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Legislative Materials - Draft Legislative Language [2]

THE WHITE HOUSE
WASHINGTON

JOHN HARTE
106 OEOB

Angus King
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Bill Marshall
OEOB 486

Department of Obstetrics & Gynecology

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BM
Am 486

March 18, 1996

Representative Charles Canady
United States House of Representatives
Washington, D.C.

Dear Mr. Canady:

I am Dr. Paul Blumenthal, a Board-Certified Obstetrician-Gynecologist practicing at Johns Hopkins Bayview Medical Center. I am an Associate Professor of Gynecology and Obstetrics at The Johns Hopkins University and am the Medical Director of Planned Parenthood of Maryland. I am also a specialist in epidemiology and reproductive health care and am a Fellow of the American College of Obstetricians and Gynecologists. In addition, I am an advisor to the World Health Organization, and the United States Agency for International Development, on issues relating to safe motherhood, contraception and reproductive health care. As a result, I have traveled extensively for the Johns Hopkins Program in International Education in Reproductive Health, particularly in Africa and Southeast Asia, setting up programs to improve maternal health and access to safe and voluntary family planning services.

I ask you to oppose HR1833, a bill designed to undermine a woman's right to proper reproductive health care, including abortion, and to interfere with a physician's ability to make proper medical decisions based on his or her judgment.

In my capacity as an international advisor, I go to countries where access to abortion services is poor, where abortion is still illegal and where maternity wards continue to be filled with women suffering the effects of unsafe abortion. Many of them die. In fact, in many countries, the situation is similar to the way things were in the United States before safe and accessible abortion services were available; unsafe abortion is still the most common cause of maternal death. We believe that, in this country we

have gotten beyond that point. We have recognized that women need and deserve access to safe abortion. It is thus our job to make *those* procedures safe, as well as to protect womens' lives during childbirth.

It is quite clear that this bill would reduce access to safe abortion and would define the doctors who perform them as criminals. There is actually no formally recognized medical procedure to which the term referred to in this bill applies; it is therefore vague and medically incorrect. None of my colleagues know or could actually state whether the procedures they now perform could be covered under this bill. One can only assume that by intimidating providers with the constant threat of criminal accusations, the intent is to frighten the medical community, the same community which swears an ancient oath to use its knowledge and skills to serve and protect the lives of its patients, from performing pregnancy terminations at all.

Proponents of the bill seem to be claiming that this will ban a particular procedure. However, as I noted, this procedure is not defined in such a way as to know exactly what it is that is being banned. However, even if it were clear, it would be unprecedented for a legislature to ban a *particular* procedure; essentially, to practice medicine from the house chamber without ever seeing a patient, understanding their needs and without knowing what physicians face on a day-to-day basis.

The practice of high quality medicine requires that, in order to accomplish a given treatment or therapy, physicians need to be knowledgeable about and be able to perform a variety of procedures. Planning such a procedure is done in consultation with the patient, based on the experience and training of the provider and the individual circumstances of the patient's condition. Sometimes, one plans to perform a certain surgical procedure, but, as a result of developments during the surgery and/or patient's condition, one must adapt and choose a different course or modify the procedure as originally planned. These decisions are often quite complex and mandate that physicians use their best professional and clinical judgment, most often, right on the spot. These are decisions which should be made by physicians and their patients alone. Indeed, when performing surgery there is no time for a call to the legislature, the supreme court, or anyone else in order to ascertain a statutory position, or to request a waiver. Physician and surgeons should be allowed to practice their art in accordance with time-honored peer review standards and with only the interests of the patient at heart.

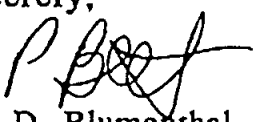
This bill evokes an image of we physicians requiring that our attorneys be present in the operating room, to advise and counsel us at

each step. If a procedure even appears to goes in a certain direction, we could be criminally charged. On the other hand, if we fail to use our best *medical* judgment, because of this law, they are exposed to charges of malpractice, negligence and would have violated both our own personal and professional standards, as well as the oath we have sworn for hundreds of years.

To be sure, discussing abortion procedures, or any other type of surgery, is often not pleasant. On the other hand, neither is it easy to discuss lethal fetal conditions like skeletal dysplasia. This is a group of genetic syndromes which result in the birth of infants who are destined to die within the first few minutes to hours of life, and whose only experience of life is that of suffocation as they gasp in an attempt to breathe.

Advances in prenatal detection may now allow a couple to know that this will be the fate of their wanted pregnancy. If a couple struggles with this information and then decide to terminate that pregnancy, it is my duty to help them, using the safest, most effective procedure I know. For these reasons and in order that physicians will always be able to put their patients' needs first, I urge you to reject HR1833.

