This is because a recently developed technique, amniocentesis, allows genetic screening of the unborn fetus for various hereditary diseases. Through this screening, a woman can learn whether the child she is carrying is free of such dreaded conditions as Downs syndrome (mongolism) or Tay-Sachs disease, a genetic disorder that is always fatal, early in childhood.

The test involves drawing off a sample of amniotic fluid, in which the fetus is immensed in the womb. This cannot be done until the 15th or 16th week. Test cultures for the various potential problems take several weeks to grow. Sometimes the result is inconclusive and the test must be repeated. The testing also reveals the unborn child's sex and can be used to detect minor genetic imperfections.

To many women, particularly those over 35, amniocentiesis seems a rational approach to minimizing the chances of bearing a defective child. A few, according to published reports, go a step further and make sure the baby is the sex they want before deciding to bear the child.

In any case, it is late in the second trimester—within weeks of the current threshold of viability—before the information becomes available on which a decision is made to abort or not abort. The squeeze will intensify as amniocentesis becomes more widely available and as smaller and smaller infants are able to survive.

The abortion live-birth dilemma has caught the attention of several experts on medical ethics, and they have proposed two possible solutions.

The simplest, advocated by Dr. Sissela Bok of the Harvard Medical School among others, is just to prohibit late abortions. Taking into account the possible errors in estimating gestational age, she argues, the cutoff should be set well before the earliest gestational age at which infants are surviving.

Using exactly this reasoning, several European counties—France and Sweden, for example—have made abortions readily available in the first three months of pregnancy but very difficult to get thereafter. The British, at the urging of Sir John Peel, an infuential physician-statesman, have considered in each of the last three years moving the cutoff date from 28 weeks to 20 weeks, but so far have not done so.

But in this country, the Supreme Court has applied a different logic in defining the abortion right, and the groups that won that right would not cheerfully accept a retreat now.

A second approach, advocated by Mrs. Bok and others, is to define the woman's abortion right as being only a right to terminate the pregnancy, not to have the fetus dead. Then if the fetus is born live, it is viewed as a person in its own right, entitled to care appropriate to its condition.

This "progressive" principle is encoded in the policies of many hospitals and the laws of some states, including New York and California. As the record shows, though, in the alarming event of an actual live birth, doctors on the scene may either observe the principle or ignore it.

And the concept even strikes some who do abortions as misguided idealism. "You have to have a feticidal dose" of saline solution, said Dr. Kerenyi of Mt. Sinai in New York. "It's almost a breach of contract not to. Otherwise, what are you going to do—hand her back a baby having done it questionable damage? I say, if you can't do it, don't do it."

The scenario Kerenyi describes did in fact happen, in March 1978 in Cleveland. A young woman entered Mt. Sinai Hospital there for an abortion. The baby was born live and, after several weeks of intensive care at Rainbow Babies and Childrens Hospital, the child went home—with its mother.

The circumstances were so extraordinary that medical personnel broke the code of confidentiality and discussed the case with friends. Spokeswomen for the two hospitals confirmed the sequence of events. Mother and child returned to Rainbow for checkup when the child was 14 months old, the spokeswoman there said, and both were doing fine.

The mother could not be reached for comment. But a source familiar with the case remembered one detail: "The doctors had a very hard time making her realize she had a child. She kept saying, 'But I had an abortion.'"

How Things Sometimes Go Wrong

Of the various ways to perform an abortion after the midpoint of pregnancy, there is only one that never, ever results in live births.

It is D&E (dilatation and evacuation), and not only is it foolproof, but many researchers consider it safer, cheaper and less unpleasant for the patient. However, it is particularly stressful to medical personnel. That is because D&E requires literally cutting the fetus from the womb and, then, reassembling the parts, or at least keeping them all in view, to assure that the abortion is complete.

Ten years ago it was considered reckless to do an abortion with cutting instruments after the first trimester of pregnancy. Now, improved instruments, more skilled practitioners and laminaria—bands of seaweed that expand when moist and are used to gently dilate the cervix, creating an opening through which to extract fetal parts—allow the technique to be used much later.

D&E is being hailed as extending the safe and easy techniques used for first-trimester abortions (cutting or vacuuming out the contents of the womb) well into the second three months of pregnancy. But there are dissenters. Dr. Bernard Nathanson, formerly a top New York City abortionist, now an anti-abortion author and lecturer, says that D&E "is a very dangerous technique in the hands of anyone less than highly skilled."

Besides, D&E puts all the emotional burden on the physicians. And there are other techniques that allow the doctor, as one physician put it, to "stick a needle in the [patient's] tummy," then leave the patient to deliver the fetus vaginally as in normal childbirth and nurses to assist and clean up.

These more common methods for abortion after the midpoint of pregnancy use the instillation of either saline solution or prostaglandin. In these procedures, some of the woman's nurturing amniotic fluid is drawn out of the womb by an injection through her belly and is replaced with the abortion-inducing drug. (The amount of fluid in the womb is kept relatively constant to make sure the womb does not rupture.)

The two instillation substances work in different ways. Saline solution poisons the fetus, probably though ingestion, though the process is not completely understood. Usually within six hours, the fetal heartbeat stops. At the same time, the saline induces labor, though supplemental doses of other labor-inducing drugs often are given to speed this effect.

Prostaglandin, on the other hand, is a distillate of the chemical substance that causes muscles to move. It is thought not to affect the fetus directly but instead is potent at inducing labor. Fetal death, if it does occur, is from prematurity and the trauma of passage through the birth canal.

Each substance also has an undesired side effect. Saline, an anti-coagulant that increases bleeding, can make minor bleeding problems more serious and in rare cases even cause death. Prostaglandin, because it causes muscles to contract indiscriminately, was found to cause vomiting and diarrhea in more than half the patients in early tests. Claims that it causes fewer major complications, which made it preferred to saline by many in the mid-1970s, have now been questioned. And the high incidence of live births (40 times more frequent than with saline, according to one study) also has lessened its popularity.

