roe* addresses the right to life, child abuse cases address the right to quality of life. *Id.*

[79] *See* Lichtenberg, *supra* note 58, at 388.

[80] Denison, *supra* note 49, at 1126. *But see* Chan, *supra* note 44, at 233 n.231 (positing fairness argument which posits that state cannot prosecute addicts in late pregnancy but not prosecute pregnant addicts who have abortions because the latter absolve themselves of liability while causing even greater harm to child than former).

[81] *See Whitner*, 1996 S.C. LEXIS 120, at *30-33 (Finney, C.J., and Moore, A.J., dissenting); *see also* Reinesto v. Superior Ct. of Ariz., 894 P.2d 733, 737 (Ariz. Ct. App. 1995) (holding that child abuse statute does not apply to prenatal conduct [heroin use] that harms fetus); Sheriff of Washoe County v. Encoe, 885 P.2d 596,

more absurd argument is that further criminalizing drug use opens the door to the extension of liability for all potentially harmful maternal conduct such as jogging, eating fattening or high cholesterol foods, or reckless driving.[82]

Drugs are illegal. Drinking, smoking, and eating fattening foods are not. Opponents argue that, if the purpose of criminal prosecution is to prevent fetal harm, then alcohol use and other harmful conduct by pregnant women must also be outlawed.[83] Drinking is a socially acceptable vice, they argue, whereas drug abuse is narrowly viewed as a plague of the urban poor that must be eradicated.[84] These critics, however, fail to see the slippery slope that they have created with such arguments. Illegal activities constitute clearly defined categories, thereby satisfying the due process requirement of fair notice.[85] True discrimination would

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597 (Nev. 1994) (concluding that it would be overbroad interpretation of child endangerment statute to prosecute mother for delivering drugs to fetus through umbilical cord). The *Encoe* court feared that such a construction would include all of a pregnant woman's conduct, including use of legal substances like alcohol and nicotine. *Id.* at 597. "Any further extension of legal protection for the unborn, even for fetuses in the latter stages of pregnancy, is seen as a slippery slope that will erode a pregnant woman's ability to make her own decisions." *See* Carlson, *supra* note 5, at A9 (comparing *Whitner* outcome to factually similar case that was dismissed in Washington and calling for state to model South Carolina decision).

[82] *See, e.g.*, Anne Marie O'Neill, et al., *Under the Influence*, PEOPLE, Sept. 9, 1996, at 53-55 (commentary on Deborah Zimmerman case).

[83] *See* Lichtenberg, *supra* note 58, at 387 (explaining that state must treat abuse of alcohol same as abuse of drugs because both involve maternal addictions that endanger fetus). Smoking can cause low birth weight; alcohol consumption can cause fetal alcohol syndrome which is characterized by mental retardation and growth deficiencies; an improper diet can cause premature births; and caffeine can cause low birth weight. Freeman, *supra* note 29, at 556. Critics fear such activities may also be subject to judicial scrutiny.

[84] *See* McGinnis, *supra* note 43, at 535. As a consequence, opponents argue, prosecutors discriminate based on class. *Id.* Additionally, low income, minority women are reported far more frequently than their prosperous counterparts because medical personnel often administer drug tests based on such class presumptions. *See* Sexton, *supra* note 24, at 427.

[85] *See* Glink, *supra* note 47, at 570 (explaining that statute proscribing all potentially harmful conduct, including legal activities, would be too vague, but one narrowly proscribing conduct that is already illegal would satisfy constitutional requirements). "The state should be able to invade a woman's right to bodily integrity and personal autonomy only when conduct being regulated is illegal. To conclude otherwise would allow a state to deny a pregnant woman the right to make choices that affect her body." *Id.*; *see, e.g.*, California v. Stewart, No. M508197 (San Diego Mun. Ct. 1987) (dismissing charge against pregnant woman who disobeyed her doctor's orders by engaging in sexual intercourse). *But see* Denison, *supra* note 49, at 1125 (arguing that legislatures have every right to declare activities legal in one

occur if criminal liability extended to activities like smoking and drinking. These are activities which the general population enjoys and they cannot be denied to a woman simply because she is pregnant.[86] There exists a clear line between harmful and unlawful conduct.

Opponents also assert that criminalizing maternal drug use would discourage women from seeking prenatal care for fear of being prosecuted.[87] This ignores the reality, however, that, for crack addicts, medical care, for themselves or their unborn children, is not a priority.[88] Other reasons exist, such as shame or lack of money to spare from their expensive habit, which may prevent such addicted women from seeking proper prenatal care.[89] Criminal prosecutions of these women are the only true deterrent to maternal drug abuse.[90]

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context and illegal in another, for example, public nuisance or drunk driving). Critics believe that a law declaring smoking or drinking illegal under the attendant circumstance of pregnancy would parallel these existing, non-vague statutes. *Id.*

[86] *See* Glink, *supra* note 47, at 568. An individual cannot be punished for his status as an addict under the 8th Amendment, absent a criminal act. *See, e.g.*, Robinson v. California, 370 U.S. 660 (1962).

[87] *See Abuse of Viable Fetus Ruled a Crime*, *supra* note 20, at A8. Patients will be distrustful of health care personnel and will not speak openly about drug use. Roper, *supra* note 66, at 180. Further, a mandatory reporting requirement would undermine the confidential doctor/patient relationship. Glink, *supra* note 47, at 546.

[88] *See* Noller, *supra* note 44, at 388 (stating that substance abuse is one of many poor health habits of addicted women, as well as failure to seek adequate medical care).

[89] *Id.*

[90] *See* Deborah Ann Bailey, *Maternal Substance Abuse: Does Ohio Have an Answer?*, 17 DAYTON L. REV. 1019, 1034 n.137 (arguing that civil penalties, such as taking custody of child after birth, are inadequate because damage occurs in utero but criminal prosecution can take place during pregnancy); Elizabeth L. Thompson, *The Criminalization of Maternal Conduct During Pregnancy: A Decisionmaking Model for Lawmakers*, 64 IND. L.J. 357, 367 n.83 (1988) (positing morality argument as justification for imprisonment because such punishment is "concrete expression of society's disapproval of an act [which] helps to form and to strengthen the public's moral code and thereby creates conscious and unconscious inhibitions against committing crimes"). Bailey further explains that the threat of losing custody of a child is not enough to deter women from using drugs. *Id. But see* Freeman, *supra* note 29, at 556 (explaining that criminal prosecutions will increase abortions which, although legal, are counterproductive to state interest in preserving life); Glink, *supra* note 47, at 572 (stating that incarceration serves no purpose because woman's past drug use poses no danger to society); Lichtenberg, *supra* note 58, at 378 (stating that civil commitment of mother after first trimester is better solution because it lacks punitive aspects of imprisonment and is long-term solution); McGinnis, *supra* note 43, at 539 (arguing that money would be better spent prosecuting drug dealers, source of problem); Phillips, *supra* note 49, at 557 (stating that reme-

Liability from a policy standpoint must be confined to illegal activities. Women have no legal right to use illicit drugs,[91] such as cocaine; they do, however, have a legal right to drink or smoke after a certain age.[92] Illegal drug use, on its own, is criminally actionable.[93] Voluntary drug use[94] that injures a viable fetus must, therefore, also be

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dies for pregnant drug abusers must be combination of prenatal care and drug treatment in order to reflect interdependence between woman and fetus); Roper, *supra* note 66, at 171 (suggesting criminal statute mandating drug rehabilitation for pregnant drug addicts and imposing incarceration only upon refusal); Thompson, *supra*, at 370-71 (relating societal costs which include: imposing affirmative duty on doctors to report patients who fail to follow advice, effectively making fetus more important patient than woman; and destroying family unit by putting mother in jail); Zitella, *supra* note 54, at 795 (stating that less intrusive means than imprisonment can protect fetuses, such as education and drug treatment programs for pregnant women). The American Medical Association believes that drug addiction is an illness and should not be prosecuted. *See* Roper, *supra* note 66, at 176; Carlson, *supra* note 5, at A9; *cf.* GREEN, *supra* note 23, at 86 (1993) (stating that criminalizing maternal drug use will only push women away from drug treatment, not scare them into seeking treatment). "Deterrence assumes an ability to change behavior through rational choice - the actor weighs the costs and benefits of his actions in an effort to determine whether or not to act." Roper, *supra* note 66, at 178; Thompson, *supra*, at 366 (emphasizing utility of imprisonment as both general deterrent, causing general population to follow law, and specific deterrent, preventing further harmful activity from this particular individual). The threat of mandatory drug treatment or education will not deter drug users. *Id. But see* McGinnis, *supra* note 43, at 523 (positing that drug addiction is involuntary and that involuntary conduct cannot be deterred). The only behavior that will be deterred is the "voluntary" decision to seek medical care, precisely the opposite aim of prosecutors. Roper, *supra* note 66, at 180; Zitella, *supra* note 54, at 790 (claiming that criminal prosecutions cannot practically serve as deterrent because crack addicts cannot control their addictions).

[91] *See* State v. Murphy, 570 P.2d 1070, 1073 (Ariz. 1977) (declaring that marijuana use is not fundamental right); Freeman, *supra* note 29, at 563. Freeman emphasizes the importance of this argument by comparing the competing interests of abortion and cocaine use. He explains that a woman has a legal right to an abortion before viability and that a state must balance the interests of protecting the fetus and preserving the mother's right to privacy. *Id.* Since there is no legal right to use cocaine, the balancing test set forth by the Supreme Court need not take place. *Id.* (citing State v. Gray, 584 N.E.2d 710, 714 (Ohio 1992) (Wright, J., dissenting)).

[92] *See* Sam S. Bailey, *Maternal Substance Abuse: The Need to Provide Legal Protection for the Fetus*, 60 S. CAL. L. REV. 1209 (1987) (noting that all women have equal rights to consume alcohol and smoke cigarettes).

[93] Prosecutors would simply be clarifying a statute that already applies to every individual. Currently, no one may make, dispense, or possess controlled substances. 21 U.S.C.S. § 841 (West 1994).

[94] *See* Bailey, *supra* note 92, at 1041 (positing that "a woman's initial use of cocaine, with the knowledge that she is pregnant, is a voluntary act and, therefore, she may be subject to prosecution"); Chan, *supra* note 44, at 232 (confirming that pregnant women who abuse drugs make deliberate choice and cannot use excuse that drug addiction is disease). "While rapists, shoplifters, and other offenders may

punished criminally and society cannot rely upon current drug laws alone.[95]

CONCLUSION

Society's most precious commodity is its children. The alarming increase in infants born addicted to drugs necessitates severe penalties for those individuals who are responsible for such suffering. Tragically, mothers comprise this class of abusive individuals. Thus, the alleviation of such suffering necessitates the criminalization of maternal drug use. Simply relying upon current drug laws for use or possession, laws that focus purely on an addict's self abuse, have not only proven ineffective, but they also ignore the crime perpetrated on another individual, the fetus. A pregnant drug abuser must not be treated the same as any other drug abuser. From a biological standpoint, a woman's liability must begin at viability of the fetus. Drawing the line at viability enables the courts to prevent substantial fetal harm while at the same time respecting the abortion rights established in *Roe v. Wade*. Criminal prosecutions of pregnant drug abusers will promote three societal values: punishing knowing criminal conduct that injures another, protecting a viable fetus from further harm, and most importantly, deterring other pregnant women from taking that first hit of cocaine. Only by fostering such values can society hope to protect all viable children from the effects of drug abuse. There is strong support for the court's holding in *Whitner* that a fetus is a person under child abuse law. This will likely spark a continued march in the direction of fetal rights.

Regina M. Coady[*]

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have a mental or psychological 'disease,' this does not affect society's mandate to prosecute such people and criminalize their conduct." *Id.*; Sexton, *supra* note 24, at 411 (declaring that real issue is accountability and drug addiction must not be valid excuse for behavior damaging fetus).

[95] *But see* Roper, *supra* note 66, at 187 (stating that focus must be on preventing drug use in general because this would ultimately decrease numbers of all drug addicts, including pregnant women).

[*] I would like to dedicate this article to Christine Allen and Jim Farrell in sincerest thanks for their friendship and support throughout my time at St. John's Law School.

MEMORANDUM

To: Senator Bert Stedman, Chair, Alaska Senate Health & Social Services Committee
From: Planned Parenthood Votes Northwest & Hawaii
Re: Opposition arguments to SB 179
Date: March 17, 2016

There are a number of significant problems with Senate Bill 179, making it both legally and medically questionable. Before outlining the numerous legal and operational problems with this bill, it is important to note that a "child removed from a pregnant woman's womb alive," as referenced repeatedly in this bill, is not referring to an abortion. It is a delivery. Therefore, regulating this through abortion code is both medically and legally inappropriate. Despite this clear confusion of medical terminology, this memo provides an analysis of the individual components of the bill that together make the bill unworkable, unenforceable, and likely unconstitutional. This document is intended to supplement and reinforce the legally sound advice from the Alaska Legal Services memorandum dated February 15, 2016.

Senate Bill 179 directs physicians to alter their practice of medicine based on vague terminology that conflicts with multiple legal precedents:

> Proposed AS 18.16.010(*l*) in Sec. 2: "When a physician performs or induces an abortion under (k) of this section, the physician shall use the method of terminating the pregnancy that provides the best opportunity for the unborn child to survive after the child is removed from the pregnant woman's womb if, in the physician's clinical judgment, the method of terminating the pregnancy does not present a serious risk to the life or physical health of the pregnant woman."

This provision directs physicians to alter their practice of medicine for interests unrelated to what is best for the patient – the pregnant woman. This would force doctors to deviate from best medical practice to achieve an intrusive legislative goal, rather than advance the woman's health. It is a dangerous precedent for legislation to direct doctors to practice medicine in a manner that may conflict with their training, expertise, and experience.

Furthermore, the provision runs contrary to Alaska court precedent on balancing the state's interest in potential human life and a woman's health:

> "Under the U.S. Supreme Court's analysis in *Roe v. Wade*, the State's interest in the life and health of the mother is paramount at every stage of pregnancy. And in Alaska, '[t]he scope of the fundamental right to an abortion … is similar to that expressed in *Roe v. Wade.*' Thus, although the State has a legitimate interest in protecting a fetus, *at no point does*

> *that interest outweigh the State's interest in the life and health of the pregnant woman."*[1] (Emphasis added.)