Sincerely,



Paul D. Blumenthal, MD, MPH
Associate Professor of Gynecology and Obstetrics
Johns Hopkins University

Note: The opinions expressed here are those of Dr. Blumenthal and not necessarily those of the Johns Hopkins University, The Johns Hopkins Health System or the Johns Hopkins Bayview Medical Center.

WILLIAM K. RASHBAUM, M.D., P.C.
208 EAST 72ND STREET
NEW YORK, N. Y. 10021
TELEPHONE: (212) 988-9300

The Honorable Charles Canady
United States House of Representatives
Washington, DC 20515-0912

March 19, 1996

Dear Representative Canady:

I write to you today to strongly urge your committee to reconsider HR #1833. I am a professor of Obstetrics and Gynecology at The Albert Einstein College of Medicine and The Cornell School of Medicine. I started performing and teaching Dilation and Evacuation techniques in 1978.

My colleagues and I have completed over 19,000 procedures since we began. We have done the D&X, method that is under consideration in HR 1833 routinely since 1979. This procedure is only performed in cases of later gestational age.

To ban the D&X would only be making a very safe procedure more dangerous. Dilation and Evacuation requires surgical instruments that could result in rare but severe damage to the mother. The D&X procedure does not require the use of these instruments.

Outlawing the D&X *will* result in higher maternal health risks and mortality. The result to the fetus is the same - unfortunate but merciful termination regardless of method.

Please reconsider HR # 1833 and leave medical decisions to physicians who are equipped with the necessary knowledge and experience to make them.

Respectfully yours,

William K. Rashbaum, MD

The Charlottesville Center
for reproductive ♀ sexual health

Herbert C. Jones, Jr., M.D., FACOG
105 South Pantops Dr.
Charlottesville, Virginia 22901
(804) 977-0200

Wednesday 20, 1996

Honorable Charles Canady
U.S. House of Representatives
The Capital
Washington D.C.
20510

Dear Sir,

As a physician who has delivered over four thousand infants during my career I feel I can comment very strongly on a subject which legislators with no obstetrical training or experience are trying to legislate.

In 1956, I was trained and delivered an infant using basically the technique which is being legislated against. This approach has been utilized for years and was advocated for the aftercoming head when undeliverable. The decompression of the cranium by needle or trocar certainly is better than a caesarean section or a hysterotomy.

To outlaw such a procedure or to make the physician under extreme stress having to worry about legality is beyond reason.

There have been two or three cases over the years that without knowledge of the ability to perform such a procedure would have left my patient in jeopardy. As a physician in the delivery room a change in type of delivery may have to be instantaneous. It is awfully lonely on the firing line, and yes, there are occasions when time for a consult is unavailable even with a termination of pregnancy.

As to the effect of anesthesia to a mother affecting a baby, only Jim McMahon knows what he intended to say and with his unfortunate demise, the women of America lost a qualified, capable, considerate and courageous physician.

Sincerly,

Dr. Herbert C. Jones M.D.

McMahon

Read

Eve Surgical Centers
Medical Corporation

TESTIMONY BEFORE THE HOUSE SUBCOMMITTEE ON THE CONSTITUTION;
Representative Charles T. Canady, Chairman
WASHINGTON, D. C.
JUNE 23, 1995

METHODS OF ABORTION IN ADVANCED GESTATIONS:
PRINCIPLES AND RISK MANAGEMENT

INTRODUCTION

It probably is not surprising to the committee members that when I was first called to testify regarding the intact D and E, I was in the middle of a very busy clinical schedule. In spite of this, I considered it an honor and a duty to accept the invitation.

Ms. Keri Harrison, counsel to the subcommittee, said the oral testimony must be limited to 5 minutes. I informed her that 5 minutes was very little time for such a complicated subject as surgery. Nevertheless, I worked on my testimony for about 15 hours the following weekend and several more hours the evening of June 12th (Monday) after Ms. Harrison replied when questioned by me that the 5 minute limit was firm. The next day I left a message with Ms. Harrison that despite my efforts, I was unable to cover even the rudiments in only 5 minutes and would not want to mislead the committee with a statement that would obscure more than clarify. I remarked finally that since written testimony had no such limitations, I would be forwarding that to Washington.