But saline is not foolproof either in preventing live births. Dr. Thomas F. Kerenyi of Mt. Sinai Hospital in New York, the best-known researcher on saline abortions, said most live births result from "errors in techniques"—either administering too small a dosage or getting some of it into the wrong part of the womb.

A wrong estimation of gestational age can cause either a saline or prostaglandin abortion to fail. A larger-than-expected fetus might survive the trauma of labor or might reject a dose of saline (or urea, a third instillation substance sometimes used).

And on the basis of physical examination alone, studies show, doctors miss the correct gestational age by two weeks in one case out of five, by four weeks in one case out of 100, and sometimes by more than that. Pregnancies can be dated more exactly by a sonogram, a test that produces an outline image of the fetus in the womb, but because of its cost (about $100) many doctors continue to rely on physical exams.

There is one other abortion technique, hysterotomy, but it is the least desirable of all from several points of view. Because it is invasive surgery (identical to a Caesarean section), it has a much higher rate of complication than do the installation techniques. Usually done only after attempts to abort with saline have failed, it has the highest incidence of all of live births.

As the infant is lifted from the womb, said one obstetrician, "he is only sleeping, like his mother. She is under anesthesia, and so is he. You want to know how they kill him? They put a towel over his face so he can't breathe. And by the time they get him to the lab, he is dead."

Over the years, the chief criterion in choosing between abortion methods has been safety for the patient. Advocates of D&E contend that bleeding, perforation of the uterus and infection all occur less frequently with D&E than with other methods. Dr. Willard Cates of the Center for Disease Control in Atlanta prefers D&E. Because it can be done—unlike instillation—in the early part of the second trimester, he has said, the need for as many as 80 percent of the very late abortions could be eliminated.

How very late are abortions performed?

His own clinic at Mt. Sinai, Dr. Kerenyi said, screens patients closely to make sure they are not past the legal 24-week limit. But in theory, he said, there is nothing to prevent successful saline abortions from being performed "virtually all the way to birth. At 30 weeks, say, you would just have to draw off and inject that much more of the solution."

Most practitioners who were interviewed say they stop doing D&E at 18 to 22 weeks. But again, there appears to be nothing to prevent the technique from being used much later.

"You can do it, you can do it," an abortionist, who would talk only if not quoted by name, said of D&Es late in pregnancy. "Some son-of-a-bitch misreads a sonogram and sends me a woman 26 weeks. I've done it. You've just got to take your time and be careful. And you're not going to end up with a live birth."

"I Stood By And Watched That Baby Die"

Nurses are the ones who bear the burden of handling the human-looking products of late abortions. And when an unintentional live birth occurs, they are the first to confront the waving of limbs and the gasping.

Reluctant to talk about their experiences, most of those interviewed for this article did not want their names to be published, and out of professional loyalty, they did not even want their hospitals to be named.

They spoke of being deeply troubled by what they have seen of late abortions in American hospitals.

Linda is a nurse in her late 50s in Southern California. Hurrying out of a patient's room one day to dispose of the aborted "tissue," as nurses were taught to think of it, she felt movement. Startled, she looked down, straight into the staring eyes of a live baby.

"It looked right at me," she recalled. "This baby had real big eyes. It looked at you like it was saying. 'Do something—do something.' Those haunting eyes. Oh God, I still remember them."

She rushed the 1½-pound infant to the nursing station. She took the heart rate—80 to 100 beats a minute. She timed the respirations—three to four breaths a minute. She called the doctor.

"I called him because the baby was breathing," Linda said. "It was pink. It had a heartbeat. The doctor told me the baby was not viable and to send it to the lab. I said, 'But it's breathing' and he said, 'It's non-viable, it won't be breathing long—send it to the lab.' "

She did not follow the order. Nor did she have resources at her command to provide any life-saving care. Two hours later the infant died, still at the nursing station, still without medical treatment. It died in a makeshift crib with one hot-water bottle for warmth and an open tube of oxygen blowing near its head.

The nursing supervisor, Linda said, had refused to let her put the baby in the nursery, where there was equipment to assist premature babies in distress. "She said to follow the doctor's orders and take it to the lab. I kept it with me at the station. We couldn't do an awful lot for it."

This happened eight years ago, in 1973, but Linda is still upset. "I stood by and watched that baby die without doing a thing," she said. "I have guilt feelings to this day. I feel the baby might have lived had it been properly cared for."

Jane, about 50, is the head floor nurse in an Ohio hospital. She and her fellow nurses successfully petitioned their hospital in 1978 to stop doing late abortions. Twice before that, she witnessed live births after abortions.

She recalls vividly the 16-year-old patient who phoned her mother after her abortion and and said in an agonized voice, "Ma, it's out—but Ma, it's alive."

That happened in 1975. Jane still speaks of it bitterly, her eyes flashing anger.

A year earlier Jane saw the second abortion live birth in her experience. "I was called by the patient's roommate," she recalled. "When I got there the baby's head was sticking out and its little tongue was wiggling. Everybody felt they couldn't do anything until they called the doctor. It was a little thing—it only lasted about 15 minutes. But it was alive, and we did nothing. And that was wrong."

It rankles, too, that she was routinely forced to handle dead fetuses, the size and shape of well-formed premature babies.

"Because of my position," she said, "I had to pick them up off the bed and put them in a bottle of formalin [a preservative fluid]. Sometimes you had to have a very large container. Our gynecologists seemed to have a very poor ability to estimate gestational age. Time and again they would say with a straight face, 'This woman is 20 weeks pregnant' when she was actually 26 weeks."