This bill would require that physicians put the interest of the fetus at the forefront of their medical decision-making instead of prioritizing a woman's health, which directly violates the underpinnings of Alaska law regarding abortion as laid out in *State v. Planned Parenthood.*

Indeed, nearly identical language[2] has been struck down because it was impermissibly vague. In *Colautti v. Franklin* 439 U.S. 379 (1979), the U.S. Supreme Court held that several provisions of a similar law in Pennsylvania were void for vagueness. Most applicable to SB 179 is a similar provision that directed physicians to use a standard of care in which "the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive." The court found that this provision was impermissibly vague and left physicians without certainty as to their legal duty:

> "Consequently, it is uncertain whether the statute permits the physician to consider his duty to the patient to be paramount to his duty to the fetus, or whether it requires the physician to make a "trade-off" between the woman's health and additional percentage points of fetal survival. Serious ethical and constitutional difficulties, that we do not address, lurk behind this ambiguity."

In light of *Colautti v. Franklin*, it is highly questionable whether the language in SB 179 could stand up in court.

Additionally, and as noted by the Alaska Legal Services memorandum, the definition of "medically necessary" in AS 47.07.068 and as referred to in SB 179 has already been found unconstitutional by the Alaska Superior Court.[3] Compounding the problems with this narrow terminology is *Roe v. Wade*'s companion case, *Doe v. Bolton* 410 U.S. 179 (1973), which upheld a broad medical definition of "medical necessity" when it pertains to abortion, writing: "We agree with the District Court that the medical judgment 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." SB 179 is in direct conflict with this well-established precedent.

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[1] *State Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 913 (Alaska 2001)

[2] Pennsylvania's law directed physicians to "exercise that degree of professional skill, care and diligence to preserve the life and health of the fetus which such person would be required to exercise in order to preserve the life and health of any fetus intended to be born and not aborted and *the abortion technique employed shall be that which would provide the best opportunity for the fetus to be aborted alive so long as a different technique would not be necessary in order to preserve the life or health of the mother.*" (Emphasis added.)

[3] The case is under appeal as *State v. Planned Parenthood of the Great Northwest,* No. S-16123

The omission of psychological conditions in this law highlights why this bill would be so harmful to Alaska women and their families. When we are talking about post-viability, the vast majority of abortions that take place this late in pregnancy are due to serious fetal anomalies that cannot be detected earlier in the pregnancy. In these situations, the infant may live a short and potentially painful life if the woman carries the pregnancy to term. This bill would strip the woman and her family of the ability to make that decision, forcing her to carry the pregnancy to term and put the fetus on artificial aid, regardless of the devastating psychological and mental health conditions she may suffer. It is hard to fathom how the bill's sponsor could argue how either the interest of the fetus *or* the health of a woman is served in this scenario as required in *State v. Planned Parenthood.*

SB 179's definition of "viable" is impermissibly vague and therefore unenforceable:

This bill is riddled with problematic clauses that are overly vague and therefore makes it impossible to enforce, opening up the law to legal challenges. Proposed AS 18.16.101(n)(8) reads: "viable" means capable of surviving outside the mother's womb, with or without artificial aid." This definition raises a number of critical yet unanswered questions:

- If a fetus could survive for several minutes, is it considered viable?
- What level of aid is required? For how long? To what extent?
- What if there is medical certainty that the infant will never survive if removed from artificial aid?
- What if the family knows that an infant will not survive and therefore do not want to put it on artificial aid? Will the state force parents to use artificial aid? For how long? At whose cost?

None of these questions are answered in this bill, putting a physician at risk of unintentionally violating this law even when acting in accordance to his/her best medical judgment. Without the ability to interpret how the state will enforce this law, it can easily be challenged on the basis of vagueness.

"Surrender of a child removed from womb alive" provisions are vague and unenforceable:

Proposed AS 18.16.012 in Section 3 also suffers from legally questionable vagueness and could deny parents of their legally protected rights: "If a child is removed from a pregnant woman's womb alive under AS 18.16.010(k) – (m), the child's parent may surrender the child…" In the rare and unlikely circumstance that this would occur, it is unclear how such surrender would work: Which parent may surrender? One? Both? What if they disagree? Could a father who is unable to fathom the idea supporting an infant who will be on unknown levels of artificial care, surrender the infant on behalf of both parents? This bill leaves these – and other – gaping holes that would render the bill unworkable.

Another section of the bill relating to the surrender is vague and its intent unclear: Proposed AS 47.10.011(13) adds the following as a "child in need of aid" through the Department of Health

and Social Services: "the infant was removed from the mother's womb alive during an abortion performed under AS 18.16.010(k) – (m) and a parent of the child is unwilling or unable to care for the infant." This language certainly implies that an infant becomes in need of public aid if just one parent expresses unwillingness or inability to provide care, yet that would certainly deprive the other biological parent of his/her parental rights. Does this provision mean that an impoverished family's inability to pay for an infant on artificial aid renders the infant eligible for aid, even if the family retains parental rights? Or does this refer solely to the proposed AS 18.16.012 that allows for surrender of such a child that is "removed from a pregnant woman's womb alive"? If the biological father walks away from the family, therefore expressing his unwillingness to care for the infant, is the infant now eligible for aid even if the mother is still there? These are important questions are left entirely unanswered in the bill and could most certainly be argued as void for vagueness.

SB 179 repeals constitutionally necessary exceptions to Alaska's parental consent law:

Lastly, the bill would repeal AS 18.16.010(g)(1), code that allows physicians to bypass the state's parental consent process for abortions on minors because "an immediate abortion of the minor's pregnancy is necessary to avert the minor's death." This eliminates a critical exception to the states parental notice and consent requirements, which threatens anew the constitutionality of the parental involvement laws already being challenged in court.[4]

As outlined here, Senate Bill 179 presents myriad legal, medical, and practical challenges that make this bill simply unworkable and legally questionable. We ask the Chair not to hold a hearing on this dangerous bill, particularly when Alaska faces an unprecedented budget crisis. We urge the Chair to use his committee to enact policies that improve and serve the health and livelihood of everyday Alaskans, rather than advance harmful legislation that steps on the constitutional rights of women.

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[4] The Alaska Supreme court has noted that "the State's interest in the life and health of the mother is paramount at every stage of pregnancy [, and] at no point does state's interest in protecting fetal life "outweigh the State's interest in the life and health of the pregnant woman." *Planned Parenthood of Alaska*, 23 P.3d at 913 (citing *inter alia Valley Hosp. Ass'n. v. Mat-Su Coalition for Choice*, 948 P.2d 963, 969 (Alaska 1997). And as to laws that delay abortions, the United States Supreme Court in Planned Parenthood of Southeastern Pennsylvania v. Casey noted that the medical emergency exception was "central to the operation of various other requirements," including a parental consent provision. The Court went on to explain that if the medical emergency provision "foreclose[d] the possibility of an immediate abortion despite some significant health risks," it would be unconstitutional because "the essential holding of Roe forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would constitute a threat to her health." *Casey*, 505 U.S. at 880. 833, 879, 899 (1992).

IN THE SUPERIOR COURT FOR THE STATE OF ALASKA

THIRD JUDICIAL DISTRICT AT ANCHORAGE

PLANNED PARENTHOOD OF THE GREAT NORTHWEST,	)	
Plaintiff,	)	
v.	)	
WILLIAM J. STREUR, et al.,	)	
Defendants.	)	
	)	Case No. 3AN-14-04711 CI

DECISION AND ORDER

I. INTRODUCTION

In 1998, Alaska Medicaid terminated funding for most medically necessary abortions for low-income women. In 2001, an Alaska Supreme Court case held that this constituted differential treatment of pregnant women and so violated the equal protection clause of Alaska's constitution.[1] A recently enacted statute and regulation again eliminate funding for most medically necessary Medicaid abortions. Under the holding of the 2001 case, this too violates equal protection.

II. FACTS AND PROCEEDINGS

a) Background.

Many Alaskan women qualify for joint federal-state Medicaid, a program enacted to provide comprehensive medical services to low-income people. In 1998, Alaska's Department of Health and Social Services ("DHSS") enacted a

[1] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904 (Alaska 2001), interpreting Alaska Const. art. I, § 1.

regulation restricting state-funded Medicaid abortions to instances of rape, incest, or risk of death to the pregnant woman.[2] This standard matched the federal Medicaid funding standard termed the Hyde Amendment,[3] which precludes federal Medicaid expenditures for abortions except:

> (1) if the pregnancy is the result of an act of rape or incest; or (2) in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed.

Plaintiff Planned Parenthood of Alaska, now Planned Parenthood of the Great Northwest (hereafter "Planned Parenthood" or "Plaintiff"), challenged the new state regulation. The superior court, Judge Sen Tan, held that the regulation violated a woman's right to reproductive freedom under the privacy clause of Alaska's constitution.[4] He subsequently issued an injunction ordering DHSS to fund "medically necessary" abortions. Judge Tan defined that term as follows:

> [T]he terms medically necessary abortions or therapeutic abortions are used interchangeably to refer to those abortions certified by a physician as necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services in his or her professional judgment.[5]

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[2] 7 AAC 43.140.
[3] The Hyde Amendment is re-enacted annually as an amendment to the appropriation bill funding the Federal Department of Health and Human Services, Department of Labor, and Department of Education.
[4] Memorandum and Decision (March 16, 1999), *Planned Parenthood of Alaska v. Perdue*, Case No. 3AN-98-07004CI, 1999 WL 34793393.
[5] Judge Tan Order (Sept. 18, 2000), (attached to Pl.'s Jan. 29, 2014 Memo Re Pl.'s Mot. for TRO and Prelim. Inj., Exhibit 3).

In *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*[6] (hereafter "*State, DHSS*") the Alaska Supreme Court held that the DHSS counterpart to the Hyde Amendment's rape, incest or life-endangerment standard violated the Alaska Constitution's equal protection clause because it denied funding for medically necessary abortions while affording medically necessary services in non-abortion contexts:

> By providing health care to all poor Alaskans except women who need abortions, the challenged regulation violates the state constitutional guarantee of "equal rights, opportunities, and protection under the law." The State, having established a health care program for the poor, may not selectively deny necessary care to eligible women merely because the threat to their health arises from pregnancy. Because we decide this case on state constitutional equal protection grounds, we do not review the superior court's privacy-based ruling. We do note, however, that our analysis today closely parallels that applied by many of the fifteen courts that have rejected similar restrictions. Although other courts' decisions have rested on a variety of state constitutional provisions, including equal protection, constitutional equal-rights-for-women clauses, due process, and privacy, the underlying logic has been the same in decision after decision: "[W]hen state government seeks to act for the common benefit, protection, and security of the people in providing medical care for the poor, it has an obligation to do so in a neutral manner so as not to infringe upon the constitutional rights of our citizens." As the Massachusetts Supreme Judicial Court observed, the constitutional principle at issue is straightforward: "It is elementary that 'when a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations.' " The State's spending discretion is limited by the constitution- "[w]hile the State retains wide latitude to decide the manner in which it will allocate benefits, it may not use criteria which discriminatorily burden the exercise of a fundamental right."[7]

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[6] *State, DHSS v. Planned Parenthood, supra* note 1.
[7] *Id.* at 908-909 (citations omitted).

The Court referenced Judge Tan's order in a footnote, acknowledging that the parties had briefed and argued his grant of injunctive relief.[8] But the Court stopped short of adopting Judge Tan's definition of "medical necessity" or otherwise explicitly defining the term. Nonetheless the Court gave examples of health conditions that qualified for funding under a constitutionally compliant medical necessity standard:

> The range of women whose access to medical care is restricted by the regulation is broad. According to medical evidence provided to the superior court, some women-particularly those who suffer from pre-existing health problems-face significant risks if they cannot obtain abortions. Women with diabetes risk kidney failure, blindness, and preeclampsia or eclampsia-conditions characterized by simultaneous convulsions and comas-when their disease is complicated by pregnancy. Women with renal disease may lose a kidney and face a lifetime of dialysis if they cannot obtain an abortion. And pregnancy in women with sickle cell anemia can accelerate the disease, leading to pneumonia, kidney infections, congestive heart failure, and pulmonary conditions such as embolus. Poor women who suffer from conditions such as epilepsy or bipolar disorder face a particularly brutal dilemma as a result of DHSS's regulation-medication needed by the women to control their own seizures or other symptoms can be highly dangerous to a developing fetus. Without funding for medically necessary abortions, pregnant women with these conditions must choose either to seriously endanger their own health by forgoing medication, or to ensure their own safety but endanger the developing fetus by continuing medication. Finally, without state funding, Medicaid-eligible women may reach an advanced stage of pregnancy before they can gather enough money for an abortion; resulting late-term abortions pose far greater health risks than earlier procedures.[9]

b) The current proceeding.

For years after *State, DHSS*, that agency funded Medicaid abortions

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[8] *Id.* at 907 n. 11.
[9] *Id.* at 907.

consistently with Judge Tan's injunctive order defining medical necessity. But during the administration of former governor Sean Parnell, the issue of Medicaid funding resurged. The governor vetoed legislation to increase the family income level for Medicaid eligibility for indigent women with children, from 150% to 200% of the federal poverty guidelines. The governor explained that his veto was necessary to preclude any increase in Medicaid-funded abortions.[10]

Subsequently DHSS commissioner William Streur drafted a regulation redefining medical necessity in the abortion context.[11] The regulation employed a standard developed by the office of state senator John Coghill, with the addition of a mental health provision. Contrary to normal procedure, the commissioner acted without DHSS staff involvement. On December 10, 2013, he signed an order amending 7 AAC 160.900(d)(30) to require the following physician certification for a state-Medicaid-funded abortion:

> I certify based upon all of the information available to me that . . . in my professional medical judgment the abortion procedure was medically necessary to avoid a threat of a serious risk to the physical health of the woman from continuation of her pregnancy due to the impairment of a major bodily function including but not limited to one of the following. . . .[12]

The regulation then listed twenty-one conditions: diabetes with acute metabolic derangement or severe end organ damage; renal disease that requires dialysis treatment; severe preeclampsia; eclampsia; convulsions; status epilepticus; sickle cell anemia; severe congenital or acquired heart disease Class IV;

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[10] Interrog. Resp. No. 3 to Def's Resp. to Pl's 2nd Disc. Req., August 18, 2014 (Pl. Trial Ex. 47).
[11] *Id.*, Int. Resp. No. 5.
[12] Pl. Trial Ex. 1.

pulmonary hypertension; malignancy where pregnancy would prevent or limit treatment; severe kidney infection; congestive heart failure; epilepsy; seizures; coma; severe infection exacerbated by the pregnancy; rupture of amniotic membranes; advanced cervical dilation of more than six centimeters at less than 22 weeks gestation; cervical or caesarian scar ectopic implantation; pregnancy not implanted in the uterine cavity; and amniotic fluid embolus. Also listed was a category for "psychiatric disorder that places the woman in imminent danger of medical impairment of a major bodily function if an abortion is not performed;" and a category for "another physical disorder, physical injury, physical illness, including a physical condition arising from the pregnancy."