Ms. Harrison called me at 5:10 the next morning (June 13th) at my home. She expressed dismay that I would be unable to come to Washington-- that the committee was expecting me. I reiterated that despite working on it for more than 20 hours, I could not write a coherent statement regarding the Intact D and E that could be presented in 5 minutes. Something so short might hinder rather help the committee get at the truth. Further, I reminded her that I still had not received a written invitation to testify nor a copy of the proposed legislation. Regarding the invitation, she responded that she wasn't "sure she could find a signed one." She did say that she would try to get me more time for my testimony and would contact me later in the day. Although I did not leave the surgical center until 11:00 P.M. Washington time, I received no word . On June 14 (Wednesday) at 3:10 P.M. I was told that the chairman was granting me 10 minutes. By that time, however, I had conflicting clinical responsibilities. I had forwarded printed

material days before. I left a message the evening of June 14th of the conflicts and hoped that the information already sent would be of some help.

When I was told that the chairman said on more than one occasion that I was unwilling to come and defend the surgery, I was dismayed at this misrepresentation of what really happened. I presume that the chairman was not told nor corrected by counsel at the hearing.

PERSONAL AND PROFESSIONAL BACKGROUND

I am a married physician with a loving wife of more than 20 years and two blessed teenage children. I am the founder and medical director of the Eve Surgical Centers in Los Angeles. It is an organization that provides abortions to patients that are almost entirely physician referred.

PATIENT REFERRAL SOURCES

Institutions that use these services include the medical schools in both northern and southern California, and medical teaching institutions from across the country and the world. Most of the physicians who refer are either Ob/Gyns, perinatologists, genetic specialists, and many physicians who perform abortions themselves. Obviously, the simpler abortions are performed by the patient's private physician, as is appropriate. The preponderance of our referrals are situations of a particularly difficult nature. We are often referred to as providing the abortion of last resort.

The heads of Ob/Gyn departments and Divisions of Perinatology at the teaching institutions refer regularly to our services. I assure you that physicians in California do not refer casually.

In addition, I direct the abortion training for the Obstetrics and Gynecology residents at Cedars-Sinai Medical Center, one of this nation's finest teaching facilities.

TYPICAL PATIENT

Our typical patient is a married housewife and mother who is 30 years old and educated beyond high school. She is accompanied by her husband and neither has a family history of genetic disease. On the average, she has previously been seen by two other physicians and was referred by one or both of them. The pregnancy is 22 weeks

along and desired. Usually it is flawed by an abnormal number of chromosomes or damage illustrated via ultrasonography. Both she and her husband have an enormous emotional investment in the pregnancy. Often, these are couples with relative infertility who have gone through in vitro fertilization or other infertility techniques. They are Christians.

The above description was generated averaging our experiences. The ages, for example, range from 11 to 50. They come from all walks of life, from the illiterate to the professional, from the secular humanist to the Christian rightist. They defy demographic classification.

LEGISLATIVE INTENT

It is evident from this legislation that it is the first volley in an attempt to remove personal choice in pregnancy from families and give it to politicians. It is ironic that the Republican party, having won control of Congress for the first time since 1952 under the banner that they were going to "get government off the people's backs" is now proposing to micro-manage the most intimate details of family life, to dictate from Washington what, specifically, should be done when a pregnancy goes wrong -- specifically, right down to the choice of surgery!

This degree of government intrusion into the personal lives of citizens is truly frightening. A case of the late discovery of a severely flawed fetus in a very much wanted pregnancy is a complicated problem that combines elements of surgery, psychiatry and genetics. These difficult decisions can only be made by a woman in the privacy of her physician's consultation room. To propose that politicians usurp her authority defies common sense.

It is difficult for me to understand how a legislator, without any facts or any understanding of the situation ,could judge these people, handcuff their physicians and compromise their safety.

CLINICAL STRATEGY OF ABORTION

There are several safe options available to the physician and patient when interruption of a pregnancy is indicated: vacuum aspiration, inducing labor, classical D and E, intact D and E, and, very rarely, hysterotomy (c-section). In every abortion, the pregnancy is evacuated by force - either pushing or pulling. The medical terms are

"induction" and "extraction", but the basic and characterizing difference is the type of force employed.

An exhaustive discussion of these various approaches is beyond the scope of this submission and not pertinent to the proposed legislation. Intact D and E will be discussed in some detail.

INTACT D AND E
(IDE)

In more than 20 years of clinical experience, I have found the intact D and E provides unique advantages and protects the woman from complications better than other methods in certain clinical scenarios. In 1983, I developed the surgical technique that makes possible the intact extraction of the fetus in advanced pregnancies. As you will see from the following testimony, it is certainly one of the safest approaches to the most difficult of abortions. Although IDE was first performed in 1983, it wasn't until 1989 that it was presented in Canada at an international risk management seminar. Experience suggests that it is safe and has special advantages over the classical methods.

D and E probably originates in the medical literature with Van De Venter in the 17th century where he describes it as a lifesaving procedure.