Planned Parenthood filed the present action to declare the regulation unconstitutional. It moved for a preliminary injunction, which this court granted. The court pointed out that the State had operated under Judge Tan's standard of medical necessity for twelve years post *State, DHSS*, and so would suffer no irreparable harm during a short period for judicial review of the new regulation.

Shortly thereafter the legislature enacted Senate Bill 49 (hereafter "SB 49"), codified as AS 47.07.068.[13] The law is nearly identical to the new regulation but lacking a psychiatric disorder category. The Plaintiff amended its complaint, and the court expanded the preliminary injunction. Plaintiff also

[13] Appendix A.

moved for a ruling that the statute impliedly repealed the regulation. The court denied that motion.

The legislative history of SB 49 begins in early 2013. Senator John Coghill, chairman of the Senate Judiciary Committee, sponsored SB 49. Its announced purpose was to define "medical necessity" in light of *State, DHSS.*[14] During the bill's consideration, the House and Senate committees heard testimony from several invited medical professionals.

Priscilla Coleman, Ph.D., a professor of developmental psychology from Kentucky, testified that abortions are a substantial contributing factor to women's mental health problems. She opined that an abortion is never justified on mental health grounds, because abortions exacerbate mental illness, and because abortions can precipitate mental illness in women with no prior history thereof.[15] Under questioning she acknowledged that she is an anti-abortion activist involved in honing the movement's message. She once exhorted the American Association of Pro-life Ob-Gyns to action:

> We need to develop organized research communities to continue the research, apply for grants, recruit young academics, critique data produced by pro-choice researchers, challenge politically biased professional organizations, train experts to testify, and disseminate cohesive summaries of evidence.[16]

Dr. John Thorp, an obstetrician and professor from North Carolina testified next. He testified that he had worked with the bill's sponsor to develop

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[14] Sen. Coghill Sponsor Statement, Sen. Fin. Comm. (3/28/2013).
[15] Sen. Jud. Comm. Min. (Feb. 27, 2013) at 1:56:11 PM, appended as Appendix C, at 6.
[16] *Id.*, at 2:08:51 PM, appended as Appendix C, at 8.

a standard similar to the life-endangerment standard of the federal Hyde Amendment:

> that unequivocally threatened the life of a mother at great magnitude, and would constitute a solid medical indication for a termination of pregnancy. And would be conditions at which even women who wanted to continue a pregnancy, or wouldn't consider abortion, might have it recommended to them as an option to protect their health . . . the bill proposes a comprehensive list of conditions. And hopefully enough specificity and the degree of severity of those conditions that it would be helpful [to the legislature]. . . [and] that would be recommended as options to protect woman's health, even for women who wanted [to] continue their pregnancy or who would not consider abortion.
>
> Chairman Coghill: So, [Dr. Coleman's testimony] talked about the psychological health issues. This is talking about the risk to the life [or] the physical health . . . we added in this that the doctor was still the one that talked about anything life-endangering . . . would you consider most of these on the list things you could end up into . . . life-endangering, physical problems?
>
> Dr. Thorp: Yes sir. I think everything on the list . . . would be more likely than not to pose a substantial risk to the life or physical health of a mother-to-be.
>
> Chairman Coghill: And for the most part, these came right from the Supreme Court. So, that is why we chose to list them the way the Court had lined them out.[17]

Ob-Gyn Dr. Susan Rutherford testified that the listed conditions comported with her view of medical necessity.[18] She recommended adding a category for fetal abnormalities.[19] She testified that she has only seen one

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[17] Tr. Dr. John Thorp, Pl. Trial Br., Ex. A, pp. 13-14; *see also Id.* pp. 73-74 (indicating Dr. Thorp's close association with Senator Coghill and the Senator's staff).
[18] Sen. Jud. Comm. Min. Feb. 27, 2013, at 2:39:48 PM, appended as Appendix C.
[19] Tr. Dr. Susan Rutherford, Pl. Trial Br., Ex. A, p. 22.

patient in thirty years whose kidney infection justified an abortion. "And we only figured that out after the fact;" in other words after the woman died.[20]

SB 49 was introduced in the House of Representatives as House Bill 173 (hereafter "HB 173"). At a hearing of the House Judiciary Committee on March 29, 2013, Dr. Rutherford informed the committee that she concurred with the conclusions of Dr. Coleman and other researchers that termination of a pregnancy actually worsens the mental health status of the woman. She acknowledged contrary views, but insisted that the weight of the evidence supports the conclusion that abortions only worsen mental health.[21]

Both bills were repeatedly characterized as conforming both to the Hyde Amendment's formulation of rape, incest, and life endangerment; and to the *State, DHSS* mandate for coverage of all medically necessary health conditions.[22] It was suggested that Alaska statutes only lacked for a definition of "medical necessity."[23] The legislature operated under the impression that many of the bill's provisions were taken directly from *State, DHSS*.[24] Legislators apparently had the sense that the bill would satisfy equal protection so long as

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[20] *Id.* pp. 25-26.
[21] House Jud. Comm. Min. March 29, 2013, appended as Appendix C, p. 17.
[22] House Fin. Comm. Min. Feb 25, 2014, at 8:06:25 AM (noting that the language "an abortion must be performed to avoid a treat [*sic*] of serious risk to the life or physical health of a woman from continuation of the woman's pregnancy" had been "taken out of the 2001 Planned Parenthood decision" and also derived from the Hyde Amendment). Appended as Appendix C, pp. 24-25.
[23] House Jud. Comm. Min. March 29, 2013, appended as Appendix C, p. 17.
[24] House Fin. Comm. Min. Feb 25, 2014 (noting that the listed medical conditions had been verified by medical experts, and were also included in *State, DHSS.*), appended as Appendix C, and beginning on p. 24.

its enumerated conditions were based on some recognized scientific standard specific to abortions.[25]

On August 22, 2013, a lawyer from the Legislative Affairs Agency, Division of Legal and Research Services issued a memorandum addressed to Senator Hollis French that evaluated the constitutionality of the proposed abortion regulation.[26] The memo concluded in relevant part:

> The *Planned Parenthood of Alaska* case strongly suggests that the Alaska Supreme Court considers women who carry their pregnancy to term to be similarly situated with women who have an abortion (in that they are both exercising their constitutional freedom of reproductive choice) . . . If the court continues to hold that position when it reviews future case, there is a reasonable possibility that the court will find that the state may not burden the right to abortion services under the state Medicaid program with special certification of a specific type of "medical necessity" unless either a similar burden is placed on medical services to continue a pregnancy or the state can show a compelling state interest . . . the new regulation appears likely to be found unconstitutionally discriminatory.

The extent of the letter's distribution is not of record.

III. FINDINGS OF FACT

The court held a seven-day evidentiary hearing, and now makes the following findings of fact. The first twenty-two findings are based on the testimony of Dr. Aaron Caughey, chairman of the Ob-Gyn Department at the Oregon Health & Science University:

1. The term "medically necessary" derives from the insurance industry rather than medical practice. Physicians more commonly use the term

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[25] *See* Sen. Coghill Memo to Sen. Fin. Comm. April 1, 2013, appended as Appendix B.
[26] Ex. 5 to Pl's Jan. 29, 2014 Memo Re Mot. for TRO and Prelim. Inj., p. 5.

"medically indicated," which signifies that a body of evidence suggests intervention will result in a better outcome. The term "elective" means non-medically indicated, *i.e.* with no attending medical benefit.

2. In humans, maternal blood is completely exposed to the placenta, in order to promote the fetus' large-brain growth. A pregnant woman's immune system may react adversely to paternal antigens present in the placenta, leading to elevated blood pressure and kidney damage, a condition known as preeclampsia, a precursor to numerous modalities of life threatening damage. Preeclampsia is most commonly diagnosed after 24 weeks, and may be analogized to a ticking time bomb. A patient must weigh the advantage to the fetus of each additional gestational week, versus immediate caesarian delivery of a preterm baby, thus relieving the mother of life threatening health risks. Preeclampsia during one pregnancy elevates the risk of reoccurrence in a repeat pregnancy by 15-50%, depending on the timing and severity of the prior occurrence. Preeclampsia entails risk to the mother twenty years in the future for heart disease and stroke, but with no measurable way to quantify that risk at present.

3. The most common condition that complicates a pregnancy in the U.S. is obesity, affecting 34% of pregnancies. Chronic hypertension or gestational diabetes complicates 5-10% of such pregnancies. Less common conditions implicating greater risks include renal disease, autoimmune disorders, cancer, or heart disease.

4. Obese patients have higher than baseline rates for congenital anomalies (birth defects) and miscarriage. Obesity renders imaging modalities less effective, complicating the diagnosis of other conditions. Obese women also experience higher than baseline preterm births and growth disorders, both over- and under-weight. Overweight fetuses are more prone to delivery by c-sections, and to metabolic disorders following their birth. Obese women suffer higher rates of preeclampsia. Preeclampsia affects 5% of pregnant women, but 10-15% of obese pregnant women. In women with morbid obesity, the gestational diabetes rate is 40-50%. Obesity increases the odds of both preterm birth and post-term birth, *i.e.* too short or too long a pregnancy. An over-length pregnancy puts both the mother and the fetus at risk; adverse long-term disorders include higher rates of caesarian delivery, postpartum hemorrhage, uterine infection during labor or post-delivery, and blood clots in the legs or pelvis that may migrate to the lungs. This latter complication is the largest cause of maternal mortality in the United States.

5. Women with chronic hyper-tension (elevated blood pressure) experience higher than baseline rates of miscarriage, preterm birth, preeclampsia, and higher rates of growth-restricted fetuses that require early delivery in the early to mid-third trimester.

6. Women with pre-gestational diabetes suffer the same risk factors as obese women, multiplied by a factor of two. Additionally, the pregnancy affects the diabetes itself. The pregnancy hormones cause increased insulin resistance over the course of the pregnancy, but the degree of resistance varies

throughout the pregnancy. Such women essentially face a new disease pattern each week of their pregnancy, which limits their ability to maintain good control over their insulin levels. Control of such diabetes may become the equivalent of a full time job during pregnancy, requiring the interruption of a career.

7. Women who are pre-diabetic due to weight and diet before pregnancy may become diabetic from the hormones of pregnancy. This is most often diagnosed in the third trimester. Such women experience all the above risk factors, except fetal abnormality.

8. Pregnancy may restrict a woman from utilizing the medication she normally takes for pre-pregnancy conditions. A bipolar patient's use of prescribed lithium may increase the risk of severe fetal heart defect. Typically such a patient will stop her use of lithium during pregnancy.

9. Dr. Caughey credibly provided an example of how factors can interact during pregnancy for a woman with comorbid bi-polar disease and diabetes. To avoid harm to the fetus, a patient discontinued her lithium. She then decompensated from normality to dishevelment and mania. Her control over her diabetes diminished, and she required hospitalization.

10. Many drugs used to control disease pose a risk to a fetus. Chemotherapeutic agents adversely affect fetal development. Many high blood pressure drugs can also impact fetal development. Diabetes patients must stop taking certain medications in favor of a limited class of drugs that are safer for pregnancies. Many antibacterials and antibiotics are not utilized during

pregnancy. Also, new drugs that have not been tested in pregnant women are constantly introduced into the marketplace. The hormones and ensuing metabolic changes of pregnancy, including increased liver and kidney function, can make dosing these drugs difficult. And the hormones of pregnancy can directly affect the performance of drugs. These challenges can make it difficult for a woman to maintain a healthy status during pregnancy.

11. Anti-epilepsy drugs are also teratogenic, *i.e.* they can cause fetal abnormality. An epileptic woman wishing to become pregnant would normally reduce her combination of anti-seizure medications to a sole medication. Proper adjustment and titration can take up to six months.

12. Pregnancy can elevate the frequency of pain crises in women with sickle cell anemia. The fetus elevates the body's production in bone marrow of incongruously shaped red blood cells, which then may become retarded in small blood vessels, causing infarctions.

13. The severe heart disease Class IV listed in the statute is heart disease of sufficient severity that a person is never asymptomatic except possibly at complete rest. Many lesser heart conditions are adversely affected by pregnancy. Blood volume increases by 50% during pregnancy, placing additional demands on the heart. A twenty year old woman may have a relatively asymptomatic heart defect such as a hole between her ventricles, that tips into florid symptoms during pregnancy, entailing a risk of death.

14. Conjoined twins always have to be delivered by a form of caesarian section that will commit the woman to preterm c-sections in all future

pregnancies. Carrying such a pregnancy to term affords only a modest chance of a good outcome for the twins.

15. Some fetuses have virtually no chance of surviving a pregnancy, surviving to age one, or developing mentally.

16. Pre-viability rupture of the amniotic sac can lead to decreased uterine pressure on the developing fetus, causing hypoplasia (low growth) of the fetal lungs.

17. In assessing risk to patients and the best interests of patients, physicians must take into account the social, economic, and other situational life factors that may affect a patient's response to illness or pregnancy. For example, if a woman with diabetes has a night job, that alone decreases the probability that she maintains good control of the disease. If such a person has a child with elevated health care needs, such will predictably degrade the patient's quality of self-care. The marginally housed have difficulty with insulin refrigeration and with self-care in general. Mothers with large families or otherwise stressed family life may also lack the capacity to adequately attend to their own health needs.

18. The statute only captures the very worst medical outcomes, the tip of the iceberg for those conditions and circumstances that would render an abortion medically indicated. The statute thus imposes a higher barrier to funding in the abortion context compared to other non-pregnancy medical needs.