CERVICAL DILATION

To determine the diameter to which the cervical canal should be stretched, an ultrasound is used to measure the fetus. The largest diameter that cannot be reduced in size becomes the target to which the cervical canal must be dilated.

The next clinical problem is pace, that is, how quickly to dilate. Every cervix is different in terms of intrinsic elasticity. The surgeon must acquiesce to cervical authority and proceed at the pace it dictates. To do otherwise, is to risk exceeding the elastic limit, perhaps tearing the cervix, or threatening its competence. The goal is to preserve the cervix so that it can sustain future pregnancies

FETAL EXTRACTION

Once dilation is sufficient, the ultrasound is repeated. Dimensions are double checked. Fetal and placental position are determined.

The most typical lie and presentation are longitudinal with the head first. With the exception of anencephaly where the brain is missing, the cervical diameter is always

smaller than the head. Therefore, it must be reduced in size to accommodate intact passage. Using a needle similar to that used in a spinal tap, fluid is removed in sufficient quantity to allow a forceps to apply routine traction and rotation maneuvers bringing the head through the cervix and out.

MISCONCEPTIONS

The fetus feels no pain through the entire series of procedures. This is because the mother is given narcotic analgesia at a dose based upon her weight. The narcotic is passed, via the placenta, directly into the fetal bloodstream. Due to the enormous weight difference, a medical coma is induced in the fetus. There is a neurological fetal demise. There is never a live birth.

BENEFITS OF IDE

In the rare circumstance of a late pregnancy's needing to be aborted, the safest surgical alternative should be used. In my clinical opinion and experience, this has been shown to be IDE. (See appendix, figure 11).

The risk of abortion is based on geometry. Something large must pass through something small. Specifically, the fetus must be brought out through a small, very vascular canal. Also, in late pregnancy, the tissue integrity of the fetus is quite substantial compared to that of the cervix. This poses an increasing threat to the cervix as the gestation gets larger. In addition, as time passes, the cervix becomes softer and its blood supply increases rapidly. This makes for a daunting situation which repays the heavy handed surgeon with brisk bleeding. The seat of risk, therefore, are these two disparities - size and tissue constitution. Before any attempt is made to remove the pregnancy, the endocervical canal must be enlarged. The critical difference in this method is the specific goal of eliminating the size difference between the fetus and the canal by simply making the cervix larger and the fetus smaller. The main benefit is the extraction requires a minimum of force which translates into less trauma to the lower uterine segment. This approach, although tedious, is remarkably atraumatic. The average blood loss is 63 ccs, less than half of a cupful. (See appendix, figure 9.) If the IDE is removed from the therapeutic armamentarium of the surgeon, unnecessary complications will occur.

Furthermore, there are emotional benefits to the family. The fetus can be dressed, photographs taken, and taken to the family so that they can hold it and spend time together. Also, since there is no disruption, a careful autopsy can be performed and a

more precise diagnosis made. This is critical for the genetic counseling that is a very important part of these services. In vast majority of these families they are keenly interested in having more children. More specific prenatal care can be instituted and a more precise prenatal evaluation can be done with the next pregnancy.

SAFETY

In our series, since IDE was begun in 1983, there have been no deaths, no uterine perforations, and no hysterectomies. For the same period, there have been no major complications in any case of a gestation of less than 24 weeks.

In the 3rd trimester, the most rare and difficult of cases, there have occurred a total of only 5 major complications. (See appendix - figures 11 and 26.) This is a 1% complication rate. Nothing lower than this is reported in the scientific literature.

CHOICES

In the desired pregnancy, when the baby is damaged or the mother is at risk, the decision to abort may be intellectually obvious, but emotionally it is always a personal anguish of enormous proportions. It is not referred to nor is it thought of as a fetus. This is this mother's baby. Even though I have counseled parents for more 20 years, I only know that I cannot know. I cannot possibly know what this kind of choice is like.

For the physician who is willing to help the patient in this dilemma, choices are few. Intact D and E can often be the best among a short list of difficult options.

CONCLUSION

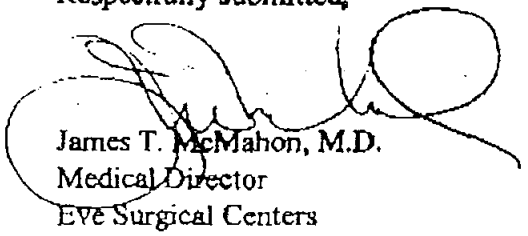
A woman late in pregnancy, i.e., beyond 18 weeks., who is considering the option of interrupting her pregnancy must analyze the options and the risks. The physician's primary duty is to educate her. The explanation must be complete, unbiased, and scientifically based. The atmosphere should be unhurried, non-judgmental, and respectful of her personal sovereignty.