19. Other than by self-injury, psychiatric illness does not generally lead to medical impairment of a major bodily function.

20. Dr. Caughey credibly testified that the field of medicine is not sufficiently advanced to predict outcomes that are distant in time. The challenged statute invites speculation or projection beyond the current medical consensus. Risk factors are probabilistic, but often cannot indicate a particular result for a particular patient.

21. The challenged statute will impose on some poor women costs that will delay or prevent their medically indicated abortion. If a woman begins setting aside funds for an abortion the instant she gets pregnant, and gathers the necessary funds in ten weeks, she will face doubled or tripled risks and a more expensive procedure. The challenged statute will thereby delay or prevent treatment for a wide array of health conditions.

22. Dr. Caughey credibly provided an example of a former patient in low-grade general health who had given birth to seven babies. While it was medically risky for her to have another child, he would have been unable to identify a specific organ more at risk than any other.

Finding No. 23 is based on the testimony of Rebecca Poedy, Executive Director of Planned Parenthood of the Great Northwest:

23. Planned Parenthood physicians performed 1410 abortions in Alaska during 2010. Of these, 474 were Medicaid-funded. Alaskan patients must travel to Seattle for second-trimester abortions, because there are no providers in-state. The Planned Parenthood fee for an abortion is $650-750 during the

first trimester, and $900-1000 during the second trimester. Alaska Medicaid pays travel expense, including travel to Seattle.

Findings Nos. 24-30 are based on the testimony of Dr. Renée Bibeault, who practices in Washington as a general and perinatal psychiatrist:

24. Mental distress that rises to the level of a psychiatric disorder is a state of altered or disturbed emotion characterized by negative emotions, fear, anguish, sadness, and difficulty coping with life. It is to be distinguished from normal sadness, or a normal or culturally approved response to loss. There is no recognized articulable standard to distinguish psychiatrically significant mental distress from normal sadness; the determination is made experientially by a treater.

25. Pregnancy is a complicated psychological event which is quite stressful for a majority of women, whether or not the pregnancy is a desired one. It can be a destabilizing event for a woman's mental health. Reproductive hormones affect brain chemistry. Previous mental health conditions can recur during pregnancy. Pregnancy can spark or exacerbate mood disorders that disturb ongoing emotional equilibrium, and that entail sadness, emptiness, and depression. Included in this spectrum are disorders of anxiety, adjustment, schizo-affect, and substance abuse. Such disorders may extend to or originate in the postpartum period (*i.e.* six months post-delivery).

26. Pregnancy and delivery are out-of-control events entailing substantial physical discomfort. The implications of child-raising, of job changes and stresses, and of relationship effects can be overwhelming to a

particular woman. Altered kidney function during pregnancy can alter a woman's response to medication or make dosing difficult. Accordingly, pregnancy may present a substantial barrier to effective treatment of mental illness.

27. A given psychiatric medication may have a 50-60% likelihood of effectiveness in a particular patient. Trial periods of 12-14 weeks, to gauge effectiveness, are normal. Some medications must be tapered off rather than abruptly discontinued. Further, if a woman on psychiatric medication becomes pregnant, changing her medication to avoid fetal toxicity can raise serious health issues. If such a woman elects to go off psychotropic medication, ensuing changes to her psychiatric state and resultant behavioral changes may pose a serious risk to the health and safety of the fetus.

28. Dr. Bibeault credibly testified to the following illustrative mental health circumstances where pregnancy served as a trigger for psychiatric symptoms:

> a) A second-grade teacher with obsessive compulsive and anxiety disorders who experienced repetitive thoughts and behaviors, including the need to tap her desk a number of times before responding to a student, became stabilized on medication for a period of years. When she became pregnant her compulsions returned. She became sufficiently dysfunctional that she elected to terminate an otherwise wanted pregnancy.

b) Similarly, a high-functioning young woman underwent three miscarriages in eighteen months. Each pregnancy was attended by depression and anxious concern for the fetus. She became psychotic during the third pregnancy. Her symptoms cleared within two weeks of each miscarriage.

c) A woman with an eating disorder became pregnant and went off psychiatric medication. She became depressed and suicidal. Termination of her pregnancy resolved her extreme mental anguish.

d) A woman with pregnancy-induced depression wished to have an abortion but did not do so due to intense family pressure. Her illness intensified postpartum into psychotic depression requiring hospitalization. She underwent electro-convulsive therapy, which disturbed her memory and cognition. She has formed very little bond with her six-year-old twins.

e) A victim of domestic violence by an abusive husband wished to flee the relationship, but was frantic that carrying her fetus to term would tie her to her abuser.

f) A young woman was impregnated by her psychotherapist. The patient presented as anxious, grieving and betrayed.

29. It is relatively rare for a mentally ill pregnant woman to be at risk for suicide or extreme self-neglect. The mental health exception in the DHSS regulation is accordingly extremely limited.

30. Dr. Bibeault credibly testified that in her clinical practice she has observed that abortions can relieve great mental suffering and improve mental stability.

Findings Nos. 31-36 are based upon the testimony of Dr. Samantha Meltzer-Brody, who is an associate professor of psychiatry at the University of North Carolina at Chapel Hill:

31. Fifty percent of all pregnancies are unplanned, and some smaller percentage are unwanted. An unplanned, unwanted pregnancy is a profound stressor for a woman. Particularly in women with prior history of mental illness, pregnancy can result in debilitating symptoms leading to total or near-total incapacitation.

32. Ten to fifteen percent of pregnant women experience major depression, and one in seven experiences psychiatric illness in some form. These statistics increase in the poverty-stricken population. Termination of hormonal fluctuations via abortion may end or ameliorate the symptoms of such patients.

33. For women who do not wish to revisit prior profound mental illness symptoms of previous pregnancies, abortion is medically indicated.

34. Dr. Meltzer-Brody credibly furnished several anecdotal examples from her practice:

a) A patient who suffered from mental illness presented naked, smeared with feces, and compulsively masturbating. The patient's pregnancy aggravated her condition.

b) An attorney experienced extreme depression during a first pregnancy, likely brought on by extreme hormonal fluctuations. She took years to recover. Her depression recurred during a second, wanted pregnancy. She became totally incapacitated, but recovered after terminating the pregnancy.

35. Upon becoming pregnant, women are generally advised to cease taking psychotropic drugs, such as lithium, Depakote, and Tegretol, which are attended by an increased risk of fetal abnormality. The main risk to a fetus from its mother ingesting lithium is a disorder called Epstein's anomaly. This occurs less than one percent of the time. Because there is an enormous social stigma against taking medications potentially adverse to a fetus, many women will cease taking medication, even when doing so goes against their best interests.

36. Substance abuse disorder is a recognized category of mental illness. Dual diagnoses of substance abuse disorder plus an axis one psychiatric disorder in a pregnant woman presents grave challenges.

Finding No. 37 is based on the testimony of Dr. Sharon Smith, a family practitioner at the Anchorage Neighborhood Health Center:

37. Dr. Smith credibly testified regarding situations where a physician practicing without legislative restraints would normally consider an abortion medically indicated. She gave the following examples:

a) A patient was desperate to terminate her pregnancy because she could not continue to be employed with another baby, such that

her family would lose half its income. She was extremely distraught. Her abortion was necessary for her health.

b) A patient's fetus presented with a lethal anomaly; the baby would have only survived an hour or two after birth. Because no physician in Fairbanks would treat her, the patient came to Anchorage, extremely distraught. Dr. Smith considered that any denial of Medicaid funding forcing the patient to carry her baby to term would be tantamount to torture.

c) A patient presented with a toxic alcohol condition. Her husband had AIDS. She was unable to stop drinking, and her pregnancy was an extreme stressor. Without an abortion, her fetus would have been born with fetal alcohol syndrome disorder.

d) Some patients are in serious domestic violence relationships. Having a child with the abuser tends to tie the mother to her abuser, with potentially fatal results.

Findings Nos. 38-39 are based on the testimony of Dr. Eric Latzman, an Ob-Gyn who works several days a month on contract for Planned Parenthood:

38. Dr. Latzman credibly testified that Planned Parenthood uses the standard set forth by Judge Tan in his injunctive order. In other words, an abortion is medically indicated if it will ameliorate a condition harmful to the physical or psychological health of the patient in the professional judgment of the treating physician. He generalized that approximately one-third of the time the abortion decision is driven by specific medical conditions, and two thirds of

the time by psychological factors, such as anxiety, depression, addiction disorders, or personality disorders. He has never concluded that an abortion is other than medically indicated when a woman wishes to terminate her pregnancy. Planned Parenthood does not log the reason why it considers an abortion to be medically indicated. Dr. Latzman takes from two to ten minutes to confer with patients to determine that an abortion is medically indicated. He would not perform a Planned Parenthood abortion for a woman with a statutorily listed condition, simply because such women are too ill to utilize a Planned Parenthood clinic. The statute would effectively eliminate all Medicaid-funded abortions at Planned Parenthood.

39. Dr. Latzman cited as an example of psychological factors a sixteen-year-old adolescent from the Yukon-Kuskokwim Delta, pregnant due to a birth control pill failure. She was a high-performing student who expected to attend college. She had been sexually abused from the age of four. She had very little family support. Following the pregnancy, she had ceased eating and was unable to function in school. Dr. Latzman considered her abortion to be medically indicated.

Findings Nos. 40-44 are based on the testimony of Dr. Jan Whitefield. Dr. Whitefield is an Ob-Gyn who provides contract services to Planned Parenthood.

40. About one third of the Planned Parenthood patients Dr. Whitefield sees are on Medicaid. Planned Parenthood charges $650 for an abortion. The normal cost of prenatal care for a woman carrying to term in Anchorage is

$8300 to $9000, and much more for a complicated pregnancy, not including hospital charges. Dr. Whitefield opined that $650 is a very substantial amount of money for women of the Medicaid population. The time necessary for a woman to acquire that sum could take a woman past the twelve-week *de facto* limit to obtain an in-state abortion, given that there are no surgical centers willing to provide abortion services in Alaska.

41. Like Dr. Latzman, Dr. Whitefield has never found that an abortion is other than medically indicated. His definition of medically indicated is a practical one: if a patient has a problem and an abortion will help resolve the problem, the abortion is medically indicated.

42. Dr. Whitefield begins his patient interview with the question, "Why are you here today?" He encounters women whose resources are stretched to the limit; women with a defined mental disorder, exacerbated by the pregnancy; women in bad relationships, sometimes deathly afraid of a partner; and women whose pregnancy will derail their ability to escape from poverty and become independent. He does not attempt to diagnose depression according to the standards of the DSM V manual, but rather assesses overall psychological health.

43. Dr. Whitefield considers the "serious bodily function" standard of the challenged statute to be extremely stringent, such that very few women would satisfy it. The statute would effectively eliminate Medicaid-funded abortions at Planned Parenthood clinics.

44. If the statute were interpreted expansively to apply to women subject to a "risk of a risk" of serious complications, that means all women. For example, all women are at risk for conditions such as preeclampsia.

Finding No. 45 is based on the testimony of Jonathan Sherwood, DHSS Deputy Director of Medicaid and Health Policy:

45. Alaska Medicaid expends over one billion dollars per year on Medicaid services. Alaska Medicaid expends less than two hundred thousand dollars on abortions.

Findings Nos. 46-53 are based on the testimony of Cindy Christensen, a Health Program Manager IV at DHSS Division of Health Care Services:

46. Contrary to normal DHSS procedure, Commissioner William Streur developed the abortion regulation on his own. DHSS staff did not participate in the drafting of the regulation. The DHSS medical director played no role. No abortion providers were consulted.

47. The Alaska DHSS has no omnibus definition of "medical necessity" by which it determines whether medical services are covered by Medicaid. The DHSS generally presumes that a physician provided a medically necessary service.

48. Medicaid pays for tubal ligations of all who request one. The surgeon's fee for this is $1,900, which does not include hospitalization expense.

49. Scheduled c-sections do not require pre-approval via certification of their medical necessity.

50. State Medicaid covers family planning services including sterilization, vasectomy, birth control pills, and IUDs.

51. A typical hospital delivery costs Medicaid approximately $12,000.

52. Medicaid funds many behavioral health services, including drug addiction and family counseling services.

53. Medicaid pays for breast reconstruction surgery, considering it necessary for the emotional wellbeing of the affected woman. Medicaid will pay for a specialist to tattoo a nipple and an areola to perfect the reconstruction. Medicaid will fund revision of a disfiguring injury to reduce stigma and psychological suffering. Medicaid will pay for removal of a disfiguring facial growth that causes emotional distress.

Findings Nos. 54-58 are based on the testimony of Minnesota Ob-Gyn Steve Calvin:

54. Dr. Calvin identifies himself as pro-life. He opined that under the statute an abortion is medically necessary when a continuation of a pregnancy poses a threat to the life of the mother.

55. C-sections are the most common major surgery in the United States. Approximately one-third of pregnant American women give birth by c-section.

56. Three to four fetuses per thousand have an anomaly that is incompatible with life. These include anencephaly (absence of brain covering), absent kidneys, and uncorrectable chromosomal problems. Such fetuses, carried to term, will not survive. In his practice, Dr. Calvin considers abortions

for lethal fetal anomaly to be medically necessary; he has participated in approximately forty such abortions

57. The physical stresses imposed by a pregnancy can cause a woman with heart disease to advance to a higher class of functional incapacity.

58. Silent dilation of the cervix during a pregnancy places the amniotic sac at risk of infection from the genital tract. Such a woman is at serious risk.

Findings Nos. 59-64 are based on the testimony of Dr. Eileen Ryan, who is an associate professor of psychiatry at the University of Virginia:

59. Pregnancy can trigger mental illness. Particularly if a woman is predisposed to mental illness, pregnancy can be an especially vulnerable time for its expression. The postpartum period presents particular vulnerabilities for the expression of major depressive disorders. Hormonal changes during pregnancy, and the significant rapid decline in estrogen and progesterone after birth, are thought to be a factor in postpartum depressions. Up to 20% of pregnant women will at some time experience a pregnancy-related depressive disorder; 9% will suffer a major depressive disorder. For women with pre-existing bipolar disorder, 20-25% will experience depression or mania during or after pregnancy.

60. If a woman has experienced a postpartum depression, and particularly one with psychotic features, the likelihood of recurrence after a succeeding pregnancy is significantly elevated. It is unknown whether early termination of pregnancy affects the likelihood of such depression.

61. A psychiatric disorder is one that meets the criteria expressed in the DSM V Manual. Emotional distress plus impairment of function is not the same as a DSM-recognized psychiatric disorder. Situationally, termination of a pregnancy might ameliorate emotional distress with impairment of function. But an abortion is not recognized as a formal treatment of a psychiatric disorder meeting DSM criteria, or a cure thereof.

62. Women who take the bipolar medication Depakote during pregnancy face a 10% risk of some major deformation to the fetus, including placement on the autism spectrum or a decrease in IQ. Research suggests that such women are 12.7 times more likely to give birth to a baby with spina bifida than a non-medicated woman; 0.6% of Depakote-exposed babies will suffer from spina bifida.

63. Abortion is medically indicated in instances of fatal fetal anomaly. In cases of anencephaly or Tay-Sachs disease, a delivered baby will undergo significant suffering pre-death.

64. Dr. Ryan was not asked to, and did not, support the testimony of Dr. Coleman and Dr. Rutherford before legislative committees that abortions cause mental illness or exacerbate pre-existing mental illness.

III. APPLICABLE LAW

When interpreting statutes, Alaska courts adhere closely to the text's plain meaning. Courts may consider alternate interpretations as suggested by legislative history. But where a law's text is clear and unambiguous, the

legislative history must be increasingly compelling to overcome the statute's apparent plain meaning:

> When we interpret this statutory language we begin with the plain meaning of the statutory text. The legislative history of a statute can sometimes suggest a different meaning, but "the plainer the language of the statute, the more convincing contrary legislative history must be." "Even if legislative history is 'somewhat contrary' to the plain meaning of a statute, plain meaning still controls."[27]

IV. DISCUSSION

a) Statutory Construction.

The State and Plaintiff interpret the statute very differently. The State reads it as a broad authorization for a physician to perform abortions and thus avoid non-trivial physical health detriments that the physician can concretely name. Plaintiff reads it as the Hyde Amendment in disguise, effectively a life-endangerment standard. These disparate readings suggest a lack of clarity in the statute. The court finds the statute to some extent susceptible to both interpretations. But the legislative history convinces the court that the legislature intended the provision as a high-risk, high-hazard standard that would preclude funding for most Medicaid abortions.

The concepts of risk and hazard are often confounded. Here the statute deals with the effects of an action, "continuation of the pregnancy." That action can entail a risk. The word "risk" in this context fairly connotes statistical likelihood and imminence, both captured by the statutory phrase "serious risk." "Hazard" connotes the bad outcome that is risked and sought to be

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[27] *Hendricks-Pearce v. State, Dept. of Corrections*, 323 P.3d 30, 35-36 (Alaska 2014) (internal citations omitted).

avoided. The statutory hazard is "death" or "impairment of a major bodily function." Neither "impairment" nor "major bodily function" is further defined. But "impairment" is qualified; the impairment must arise from one of twenty-one discrete adverse health conditions, or fall into a catch-all category for other physical conditions subject to like parameters of risk and hazard.

Plaintiff plausibly argues that the plain wording of the statute sets a high-risk high-hazard bar for Medicaid-funded abortions. Not just any adverse health effect of continuing the pregnancy qualifies. A woman is only eligible for state funding if she suffers one of the enumerated conditions, or that condition is imminent. By limiting causation of the impairment to blindingly obvious, highly deteriorated physical health conditions, the statute assures that the health detriment is significant and verifiable. Thus a physician's judgment that a pregnant woman's pre-existing kidney disease would get worse during pregnancy would not justify a funded abortion, because the health detriment did not arise from "renal disease that requires dialysis," as required by the statute. And Plaintiff convincingly argues that the hazardous condition must be, if not fully realized, at least imminent:

> The Statute's restrictive terms and detailed list of eligible conditions—many of which are deliberately qualified with the word "severe" or comparable language—make overwhelmingly clear that the Legislature did not intend for the definition to encompass all medical conditions that *potentially* could pose a serious medical risk, regardless of how distant, as Defendants contend.[28]

[28] Pl's Jun. 20, 2014 Reply to Def's Opp'n to Pl's 2nd Mot. for TRO, at p. 15 (emphasis in original).

The State reads the statute quite differently. The purport of the statute is not to limit abortions to women at risk of impairment from a select few obvious health catastrophes. Rather, it is to put an end to the funding of truly elective abortions by using a purely physical standard, without resort to the soft social, emotional, psychological, economic, or behavioral factors that Planned Parenthood physicians routinely use to qualify all abortions as medically necessary. Thus the State argued during final summation that the court should interpret the abortion funding statute's "threat of a serious risk" language fairly broadly. In other words, the statute authorizes an abortion when there is any non-trivial possibility (*i.e.* beyond the baseline risk inherent in all pregnancies) that a cited condition might ensue in the future, even if such risk could not fairly be characterized as either serious or imminent. The State argued that the statute leaves

> a lot of room for the doctor's discretion to operate here, and there is no reason to read the statute as somehow foreclosing that sort of freedom for the doctor and patient together to make an assessment about the risk and where they fall in this coverage . . . . . All the physician has to do is apply professional judgment, look at relevant factors to determine that there is a physical issue here . . . . [The legislature thinks] the best way is to tie medical necessity to a physical health condition [related to a] major bodily function, not morning sickness.[29]

But the legislative history is consistent only with a hard-core standard based on definitive bright lines. Dr. Thorp, who helped draft the bill, testified that the standard entails conditions so present and so dangerous that even a pro-life

[29] State's Final Argument, Feb. 25, 2015 at 11:47:47 AM.

Ob-Gyn would advise a pro-life patient who desired to carry to term to have an abortion for her own safety.

Plaintiff's medical experts testified that women with the enumerated conditions are so sick that they would not be eligible for a clinic abortion. The explicitly catastrophic nature of the enumerated conditions in the statute and the regulation, viewed in the light of the legislative history, contradicts the State's statutory construction. The phrase "a threat of a serious risk to the physical health of the woman from continuation of her pregnancy" cannot reasonably be read to mean a mere distant "risk of a serious risk." Indeed, Dr. Caughey and Dr. Whitefield testified that all pregnancies entail a risk that a serious risk will arise. There is no indication in the legislative history that "a threat of a serious risk" means anything less than "a serious risk." The word "threat" in the statute must be taken as a mere reiteration of the phrase "serious risk." Read thusly the statute addresses "a threat [consisting] of a serious risk to the physical health of the woman," and not merely possible remote risks.

The court concludes that the statute recognizes as medically necessary only abortions required to avoid health detriments attributable to the enumerated conditions, either fully realized or demonstrably imminent. The catch-all twenty-second category applies to unspecified physical conditions of like gravity and imminence. [30] The regulation's mental health category

[30] *See Theresa L. v. State, Department of Human Services, OCS*, Op. No. 7029 p.18 (August 7, 2015) (non-exclusive listing of illustrative conditions implies that non-listed conditions should be of equal gravity).

implicates a "psychiatric disorder that places the woman in imminent danger of medical impairment of a major bodily function if an abortion is not performed." No testifying witness propounded any hypothetical beyond that of a full-fledged psychiatric disorder per DSM V criteria that posed an imminent risk of suicide. The State conceded as much in final argument,[31] and the court so finds.

b) The statute as construed violates state equal protection under the holding of *State, DHSS*.

The *State, DHSS* decision applied strict constitutional scrutiny to a regulation limiting Medicaid funding of abortions to cases of rape, incest, or life endangerment of the mother:

> The regulation at issue in this case affects the exercise of a constitutional right, the right to reproductive freedom. Therefore, the regulation is subject to the most searching judicial scrutiny, often called "strict scrutiny." We have explained in the past that such scrutiny is appropriate where a challenged enactment affects "fundamental rights," including "the exercise of intimate personal choices." This court has specified that the right to reproductive freedom "may be legally constrained only when the constraints are justified by a compelling state interest, and no less restrictive means could advance that interest.[32]

The Court then provided examples of care it deemed medically necessary. It characterized denial of such case as discrimination due to State disapproval of abortions. The Court held that this discrimination violated the equal protection clause of Alaska's Constitution. This was so under strict scrutiny, or even under a lower rational-basis standard.[33]

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[31] State Final Argument, February 25, 2015 at 11:51:40 AM.
[32] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, *supra* note 1 at 909.
[33] *State, DHSS*, 28 P.3d at 912 ("DHSS's differential treatment of Medicaid-eligible Alaskans

The legislature's response, enacted some fourteen years later, was to expand the unconstitutional 2001 regulation by nominally adding a health endangerment component to its definition of medical necessity. But the statute remains problematic in that it only applies to situations where the woman's health is so compromised that, in general, she suffers a risk of death. The purported broadening of the standard is largely illusory because the enumerated conditions would likely qualify for federal Medicaid funding under the life-endangerment standard of the Hyde Amendment. And the statute completely fails to cover several deprivations of medically necessary care noted in the *State, DHSS* decision, including for women who must choose between the risks of teratogenic effects of psychotropic medications needed for their bipolar or epileptic status, versus real but sub-catastrophic health risks if they forego these medications; and for women who require months in order to self-fund their procedures and so incur increased medical risk due to the delay. The State argues that these examples in *State, DHSS* are *dicta* because hypothetical scenarios were unnecessary to the decision. But the scenarios are more aptly characterized as important descriptors of the amplitude of "medical necessity" as that phrase is used in *State, DHSS.*

The statutory standard limits Medicaid funding to high-risk high-hazard situations while failing to address serious but less-than-catastrophic health detriments. This can readily be seen by reviewing the American Heart

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violates equal protection under rational basis review as surely as it does under strict scrutiny. Under any standard of review, "the State may not jeopardize the health and privacy of poor women by excluding medically necessary abortions from a system providing all other medically necessary care for the indigent." (internal citation omitted)).

Association's classification system for patients suffering heart disease.[34] Class I patients suffer some form of cardiac disease, be it occluded arteries, valvular problems, ventricular fistulae, or the like. But they are functionally asymptomatic. Class II patients experience fatigue, palpitation, dizziness, or angina with ordinary activity. Class III patients experience those same symptoms but with less than ordinary activity. And Class IV patients are unable to carry out any physical activity without discomfort, and may even experience symptoms at rest.

A woman occupying any of those categories may experience dramatic impacts during pregnancy. Blood volume increases by fifty percent, placing an added demand on the heart. A variety of pregnancy-induced conditions including preeclampsia can dramatically increase blood pressure and damage the heart. Dr. Calvin testified that a pregnancy can permanently advance a woman's functional capacity class by one level. Yet the statute only addresses the direst status, Class IV, which must be either fully realized or imminent. Notably, in other contexts Medicaid routinely funds statins, blood thinners, and blood pressure medication to minimize the risk of symptom development from class to class. Each class progression entails huge implications for the quality of a woman's daily life, her work, and her family. Inexplicably the statute discriminates against women who opt for an abortion in order to avoid a risk of such a critical but sub-catastrophic deterioration of their health.

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[34] Filed in open court by Planned Parenthood and now marked as Trial Ex. 53 for identification.

Juveniles also face a discriminatory impact. Under Alaska's parental notification statute, juveniles who seek abortions without alerting parents to their pregnancy may seek authorization by a judge.[35] This "judicial bypass" safety valve is required by the U.S. Supreme Court.[36] It protects juveniles who would likely suffer assault, abuse, or familial rejection, were they to disclose to parents. Yet the Medicaid funding statute effectively nullifies that right by denying a Medicaid-funded abortion to juveniles who lack economic means. At final argument the State was clearly troubled by the example of a hypothetical twelve-year-old impregnated by a fifteen-year-old. The State instead argued that such a young child should lodge an "as applied" constitutional challenge; it did not suggest how she might fund that expensive and time-consuming lawsuit.

The statute denies funding to resolve fetal anomalies, even lethal fetal anomalies where a delivered infant will suffer an inevitable and at times painful death. Dr. Caughey termed this deficiency "unconscionable." The State's experts agreed that such abortions are medically necessary. The statute also denies coverage for non-lethal but still grave fetal abnormalities limiting life quality or life expectancy that a woman may deem well beyond her capacity to manage, and that will cause her extreme emotional distress and detriment to her general health. And the statute denies a Medicaid abortion to a woman whose inability to overcome addiction virtually guarantees that she will deliver

[35] AS 18.16.020; AS 18.16.030.
[36] *Bellotti v. Baird*, 443 U.S. 622 (1979).

a baby debilitated by prenatal exposure to drugs or alcohol. This denial of coverage in instances of fetal abnormality is wholly uncharacteristic of, and at odds with, the more universal tendency of Medicaid to assuage dire medical outcomes.

Nor do mental illness or extreme emotional distress qualify. The legislation's sponsors argued that mental health considerations can never justify an abortion. They cited Dr. Coleman, who testified that an abortion uniformly worsens a woman's mental health, or can itself trigger mental illness. But a countervailing body of medical researchers regards that view as a canard. In any event, the State did not present Dr. Coleman's rationale at trial. Instead psychiatrist Eileen Ryan testified that an abortion is not formally recognized by the DSM V manual as a treatment modality or cure for mental illness; only DSM-style treatments should qualify for Medicaid funding. And Dr. Ryan testified that only a psychiatric disorder of such severe magnitude as to require hospitalization should qualify. As to women severely distressed by a fetal anomaly, their remedy is to have an "elective" abortion. Her exception for lethal fetal anomalies arose not from the mental state of the mother, but from the likelihood that a non-survivable defect would cause an infant physical suffering after a live birth.

But credible expert testimony by Dr. Bibeault and Dr. Metzler-Brody established that an abortion can in fact resolve psychiatric symptoms of women with anxiety, depression or obsessive-compulsive disorders. It can also be critical in the management of patients suffering psychotic breaks or

schizophrenia. It seems hardly controversial that a schizophrenic woman who presents as naked, smeared with feces, and compulsively masturbating, as described by Dr. Meltzer-Brody, is an obvious candidate for a medically-necessary abortion, even if that abortion will not "cure" her condition. The pregnancy will limit the range of psychoactive medication that such a patient can receive; she may lack the resiliency to withstand constant hormonal surges.