Dealing with the tragic situations that I confront daily makes me constantly aware that I can only limit the hurt by doing gentle surgery and giving sympathetic counsel. Medical science cannot offer what is presently out of its reach and save this family's child. The best it can do is spare these families the worse alternative of continuing the pregnancy, which would only increase the risk and perpetuate the misery.

CONGRESSIONAL TESTIMONY
H.R.: 1833
JUNE 23, 1995

My colleagues and I are driven by our concern for the health and well-being of our patients. To be able to do our best for them, we must be unfettered and be allowed the professional freedom to offer the safest alternatives. This attempt by congress to micro-manage one of the most difficult and private problems that can befall any of us is folly of the highest order.

Respectfully submitted,



James T. McMahon, M.D.
Medical Director
Eye Surgical Centers

Major Complications

Case #	Date	LOG	Age	G	P	A	C-Section	Dx	Time & Type of Complication
1	12/28/91	28	33	4	1	3	Yes	Omphalocoele	Time: Delayed Type: Infection
2	2/6/92	32	37	4	2	2	Yes	Hydrocephaly	Time: Dilatation Type: Hemorrhage
3	3/9/93	28	30	6	2	4	Yes	Fetal Anasarca Polyhydramnios	Time: Dilatation Type: Hemorrhage
4	4/14/93	40	39	3	1	2	Yes	Fetal Demise DIC	Time: Extraction Type: Hemorrhage
5	12/9/94	24	43	9	5	4	Yes	Potter's Syndrome DIC	Time: Extraction Type: Hemorrhage

Case #	Acute Blood Loss	Transfusion No. of Units	Days of Hospitalization	Final Disposition
1	75 cc	0	14	Recovered
2	1500 cc	4	5	Recovered
3	500-600 cc	0	1	Recovered
4	>1500 cc	>100	12	Recovered
5	650cc	4	3	Recovered

The above tabulates the main characteristics of the 5 major complications* in this series of more than 2,000 IDE cases.

All were more than 30 years old, had children by prior c-section and were more than 5 1/2 months pregnant.

Although this limited experience is not statistically significant, our major complication rate using intact D&E is approximately 1% at extreme lengths of gestation (24 to 40 wks).

* Major complications are defined as death, hysterectomy, unscheduled surgery, persistent temperature greater than 101° for three days or blood loss requiring transfusion.

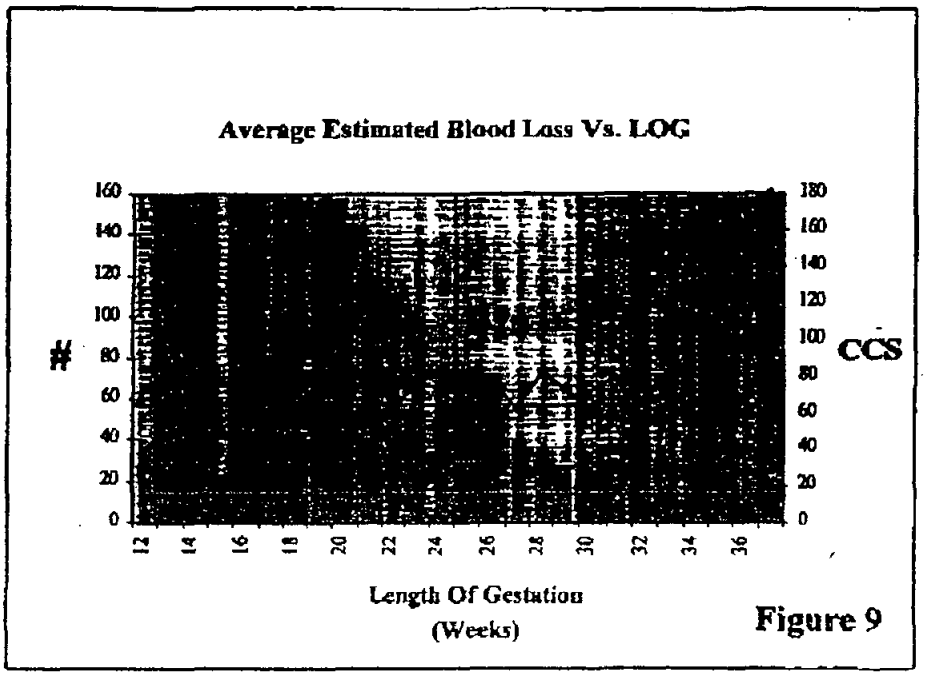


Figure 9

Average estimated blood loss vs. length of gestation.

This figure shows two things. The background is a bar graph in which the number of cases is shown at each length of gestation. Overlying this is a line graph whose points are made up of the averages of blood loss for each length of gestation.

In general, the blood loss increases as one proceeds from 12 to 40 weeks, but does not increase substantially. There are two rather large average blood losses at 34 and 40 weeks, but there were very few cases done at these lengths of gestation and that should not be regarded as part of the trend. The horizontal line shows the average blood loss for the entire case population, which was 63 cc.

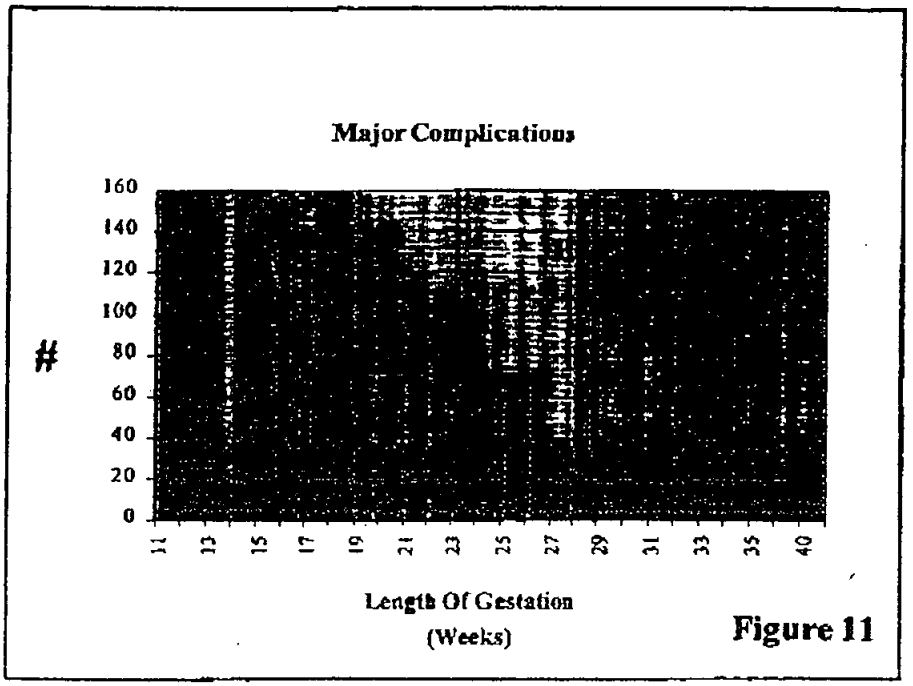


Figure 11

Major complications.

In this series, there were five major complications.

The background is generated by a bar graph which shows the number of cases at each length of gestation. The first one was a case of subacute bacterial endocarditis at 28 weeks that occurred the second week after the IDE. The fever persisted and was resistant to outpatient antibiotics. This was eventually diagnosed as SBE via a transesophageal ultrasound which showed vegetations on the cardiac valves. She was treated with intravenous antibiotics for six weeks, two weeks in the hospital and four weeks as an outpatient. She recovered without sequelae.

The other four complications all involved hemorrhage. Two occurred during the dilatation process and two occurred during the extraction. The latter two were caused by disseminated intravascular coagulopathy. Three out of the four were transfused. The one illustrated at 40 weeks had fulminant fibrinolysis and had to be given over 100 units of blood products. The other two patients needed transfusions of four units each. The longest hospitalization was 14 days.

TESTIMONY OF DR. MARY CAMPBELL,
MEDICAL DIRECTOR

PLANNED PARENTHOOD OF WASHINGTON, D.C.

BEFORE THE SENATE JUDICIARY COMMITTEE
ON H.R. 1833

NOVEMBER 17, 1995

Good morning.

I'm Dr. Mary Campbell, Medical Director of Planned Parenthood of Metropolitan Washington and a fellow of the American College of Obstetrics and Gynecology. I earned my medical degree and my masters in public health at Johns Hopkins University. I did a pediatric internship at the Children's Hospital in Oakland, California and did my OB/GYN residency at Sinai Hospital in Baltimore and Georgetown University. An additional qualification -- I spent last time last summer observing in Dr. James McMahon's clinic. Dr. McMahon was a leading practitioner of the intact D and E procedures. He died last month after a battle with cancer.

Discussing abortion requires some basic knowledge about pregnancy. A pregnancy lasts about forty weeks from the last menstrual period until birth, or about thirty-eight weeks from conception to birth. In thinking about pregnancy, possible complications, and the possibility and mechanics of termination, doctors divide pregnancy into thirds called trimesters.