Simply put, an unwanted pregnancy is a crisis for any woman. To an impoverished woman without recourse to an abortion, the crisis may be extreme. Indigent women often face a panoply of stressors, including large families, homelessness, addiction, their own adolescent immaturity, and domestic violence. The added stressor of an unwanted pregnancy with no recourse to an abortion can create clinically significant mental distress such that a Medicaid abortion is medically necessary.

How did the State justify these exclusions from Medicaid coverage? Dr. Calvin and Dr. Bramer, self-identified pro-life physicians, testified in favor of a high-risk high-hazard standard. In Dr. Calvin's case, his testimony was at odds with his home state's definition of medical necessity: Minnesota Medicaid funds all abortions. Notably, Dr. Calvin cannot be seen as testifying to some universally recognized standard of practice. Rather, he advocated the proposition that "medical necessity" should mean "necessary to avoid fatal or near-fatal health crises." But he never explained why that should be so. Viewed thusly his testimony amounted to an *ipse dixit*: he approved of a high-

risk high-hazard standard for Medicaid abortions because such a standard accords with his personal religious precepts against abortion. Psychiatrist Dr. Ryan was similarly dogmatic: the only medically necessary psychiatric treatments are medications or therapy for formally diagnosed psychiatric disorders. An abortion is not such a treatment. Amelioration of mental suffering via an abortion is not medically necessary because this would contradict her personal moral standards.

The State has identified no other context in which medical service to poor people is titrated with such exacting rigor, with such indifference to risk factors, to sub-catastrophic physical heath detriments, and to human suffering. In numerous other contexts, Medicaid relieves human suffering unrelated to serious end-organ damage. Medicaid will cover procedures to remediate disfiguring conditions, not because such conditions seriously impair a major bodily function, but because doing so relieves great emotional distress. The essential humanity of the program is symbolized by its willingness to spend thousands of dollars for a realistic tattoo of an areola and nipple on a woman's reconstructed breast. Medicaid will provide behavioral counseling for the family of an errant youth. It will fund an expensive elective tubal ligation or vasectomy; or drug or alcohol counseling for the addicted; or non-emergency caesarian sections, without elaborate standards. And when Medicaid curtails spending, it does so for genuinely neutral reasons. When unscrupulous group homes peddle surplus diapers, DHSS sensibly imposes a per-patient quota. No constitutional principle is implicated.

But under AS 47.07.068, abortions for poor women are subject to an entirely different register of scrutiny. Medicaid will pay $9,000 in routine prenatal care and $12,000 in routine delivery expense for a pregnancy where a poor woman elects to carry to term in the face of significant risks. But it cannot pay $650 for the same poor woman who is unwilling to bear those risks and who exercises her constitutional right to terminate her pregnancy. The court is aware of no other context where Medicaid engages in such a relentlessly one-sided calculus.

The equal protection issue posed in *State, DHSS* was whether the standard applied to women seeking abortions accorded with Medicaid treatment of patients in general. This court must gauge whether the statute's high-risk high-hazard standard is compatible with the broad tendency of Medicaid to defer to a physician's judgment the question of what treatment is medically necessary to advance physical and mental health, taking into account the patient's individual nature and specific life circumstances.

The State resists this court's frame of the equal protection issue, arguing that this is not an equal protection case at all. It instead contends that the statute complies with the *State, DHSS* holding by adding a health-of-the-woman component; and that the legislature applied neutral criteria, *i.e.* the testimony of medical professionals, in formulating the standard. Per the State, the interest at stake is purely monetary, *i.e.* the $650 cost of abortions. A rational-basis standard applies, not the strict scrutiny of *State, DHSS.* The statute is neither pro- nor anti-abortion; it simply reflects a mundane drawing

of lines pursuant to neutral criteria, just as DHSS limits diaper allocations to group homes.

But the court concludes that the legislature fundamentally misunderstood *State, DHSS*. The Supreme Court clearly held that the relevant standard of medical necessity is that applied by Medicaid to its general population. In contrast, the legislature uncritically accepted the testimony of self-identified anti-abortion advocates promoting a fabricated consensus on medical necessity. Impelled by this contrived testimony, the legislature then enacted a minimal tweak to the restrictive Hyde Amendment standard of rape, incest, or life endangerment. The State at trial presented similar self-identified pro-life advocates. It too contended that the high-risk high-hazard standard is neutral because neutral pro-life physicians endorse it. The State's credulous analysis is incompatible with the holding of *State, DHSS*. The high-risk high-hazard standard of the statute and DHSS regulation denies low-income women seeking Medicaid abortions the equal protection of Alaska law.

c) What standard for Medicaid-funded abortions accords with the equal protection holding of *State, DHSS*?

Having concluded that AS 47.07.068 sets the bar for Medicaid-funded abortions too high, this court could decline to define a standard that is actually consistent with *State, DHSS*. Courts often avoid broader than strictly necessary holdings in constitutional litigation for sound prudential reasons. But here the parties have with great professionalism and skill conducted a comprehensive evidentiary hearing on the issue of election versus necessity. The parties fairly

invite this court to declare an appropriate standard. The Alaska Supreme Court will decide the matter *de novo*, without deference to this court's decision. But some defined standard should prevail during the period of Supreme Court review.

For nearly fifty years Alaska Medicaid has operated under a physician-deferential standard of medical necessity in the abortion context. That standard was articulated in Judge Tan's 2000 order:

> [T]he terms medically necessary abortions or therapeutic abortions are used interchangeably to refer to those abortions certified by a physician as necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services in his or her professional judgment.[37]

The State proved at trial that Planned Parenthood physicians uniformly certify a Medicaid abortion as medically necessary. The State argues that Judge Tan's standard is so broad and nebulous that it permits a doctor to consider factors it believes should be irrelevant to medical decision-making. These include social and economic considerations. Does the woman have a large family under stress from multiple factors such as poverty, unemployment, lack of housing, domestic violence, and the like? Does the woman suffer from drug addiction, or exhibit reckless adolescent immaturity, or other behaviors signaling an inability to parent? Is a young woman, forced by poverty to carry to term absent Medicaid funding, subject to extreme

[37] Judge Tan Order (Sept. 18, 2000), (attached to Pl.'s Jan. 29, 2014 Memo Re Pl.'s Mot. for TRO and Prelim. Inj., Exhibit 3).

emotional distress over loss of an educational opportunity that is her sole hope for an escape from poverty and social disarray? Recognition of such concerns, the State argues, is incompatible with an effort to preclude truly elective abortions.

In contrast Plaintiff's physicians consider life circumstances and mental health to be critically important. To Dr. Whitefield, his introductory question to a patient, "Why are you here?" always elicits a response that places the patient somewhere along the spectrum of medical necessity. "Medically necessary," a term mainly used in the insurance industry to deny claims, is thereby recast into the term that doctors more commonly use, "medically indicated." A procedure is medically indicated if it would result in some benefit to the patient. Dr. Whitefield's inquiry to his patients leads either to an inevitable conclusion of medical necessity, or to a decision by the woman that she does not wish to proceed with an abortion.

The court, in resolving these disparate contentions of the parties, finds guidance in *State, DHSS*. First, the Alaska Supreme Court explicitly described conditions qualifying as medically necessary. For example, the Court telegraphed that a bipolar woman taking psychotropic medications should be entitled to a funded abortion to avoid risk of injury to the fetus or to her own mental health. The Court also suggested that a delay of months while a woman raises the money for an abortion adds unacceptable risk. This court concludes deductively that *State, DHSS* signals the Alaska Supreme Court's intolerance toward subjecting impoverished Alaskan women to non-trivial and

avoidable physical risks, to material mental health detriments, or to mental distress due to serious fetal anomalies.

Moreover, the *State, DHSS* Court highlighted the U.S. Supreme Court case *Roe v. Wade* as an underpinning of Alaska law:

> Under the U.S. Supreme Court's analysis in *Roe v. Wade*, the State's interest in the life and health of the mother is paramount at every stage of pregnancy. And in Alaska, "[t]he scope of the fundamental right to an abortion ... is similar to that expressed in *Roe v. Wade*." Thus, although the State has a legitimate interest in protecting a fetus, at no point does that interest outweigh the State's interest in the life and health of the pregnant woman.[38]

Roe v. Wade is commonly thought of as legalizing abortion; in fact, *Roe* only legalizes *medically necessary* abortions. Yet no state prosecutes physicians providing, or women undergoing, elective abortions. This is largely because on the same day that the U.S. Supreme Court decided *Roe v. Wade*, it also decided *Doe v. Bolton*,[39] and ordered that the two be read together.[40] *Bolton* held that a Georgia criminal statute restricting abortions to those that are medically necessary was permissible, in light of the Georgia statute's broad definition of "medical necessity":

> We agree with the District Court that the medical judgment 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. This 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.[41]

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[38] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 913 (Alaska 2001).
[39] *Doe v. Bolton*, 410 U.S. 179 (1973).
[40] *Roe*, 410 U.S. at 165.
[41] *Bolton*, 410 U.S. at 192.

Then in 1980 the U.S. Supreme Court case *Harris v. McRae* upheld the federal Hyde Amendment and state statutes with a similar life-endangerment, rape, or incest standard as permissible under the U.S. Constitution.[42] The *Harris* holding and its rationale are set forth in the Massachusetts case *Moe v. Sec'y of Admin. & Finance:*

> In *Harris v. McRae* and its companion case *Williams v. Zbaraz,* the Supreme Court of the United States upheld enactments substantially identical to those challenged here against claims that they violated the due process and equal protection components of the Fifth and Fourteenth Amendments to the United States Constitution. In the view of five members of the Court, neither the Federal nor the parallel State funding restriction denied any federally protected constitutional right. While granting the importance of a woman's interest in protecting her health in the scheme established by *Roe v. Wade*, supra, the Court held that "it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices. The reason why was explained in *Maher v. Roe*: although government may not place obstacles in the path of a woman's exercise of her freedom of choice, it need not remove those not of its own creation. Indigency falls in the latter category.... Although Congress has opted to subsidize medically necessary services generally, but not certain medically necessary abortions, the fact remains that the Hyde Amendment leaves an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all." The Court went on to reject claims based on the free exercise and establishment clauses of the First Amendment, and on the Fifth Amendment guarantee of equal protection. Concluding that to be upheld the funding restriction need only be rationally related to a legitimate State interest, the Court held that the establishment of financial incentives making childbirth "a more attractive alternative" than abortion for Medicaid recipients has a "direct relationship to the legitimate [governmental] interest in protecting potential life."[43]

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[42] *Harris v. McRae*, 448 U.S. 297 (1980).
[43] *Moe v. Sec'y of Admin. & Finance*, 417 N.E.2d 387, 399-400 (Mass. 1981) (internal citations omitted).

The *Moe* court rejected the *Harris v. McRae* rationale pursuant to the privacy clause of the Massachusetts Constitution:

> In our view, "articulating the purpose [of the challenged restriction] as 'encouraging normal childbirth' does not camouflage the simple fact that the purpose, more starkly expressed, is discouraging abortion." As an initial matter, the Legislature need not subsidize any of the costs associated with child bearing, or with health care generally. However, once it chooses to enter the constitutionally protected area of choice, it must do so with genuine indifference. It may not weigh the options open to the pregnant woman by its allocation of public funds; in this area, government is not free to "achieve with carrots what (it) is forbidden to achieve with sticks." We are therefore in agreement with the views expressed by Justice Brennan, writing in dissent to *Harris v. McRae*:
>
> > In every pregnancy, [either medical procedures for its termination, or medical procedures to bring the pregnancy to term are] medically necessary, and the poverty-stricken woman depends on the Medicaid Act to pay for the expenses associated with [those] procedure[s]. But under [this restriction], the Government will fund only those procedures incidental to childbirth. By thus injecting coercive financial incentives favoring childbirth into a decision that is constitutionally guaranteed to be free from governmental intrusion, [this restriction] deprives the indigent woman of her freedom to choose abortion over maternity, thereby impinging on the due process liberty right recognized in *Roe v. Wade*.[44]

This court notes a nuance in the Brennan formulation adopted by Massachusetts. The relevant datum is not a health-endangering condition establishing medical necessity. Rather, the woman's constitutional right to reproductive choice can only be realized with the help of a physician. This need for a physician's participation in an abortion, and not some underlying health problem, defines "medically necessary" in this unique context.

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[44] *Id.* at 402, *citing Harris*, 448 U.S. at 333 (Brennan, J., dissenting).

During the ensuing twenty years after *Harris v. McRae*, fifteen of the twenty states addressing Medicaid abortions under state law aligned with Massachusetts in rejecting the U.S. Supreme Court's holding. In 2001 Alaska became the sixteenth state to do so, joined by Arizona in 2002.[45] Four states (Hawaii, Washington, New York, and Maryland) place no restrictions on Medicaid abortions, without a court order compelling this. The remaining majority of American states follow the federal standard of life endangerment, rape, or incest; although Iowa, Mississippi, and Virginia add fetal impairment.[46]

Our Court's constitutional analysis in *State, DHSS* is very similar to that of the many other courts rejecting a high-risk high-hazard standard and their accompanying approval of virtually unfettered physician discretion. The State's prediction that our Court will now distinguish those other states' holdings and impose a fresh variant of a high-risk high-hazard standard must rest, not on any language found in *State, DHSS*, but on the possibility that the current Court will reconsider the logical implication of that decision.

To illustrate the implausibility of the State's prediction, the court notes that the U.S. Supreme Court in *Harris v. McRae* literally held that discriminatory denial of medically necessary Medicaid abortions constitutes a permissible state-sponsored celebration of potential life. The *State, DHSS* Court definitively rejected this rationale, but without identifying its origin in

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[45] *Simat Corp. v. Ariz. Health Care Cost Containment Sys.*, 56 P.3d 23 (Ariz. 2002).
[46] State Funding of Abortion Under Medicaid, Guttmacher Institute January 1, 2015, appended as Appendix D.

Harris v. McRae. The Court distinguished *Harris v. McRae* in a cursory footnote.[47] Perhaps this led the legislature to credit *Harris v. McRae* as good law. A legislative memo cites *Harris* for the proposition that SB 49 satisfies state equal protection:

> Additionally, the United States Supreme Court, in 1980, ruled that the Hyde Amendment (which is the foundation for SB 49) does not violate women with lower incomes right to obtain a medically necessary abortion. The case was *Harris v. McRae*, 448 US 297 (1980). The State has no obligation to remove obstacles that it did not create (namely the woman's status of being of little means).[48]

Several of the fifteen courts that Alaska joined in rejecting the federal standard afford explicit guidance as to the contours of medical necessity. Because those cases were cited in *State, DHSS*, it is likely that Alaska's Supreme Court will re-examine them closely as it decides whether to itself promulgate a definitive standard.

As noted above, the Massachusetts Supreme Court in *Moe* accepted Justice Brennan's formulation that medical care is always a necessary response to pregnancy, either to terminate or to carry to term. Speaking of an "elective" abortion in isolation from an "elective carriage-to-term" is thus to obscure critical thought; either describes a single choice between mutually exclusive, constitutionally protected options, both equally legitimate in the State's eyes.

The State argues that the *State, DHSS* Court rejected the Brennan approach when it said:

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[47] *State, DHSS*, 28 P.3d at 911 n. 56.
[48] Sen. Coghill Memo to Sen. Fin. Comm. April 1, 2013, appended as Appendix B.

> This case concerns the State's denial of public assistance to eligible women whose health is in danger. It does not concern State payment for elective abortions. . .[49]

But that language may merely allude to the propensity of courts to subdivide complex constitutional issues into discrete sub-topics and to decide only those immediately at hand. For example, the U.S. Supreme Court incrementally held that the Medicaid statute did not require state funding of non-therapeutic abortions in *Beal v. Doe*;[50] validated this statutory construction against constitutional challenge in *Maher*;[51] rejected a due-process challenge to federal and state application of the life endangerment, rape, or incest Hyde standard in *Harris*;[52] and dismissed an equal protection challenge to state and federal Hyde provisions in *Zbaraz*.[53] It took at least four cases to delineate the federal law of Medicaid funding of abortions. It thus remains an open question whether the Alaska Supreme Court would adopt the Brennan-Massachusetts standard; but given the focus in *State, DHSS* on the exclusion from funding of women with discrete health-related conditions, the Court would have to somewhat shift analytical gears to adopt that standard.

Other states mirror Judge Tan's order and simply delegate the medical necessity decision to the unfettered discretion of the physician. The Minnesota formulation disclaims authorizing on-demand Medicaid abortions, even while relegating the decision to a woman's physician:

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[49] *State, Dept. of Health & Social Services v. Planned Parenthood of Alaska, Inc.*, 28 P.3d 904, 905 -906 (Alaska 2001)
[50] *Beal v. Doe*, 432 U.S. 454 (1977)
[51] *Maher v. Roe*, 432 U.S. 464 (1977)
[52] *Harris v. McRae*, 448 U.S. 297 (1980).
[53] *Williams v. Zbaraz*, 448 U.S. 358 (1980).

> Contrary to the dissent's allegations, this court's decision will not permit any woman eligible for medical assistance to obtain an abortion "on demand." Rather, under our interpretation of the Minnesota Constitution's guaranteed right to privacy, the difficult decision whether to obtain a therapeutic abortion will not be made by the government, but will be left to the woman and her doctor.[54]

Presumably Minnesota abortion providers are as inclined to discern medical necessity as Alaska ones, who have apparently never failed to do so.

A West Virginia case overturned legislation requiring irreversible loss of a major bodily function in order to justify a Medicaid abortion. The holding reverted West Virginia law to a prior administrative standard that echoed the *Doe v. Bolton* approach and was similar in effect to Judge Tan's formulation:

> For determining whether a submitted medical expense qualifies as medically necessary, the West Virginia Department of Health and Human Services has adopted [a regulation that] provides that the Department:
>
> > makes reimbursement for pregnancy termination when it is determined to be medically advisable by the attending physician in light of physical, emotional, psychological, familial, or age factors (or a combination thereof) relevant to the well-being of the patient.[55]

Thus, a West Virginia physician may consider factors such as youth, pre-existing children, family income, the likelihood of family breakup, domestic violence, and similar stressors that affect a woman's general well-being.

A third iteration of this permissive standard for medical necessity emerges from New Mexico. There, a regulation imposed a life endangerment

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[54] *Women of State of Minn. by Doe v. Gomez*, 542 N.W.2d 17, 32 (Minn. 1995).
[55] *Women's Health Center of West Virginia, Inc. v. Panepinto*, 446 S.E.2d 658, 661 (W. Va. 1993).

standard. The New Mexico Supreme Court reinstated a prior state regulation that more broadly defined medical necessity:

> [A]n abortion is "medically necessary" when a pregnancy aggravates a pre-existing condition, makes treatment of a condition impossible, interferes with or hampers a diagnosis, or has a profound negative impact upon the physical or mental health of an individual.[56]

Although the court did not say so, the conditions of juvenile pregnancy, fetal abnormality, rape, and incest all appear to be reasonably accommodated by the mental health formulation.

The Brennan and Massachusetts standard posits that all abortions are medically necessary. Judge Tan's order, Minnesota, and West Virginia grant unfettered physician discretion. New Mexico broadly guides that discretion. All three approaches arrive at the same outcome. For all practical purposes, they empower a physician to certify virtually any pregnancy as medically necessary within the physician's discretion.

This court's largely undisputed findings of fact indicate that the decision to carry a fetus to term exposes a woman to an inevitable array of foreseeable and unforeseeable risks. A condition as mundane as obesity seriously heightens a woman's pregnancy risk. And all pregnant women face a 30% risk that their pregnancy will terminate in the major surgery of a caesarian delivery. As Dr. Caughey testified, the woman with the lowest statistical pregnancy risk is Caucasian with a normal body-mass ratio, aged 25-29, employed, and with

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[56] *New Mexico Right to Choose/NARAL v. Johnson*, 975 P.2d 841, 844 (N.M. 1998).

access to permanent housing and health insurance. Those qualities are likely not descriptive of many low-income women seeking Medicaid abortions.

Women voluntarily assume the risks of pregnancy in the joyful context of a wanted child. But Alaskan women denied Medicaid abortions by a restrictive standard who are unable to beg, borrow, or earn $650 (or far more for an out-of-state second-trimester abortion) would be forced to carry to term without voluntarily assuming those risks. Meanwhile, Medicaid would expend thirty-two times the $650 cost of their abortion for their prenatal care and delivery expense.

This court concludes no standard that is limited to somatic conditions can be fairly applied to indigent women in all their extraordinary diversity of circumstance, without unjustifiably delaying many abortions until they are riskier, or without imposing an involuntarily assumption of significant risks on those forced by circumstance to carry to term. Doctors routinely consider the life circumstances and mental health of their patients, and abortion-seeking Medicaid patients are entitled to no less quality of care. Once the door is opened to considerations of general physical and mental health as influenced by particular life circumstances, application of any rigid standard becomes wholly impractical. That conclusion belies this court's prediction at the outset of the case that some firm boundary between a medically necessary abortion and an elective abortion would emerge.

The court adopts Judge Tan's formulation of medical necessity as the one most consistent with the rationale and holding of *State, DHSS*. This ruling, if

upheld, means as a practical matter that virtually all indigent Alaskan women seeking abortions will receive state Medicaid funding. Such is consistent with the rights of indigent Alaska women during the last 45 years, and with the rights of indigent women in the sixteen other American states rejecting the federal standard.

V. ORDER

AS 47.07.068 and 7 AAC 160.900(d)(30) violate the equal protection clause of Alaska's Constitution. The court permanently enjoins their enforcement. DHSS will fund all medically necessary Medicaid abortions under the following definition of that term:

> The terms medically necessary abortions or therapeutic abortions are used interchangeably to refer to those abortions certified by a physician as necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services in his or her professional judgment.

DATED at Anchorage, Alaska this 27th day of August, 2015.

John Suddock
Superior Court Judge

I certify that on 8-27-15
a copy of the above was mailed
to each of the following at their
addresses of record:

Janet Crepps	*Susan Orlansky*
Laura Einstein	*Stacie Kraly*
Helene Krasnoff	*Autumn Katz*
Julia Kaye	*Brigitte Amiri*
Thomas Stenson	*Margaret Paton-Walsh*

Mary Brault - Judicial Assistant

PRESS RELEASE

Lehner Announces "Ohio Viable Infants Protection Act" Approved By Senate

April 06, 2011

[Peggy Lehner Home | Peggy Lehner Press]

Columbus - State Senator Peggy Lehner (R- Kettering) announced today that the Ohio Senate voted to approve Senate Bill 72, legislation that would prohibit abortions once the viability of the child has been confirmed. "Abortions can currently be performed in Ohio up to the moment of birth, but many doctors agree that a child can live outside the womb after just 22-24 weeks," Lehner said. "This bill will prevent late-term abortions - which are done when the child has a good chance of surviving and is old enough to feel pain - and help better protect our youngest and most vulnerable citizens." Under Senate Bill 72, if a pregnant woman seeking an abortion is at 20 weeks gestation or older, the doctor must test the child to see if he or she is viable. If the determination is made that the child is viable, an abortion cannot be performed except in the case of a medical emergency, in which case the abortion must be performed where there is a neonatal care facility and done using the method that is most likely to permit the child to survive. In addition, another doctor must be present to care for the child. The bill also requires doctors to report on circumstances that still allow an abortion to take place, and holds physicians accountable for failing to determine viability prior to performing later-term abortions. Lehner noted that 39 other states have enacted a form of legislation limiting postviability abortions. Senate Bill 72 now moves to the Ohio House for further consideration.

Featured Posts

Lehner Explores Innovative Solutions During Visit To Southwest Ohio Charter School

COLUMBUS - "Taking the time to experience firsthand the innovative models that schools across the state are using to produce successful outcomes is crucial to meaningful education policymaking," said Lehner. "It was fascinating to speak with students to better understand what is working, and not working, so that our children are receiving the highest quality education possible."

[Read Full Story]

Lehner Highlights Growing Economic Success Throughout Dayton Region

COLUMBUS - "Collaboration between our regional economic assets has been key to rejuvenating our workforce and bringing jobs back to the area throughout the past several years," said Lehner.

[Read Full Story]

Lehner Praises National Education Initiative To Restore Local Control Of Schools

COLUMBUS - The overwhelming bipartisan support for the rewritten national education legislation now known as the Every Student Succeeds Act is the most significant education reform bill in the past 14 years. While not retreating from higher standards and accountability for our nations schools, it returns considerable control to the state and local districts, rather than investing control in the federal government. The legislation is a welcome change and I look forward

David Scott

From: Randy Ruaro
Sent: Sunday, March 27, 2016 10:09 AM
To: David Scott
Subject: FW: Yes on 179

David,

For the committee record on SB 179.

Randy

-----Original Message-----
From: Pamela Lynn [mailto:aksunshine123@gmail.com]
Sent: Thursday, March 24, 2016 12:45 PM
To: Sen. Bert Stedman <Sen.Bert.Stedman@akleg.gov>
Subject: Yes on 179

>
>
>
> Dear senators
> Good afternoon. I hear SB 179 is in your Health commitee. I would like to please encourage full support of this bill and here's a couple of reasons why:
>
> http://www.lifenews.com/2016/03/22/baby-born-alive-after-botched-24-week-abortion-screamed-for-an-hour-as-doctors-left-child-to-die/
>
> https://m.youtube.com/watch?v=yHnaQiOxGfg
>
> http://www.lifenews.com/2015/09/09/abortion-survivor-tells-congress-planned-parenthood-would-have-killed-me-if-given-the-chance/
>
> Please don't let Alaska be one of those states that does this to children.
> Thank you
> Pamela Samash
> Nenana
> 322-2201

David Scott

From: Randy Ruaro
Sent: Thursday, March 31, 2016 9:45 AM
To: David Scott
Subject: FW: SB 179

Follow Up Flag: Follow up
Flag Status: Flagged

For the record of public comment on SB 179.

From: Cyndy Cox [mailto:chilitattoo1@gmail.com]
Sent: Wednesday, March 30, 2016 5:42 PM
To: Sen. John Coghill <Sen.John.Coghill@akleg.gov>
Cc: Sen. Bert Stedman <Sen.Bert.Stedman@akleg.gov>; Kenni Linden <kenni.linden@ppvnh.org>
Subject: SB 179

Dear Senators Coghill and Stedman,

This letter is being written to urge you to rescind SB 179. It's appalling to think anyone would deem it appropriate or even ethical to force a woman into giving birth against her will. The decision to terminate a pregnancy is private, personal and none of a legislator's business. Most fetal anomalies are not detected until after 20 weeks and sometimes as late as into the third trimester. The decision to continue or not to continue with such a pregnancy is one no woman wants to make, but should remain hers and hers alone. Viability does not justify the extensive medical intervention necessary for the survival of the fetus, nor does it justify forcing a family to endure the possibility of a lifetime of medical procedures, expenses and pain, and it does not justify countermanding a woman's medical decisions.

As the legislature looks for ways to eliminate unnecessary costs, why would you deliberately incur huge and unnecessary expenses of caring for unwanted and possibly malformed fetuses? Your bill mandates fetuses deemed viable be kept alive, rescinds all late term abortions regardless of medical advice, and says that if a woman can't or is unwilling to care for a fetus she has already decided to terminate, she can relinquish it to the state. It defies logic. Women should not be shamed or bullied because of their reproductive decisions.

I urge you to kill this bill. Please rest assured and respect the fact that women have the ability and are capable of making informed decisions regarding what is best for her and her family without legislative interference.