The first trimester is the first fourteen weeks of pregnancy. During this time, between one-fifth and one-sixth of all pregnancies abort spontaneously. At least fifty percent of these losses result from chromosomal abnormalities. 95.5 percent of other abortions are done before 15 weeks. First trimester abortions are safe, simple procedures. Dilation of the cervix and aspiration or suction of the uterine contents generally takes only a few minutes.

The second trimester is the period between fourteen and twenty seven weeks gestation. When I started my training in OB/GYN, twenty-seven weeks was the earliest a normal baby could be born and have any chance of living. Over the past 15 years, the threshold of viability has been pushed back to about twenty-five weeks.

Previability second trimester abortions pose more risk to a woman than a first trimester procedure because the fetus is larger, the uterus is larger and thinner and blood flow in the area is much increased.

There are two major ways of performing a second trimester abortion. One method involves injecting into the amniotic fluid a substance that starts labor. This is called "instillation-induction." The woman has contractions and goes through labor before delivering her fetus. This method requires a day or two or more in the hospital.

A second method involves dilating the cervix (mouth of the womb) vaginally and removing the fetus passed into the uterus through the vagina. The fetus can be removed intact or not intact. It is not necessarily clear ahead of time which will happen. The woman receives pain medicine for this procedure, which can be done on an outpatient basis. This procedure, dilation and extraction, has been shown in several studies -- including those sponsored by the Centers for Disease Control -- to be safer for the mother than instillation-induction.

In the third trimester, abortion is nearly as dangerous as childbirth for the same reasons childbirth is dangerous. I must repeat, third trimester abortion for healthy babies is not available in this country. Indeed, it is the likelihood of anomalous babies dying in utero that causes their families and doctors to consider abortion, since fetal death in utero eventually disrupts mom's clotting system and leads to bleeding.

In the third trimester, a very large object needs to come through a very small opening which is supplied with huge blood vessels. And since third trimester abortions most often involve fetal malformations, the fit can be much more difficult than that of a normal birth.

The methods that I described for second trimester abortions are used with adaptations in the third trimester. Induction of labor remains a possibility. But many of the malformed babies we are discussing can't assume a position necessary to help the uterine contractions dilate the cervix. Many cannot assume any position compatible with spontaneous vaginal delivery.

For instance, if a baby is lying sideways in the uterus, no amount of labor will result in delivery. Prolonged labor will eventually result in uterine rupture and maternal death. A woman is twice as likely to die with an induction procedure as with a D and E.

Cesarian delivery becomes a possibility, but physicians are reluctant to subject a woman to a surgery that will not save her baby's life. A woman loses twice as much blood with a cesarian as with a vaginal delivery and a uterine scar -

especially from the vertical incision most often used with abnormal preterm fetuses - create an increased risk of uterine rupture in future pregnancies. A woman is 14 times as likely to die with a cesarian as with a D and E.

The third alternative is a variant of the D and E I described for the second trimester. The cervix is dilated from below using small rods that absorb fluid and dilate the cervix over hours to days. When the cervix is open as wide as the fetal hip width, the mother is given pain medicine and the baby is drawn through the cervix.

Much has been made of the fact that the head is decompressed before delivery. Only two-thirds of the dilation necessary for spontaneous vaginal delivery is necessary for intact D and E, because this fluid is withdrawn from the fetal head to permit easier delivery. This decreases the chances of cervical lacerations during the procedure and cervical incompetence in future pregnancies. Cervical incompetence refers to a cervix so weakened by trauma that it opens too early in pregnancy. In fact, decompressing the fetal head makes the procedure safe enough that Dr. McMahon performed over 2000 D and E's with no maternal deaths and only five complications. The Drusshen's incisions that Dr. Pamela Smith refers to are not used in this country because of the danger of maternal hemorrhage. They were referred to in out of date textbooks as a way to save a baby's life when the mother was dying.

Because of their severe malformations, an inch and a half is not all that prevents these infants from leading long, happy lives.

I oppose this bill for three medically-based reasons.

First, this bill is intolerably vague. It attempts to prohibit a medical procedure without adequately describing the procedure in terms that doctors understand.

Second, the bill's vagueness will have a chilling effect on the availability of abortion services. Physicians are unwilling to do things that might be illegal.

Third, and most seriously, this bill outlaws the safest way of ending a third trimester pregnancy. Dilation and intact extraction is a safe procedure -- safer than induction, far safer than hysterotomy. There are no compelling reasons for Congress to ban the safest way to end these wanted pregnancies gone tragically awry.

Boulder Abortion Clinic P.C.

1130 Alpine Avenue
Boulder, Colorado 80304
(303) 447-1361

20 March 1996

Hon. Charles Canady
House of Representatives
Washington, D.C. 20515

Dear Representative Canady:

RE: HR1833

As I stated in my prepared testimony for the U.S. Senate on 17 November, 1995 (copy enclosed for inclusion in the current record), I wish to state here again my opposition to HR1833. It is extremely bad legislation that sets a most dangerous precedent of legislative interference with medical and surgical practice.