Thank you for your time,

Cyndy Cox
Anchorage, Alaska 99507

LEGAL SERVICES

DIVISION OF LEGAL AND RESEARCH SERVICES
LEGISLATIVE AFFAIRS AGENCY
STATE OF ALASKA

(907) 465-3867 or 465-2450
FAX (907) 465-2029
Mail Stop 3101

State Capitol
Juneau, Alaska 99801-1182
Deliveries to: 129 6th St., Rm. 329

MEMORANDUM February 24, 2016

SUBJECT: Constitutionality of SB 179
(SB 179; Work Order No. 29-LS1236\W)

TO: Senator Bert Stedman
Attn: David Scott

FROM: Kate S. Glover KG
Legislative Counsel

You requested an opinion on the constitutionality of SB 179, which bans abortions after an unborn child is, in the opinion of the physician, viable outside the mother's womb. The bill includes exceptions allowing abortions to be performed after the unborn child is viable if the pregnancy is the result of sexual assault or incest, or if the abortion is medically necessary. In my opinion, the narrow definition of "medically necessary" used in the bill is likely unconstitutional under a recent superior court decision finding this definition unconstitutional in the context of the state's obligation to fund medically necessary abortions through the medical assistance program.[1]

The privacy clause or the Constitution of the State of Alaska, art. I, sec. 22, protects a woman's fundamental right to choose whether to terminate her pregnancy and is generally more protective of this right than the United States Constitution.[2] Under *Roe v. Wade*, after the point of viability, "[i]f the State is interested in protecting fetal life . . ., 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*" (emphasis added).[3] The Alaska Supreme Court has stated that the "scope of the fundamental right to an abortion" under the Constitution of the State of Alaska "is similar to that expressed in *Roe v. Wade*."[4] Although the prohibition under SB 179 applies after viability, the exception for medically necessary abortions allows an abortion only if necessary to "avoid a threat of serious risk to the life

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[1] *See Planned Parenthood of the Great Northwest v. Streur*, No. 3AN-14-04711 CI (Aug. 27, 2015); *see also Planned Parenthood of Alaska v. Perdue*, No. 3AN-98-07004 CI (Mar. 16, 1999), *aff'd in part by State v. Planned Parenthood of Alaska*, 28 P.3d 904 (Alaska 2001).

[2] *See Valley Hospital Ass'n v. Mat-Su Coal. for Choice*, 948 P.2d 963 (Alaska 1997).

[3] *Roe v. Wade*, 410 U.S. 113, 163 – 65 (1973).

[4] *See Valley Hospital Ass'n*, 948 P.2d at 969, *see also DeJarlais v. State*, 300 P.3d 900, 904 (Alaska 2013).

or physical health of a woman from continuation of the woman's pregnancy."[5] The definition lists a series of physical conditions that constitute a "serious risk to the life or physical health" of the mother.[6] A superior court found this definition to be unconstitutional last fall in a similar context, because the definition excludes conditions that are harmful to a woman's psychological health.[7] Although the superior court decision analyzed the definition under the equal protection clause, the decision provides guidance for what is required under the privacy clause of the Constitution of the State of Alaska as well. The superior court ordered that, for purposes of the state medical assistance program, "medically necessary" should be defined as follows:

> The terms medically necessary abortions or therapeutic abortions are used interchangeably to refer to those abortions certified by a physician as necessary to prevent the death or disability of the woman, or to ameliorate a condition harmful to the woman's physical or psychological health, as determined by the treating physician performing the abortion services in his or her professional judgment.[8]

Because the definition used in SB 179 does not allow an abortion to be performed after viability in a case where a woman is likely to suffer severe psychological, but not physical, harm if she carries the pregnancy to term, it may be too narrow to meet the requirements of the state constitution.

If I may be of further assistance, please advise.

KSG:lem
16-173.lem

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[5] AS 47.07.068(b) (cross-referenced in SB 179 in proposed AS 18.16.010(k) and (n)).

[6] *Id.*

[7] The case is under appeal as *State v. Planned Parenthood of the Great Northwest*, No. S-16123. The superior court decision, Case No. 3AN-14-04711 CI, was issued Oct. 7, 2015, and the case status in the Alaska Supreme Court is listed as "Briefing Stage."

[8] *See Planned Parenthood v. Streur*, No. 3AN-14-04711 CI, Decision and Order at 53 (Aug. 27, 2015); *see also id.* at 36. You can find the decision on the Alaska Court System website, under "Cases of Current Interest": http://courts.alaska.gov/media/index.htm#cases. The court's definition of medical necessity comes from an earlier superior court decision considering restrictions on funding abortions through the state medical assistance program. The earlier decision found, under both the equal protection and privacy clauses, that the state must fund medically necessary abortions for medical assistance recipients if the state funds other pregnancy related services. *See Perdue*, No. 3AN-98-07004 CI. The Alaska Supreme Court affirmed the decision on equal protection grounds, but declined to rule on the privacy clause question. *See State v. Planned Parenthood*, 28 P.3d 904.

LAWS OF ALASKA

2014

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Chapter No.
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AN ACT

Relating to existing women's health programs; and defining "medically necessary abortion" for purposes of making payments under the state Medicaid program.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF ALASKA:

THE ACT FOLLOWS ON PAGE 1

AN ACT

Relating to existing women's health programs; and defining "medically necessary abortion" for purposes of making payments under the state Medicaid program.

*** Section 1.** The uncodified law of the State of Alaska is amended by adding a new section to read:

LEGISLATIVE INTENT; FUNDING OF WOMEN'S HEALTH PROGRAMS. It is the intention of the legislature to define the phrase "medically necessary" for purposes of Medicaid funding of abortion services and to continue to fund existing women's health programs in the state.

Sec. 2. AS 47.07 is amended by adding a new section to read:

Sec. 47.07.068. Payment for abortions. (a) The department may not pay for abortion services under this chapter unless the abortion services are for a medically necessary abortion or the pregnancy was the result of rape or incest. Payment may not

be made for an elective abortion.

(b) In this section,

(1) "abortion" has the meaning given in AS 18.16.090;

(2) "elective abortion" means an abortion that is not a medically necessary abortion;

(3) "medically necessary abortion" means that, in a physician's objective and reasonable professional judgment after considering medically relevant factors, an abortion must be performed to avoid a threat of serious risk to the life or physical health of a woman from continuation of the woman's pregnancy;

(4) "serious risk to the life or physical health" includes, but is not limited to, a serious risk to the pregnant woman of

(A) death; or

(B) impairment of a major bodily function because of

(i) diabetes with acute metabolic derangement or severe end organ damage;

(ii) renal disease that requires dialysis treatment;

(iii) severe pre-eclampsia;

(iv) eclampsia;

(v) convulsions;

(vi) status epilepticus;

(vii) sickle cell anemia;

(viii) severe congenital or acquired heart disease, class IV;

(ix) pulmonary hypertension;

(x) malignancy if pregnancy would prevent or limit treatment;

(xi) kidney infection;

(xii) congestive heart failure;

(xiii) epilepsy;

(xiv) seizures;

(xv) coma;

(xvi) severe infection exacerbated by pregnancy;

(xvii) rupture of amniotic membranes;

(xviii) advanced cervical dilation of more than six centimeters at less than 22 weeks gestation;

(xix) cervical or cesarean section scar ectopic implantation;

(xx) any pregnancy not implanted in the uterine cavity;

(xxi) amniotic fluid embolus; or

(xxii) another physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy that places the woman in danger of death or major bodily impairment if an abortion is not performed.

David Scott

From: Mills, Cori M (LAW) <cori.mills@alaska.gov>
Sent: Tuesday, March 22, 2016 10:09 AM
To: David Scott
Cc: Peterson, Darwin R (GOV)
Subject: RE:

David, I apologize. I thought I sent this to you but apparently it slipped through the cracks. SB 179 actually incorporates the statute that was challenged two years ago involving the definition of when an abortion is medically necessary. Because it incorporates that statute and that statute was found unconstitutional by the superior court, it is currently not enforceable. That decision was appealed, so we are still in litigation over that question.

I hope that helps.

Cori Mills

From: David Scott [mailto:David.Scott@akleg.gov]
Sent: Tuesday, March 22, 2016 10:04 AM
To: Mills, Cori M (LAW)
Subject:

Hi Cori:

Just checking in on the status of the legal opinion we requested re: SB 179.

Thanks,

Dave

David Scott
Office of Senator Stedman
465-3712

Alaska Dispatch News

Published on *Alaska Dispatch News* (http://www.adn.com)

Becky Bohrer | Associated Press
August 27, 2015

JUNEAU, Alaska -- A state court judge in Alaska ruled Thursday that a law further defining what constitutes a medically necessary abortion for purposes of Medicaid funding is unconstitutional.

Superior Court Judge John Suddock ordered that the state be blocked from implementing the law, passed last year, and a similar regulation, finding both violated the equal protection clause of the Alaska Constitution.

"This ruling, if upheld, means as a practical matter that virtually all indigent Alaskan women seeking abortions will receive state Medicaid funding," he wrote.

The Alaska Supreme Court has held that the state must pay for medically necessary abortions if it pays for other procedures deemed medically necessary. The regulation and law sought to further define what constitutes a "medically necessary" abortion.

Supporters of the measures have said the state should not be required to pay for elective abortions.

In his decision, Suddock said an unwanted pregnancy is a crisis for any woman and for an impoverished woman without recourse to an abortion, the crisis "may be extreme," noting that indigent women often face stressors such as homelessness, addiction or domestic violence. He wrote that the added stressor of an unwanted pregnancy with no recourse to an abortion "can create clinically significant mental distress such that a Medicaid abortion is medically necessary."

The lawsuit was brought by Planned Parenthood of the Great Northwest, which hailed the decision.

"Every Alaskan woman, regardless of income, should be able to make the pregnancy decision that's best for herself and her family," Chris Charbonneau, CEO of Planned Parenthood of the Great Northwest and the Hawaiian Islands, said in a release. Charbonneau applauded Suddock for "striking down these cruel restrictions on women's health and rights that violate the Alaska constitution."

The state was reviewing the decision and would evaluate its options, Department of Law spokeswoman Cori Mills said by email.

The law defined medically necessary abortions as those needed to avoid a threat of serious risk to a woman's life or physical health from continuation of a pregnancy. That could mean a serious risk of death or "impairment of a major bodily function" caused by one of 21 different conditions, such as coma, seizures and epilepsy.

It also included a more general category: "another physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy

that places the woman in danger of death or major bodily impairment if an abortion is not performed."

The regulation is similar but also included consideration of psychiatric disorders.

Suddock said the law seeks to limit Medicaid funding to high-risk, high-hazard situations while failing to address serious but "less-than-catastrophic" health detriments. It also would deny funding in cases involving fetal anomalies, even situations "where a delivered infant will suffer an inevitable and at times painful death," or women dealing with mental illness or addiction, he wrote.

Medicaid funds a wide range of services but abortions for poor women would be subject to another level of scrutiny, he said.

Medicaid will pay $9,000 in routine prenatal care and $12,000 in routine delivery expenses for a pregnancy where a low-income woman decides to carry to term "in the face of significant risks," he wrote.

But under the law that was challenged in this case, "it cannot pay $650 for the same poor woman who is unwilling to bear those risks and who exercises her constitutional right to terminate her pregnancy. The court is aware of no other context where Medicaid engages in such a relentlessly one-sided calculus," he wrote.

APNewsBreak: Alaska appeals abortion funding decision

By Becky Bohrer, Associated Press | Posted Nov 6th, 2015 @ 7:30pm

JUNEAU, Alaska (AP) — The state of Alaska is appealing a judge's decision that found a state law and regulation further defining what constitutes a medically necessary abortion for purposes of Medicaid funding to be unconstitutional.

Jonathan Woodman, a senior assistant attorney general, said by email that the appeal will argue that the state can establish standards to distinguish between elective and medically necessary abortions so that Medicaid pays only for those medically necessary.

Planned Parenthood of the Great Northwest sued the state over the law and regulation, and Superior Court Judge John Suddock ruled in the group's favor in August. The state filed a notice of appeal with the Alaska Supreme Court on Friday.

Senior Assistant Attorney General Stuart Goering said it is routine to do this in situations where state laws are challenged.

The Alaska Supreme Court has previously held that the state must pay for medically necessary abortions if it pays for other procedures deemed medically necessary.

The regulation and law sought to further define what constitutes a medically necessary abortion.

In his ruling, Suddock said the law seeks to limit Medicaid funding to high-risk, high-hazard situations while failing to address serious but "less-than-catastrophic" health detriments. He also wrote that it would deny funding in cases involving fetal anomalies or women dealing with mental illness or addiction.

Jessica Cler, Alaska spokeswoman for Planned Parenthood Votes Northwest, said the group was disappointed that the state was "defending a law that has such harsh impacts on women.

"Every woman in Alaska deserves the right to make the pregnancy decision that is best for her and her family," she said in a statement. "For far too long, politicians in Alaska have tried to sidestep women's constitutional rights. By appealing this decision, the state is compromising the health of low-income women."

Lehner Announces "Ohio Viable Infants Protection Act" Approved By Senate

April 06, 2011

[Peggy Lehner Home | Peggy Lehner Press]

Columbus - State Senator Peggy Lehner (R- Kettering) announced today that the Ohio Senate voted to approve Senate Bill 72, legislation that would prohibit abortions once the viability of the child has been confirmed. "Abortions can currently be performed in Ohio up to the moment of birth, but many doctors agree that a child can live outside the womb after just 22-24 weeks," Lehner said. "This bill will prevent late-term abortions - which are done when the child has a good chance of surviving and is old enough to feel pain - and help better protect our youngest and most vulnerable citizens." Under Senate Bill 72, if a pregnant woman seeking an abortion is at 20 weeks gestation or older, the doctor must test the child to see if he or she is viable. If the determination is made that the child is viable, an abortion cannot be performed except in the case of a medical emergency, in which case the abortion must be performed where there is a neonatal care facility and done using the method that is most likely to permit the child to survive. In addition, another doctor must be present to care for the child. The bill also requires doctors to report on circumstances that still allow an abortion to take place, and holds physicians accountable for failing to determine viability prior to performing later-term abortions. Lehner noted that 39 other states have enacted a form of legislation limiting postviability abortions. Senate Bill 72 now moves to the Ohio House for further consideration.

Featured Posts

Lehner Explores Innovative Solutions During Visit To Southwest Ohio Charter School

COLUMBUS - "Taking the time to experience firsthand the innovative models that schools across the state are using to produce successful outcomes is crucial to meaningful education policymaking," said Lehner. "It was fascinating to speak with students to better understand what is working, and not working, so that our children are receiving the highest quality education possible."

[Read Full Story]

Lehner Highlights Growing Economic Success Throughout Dayton Region

COLUMBUS - "Collaboration between our regional economic assets has been key to rejuvenating our workforce and bringing jobs back to the area throughout the past several years," said Lehner.

[Read Full Story]

Lehner Praises National Education Initiative To Restore Local Control Of Schools

COLUMBUS - The overwhelming bipartisan support for the rewritten national education legislation now known as the Every Student Succeeds Act is the most significant education reform bill in the past 14 years. While not retreating from higher standards and accountability for our nations schools, it returns considerable control to the state and local districts, rather than investing control in the federal government. The legislation is a welcome change and I look forward