The bill purports to ban an operation, "Partial Birth Abortion," which has not been described in the medical literature. The title is itself a political statement which has no connection to medical facts. There is no demonstrated need for this legislation. There is no demand for this legislation by the medical community or by women who seek abortion services. This bill is not about medicine but about politics. It should be eliminated from the legislative agenda.

As a physician providing late abortion services, I see many women who are in extremely dangerous and precarious medical and surgical conditions. They require my assistance as a physician expert in abortion to save their lives and preserve their health. Any restrictions such as those proposed by HR1833 would have catastrophic consequences for the lives of those women. Sponsors of this bill obviously have no concept of the difficult choices and dangers faced by these women, nor, apparently, do the sponsors care about the fate of these women. This legislation is a grave disservice to them, and I will continue to speak out to inform the public of the utter stupidity and cruelty of this legislation.

As for the spurious issue of whether the fetus is dead or alive at the time of the abortion procedure, and the cause of death, this is merely a pretext for stirring up fanatical and potentially lethal hatred for physicians who assist women with these difficult problems. It is moot. There is no fetal survival with current techniques of late abortion, regardless of anesthesia.

Warren M. Hern, M.D., M.P.H., Ph.D.

Diplomate, American Board of Preventive Medicine
Fellow, American College of Preventive Medicine

As a physician who has provided abortion services for tens of thousands of women since 1971, as the author of a major textbook on abortion and the author of dozens of professional and scientific papers on this subject, I condemn this blatant attempt to subvert the Roe v. Wade decision and the majority view of the American public that abortion should be safe, legal, and a matter between patient and physician.

There must be no legislative interference with efforts by physicians to provide women with the safest possible health care in matters of abortion.

HR1833 is a shameful and shamelessly cynical attempt to exploit the abortion issue for political gain.

If the bill is passed in final form, I will strongly urge President Clinton to use his veto power to stop this demagogic attack on the rights and welfare of women.

Sincerely,

Warren M. Hern, M.D., M.P.H., Ph.D.

STATEMENT

of

Warren M. Hern, M.D., M.P.H., Ph.D.
Director
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Before the Judiciary Committee
of the
United States Senate

Concerning S. 939
17 November 1995

Thank you, Mr. Chairman, for the opportunity to submit a statement to this body concerning S. 939, the so-called "Partial Birth Abortion Ban Act" of 1995. I appreciate the invitation to prepare a statement that came to me from Senators Kennedy, Biden, and Specter as members of the Judiciary Committee. I also deeply appreciate the joint request by Senators Hank Brown and Ben Nighthorse Campbell of Colorado that I be given an opportunity to testify in person and that my remarks be inserted in the record. Since I was not permitted to testify in person, I request that this written statement be entered into the record as per the requests by Senators Brown and Campbell.

My name is Warren Martin Hern. I am a physician engaged in private medical practice in Boulder, Colorado, where I specialize in outpatient abortion services. My formal medical training includes graduation from the University of Colorado School of Medicine in 1965 followed by a one-year rotating internship at Gorgas Hospital in the Panama Canal Zone. I subsequently served for two years as a commissioned officer in the United States Public Health Service assigned as a Peace Corps physician in Brazil. Following that, I studied public health and epidemiology at the University of North

In addition to my private medical practice, I hold several academic appointments. I am Assistant Clinical Professor of Obstetrics and Gynecology at the University of Colorado Health Sciences Center and Professor Adjunct in the Department of Anthropology, University of Colorado at Boulder. I also hold appointments in the USHSC Department of Preventive Medicine and Biometrics, Department of Family Medicine and at the University of Colorado at Denver, Department of Anthropology.

Senate Bill 939

The bill under consideration, S. 939, is called the "Partial Birth Abortion Ban Act," but there is no such thing as a "partial birth abortion." This is an operation which has never been described in the medical literature, and as far as I know, it does not exist. The bill's sponsors describe some procedures which have been performed for many generations in the case of obstetrical emergency. The operation mentioned in the Senate bill contains some elements of a procedure called an "Intact D & E," or "Intact Dilation and Evacuation" by some physicians during the course of scientific discussions of late abortions, but I have never heard the term, "partial birth abortion" in these discussions. As written, the bill describes aspects of an operation which

Amazon for a similar period. This is not a new idea.

The specific operation described by the bill's sponsors involves routine version of a 20-week or later fetus into a breech (feet first) position, followed by extraction of the fetus up to the neck, when the base of the fetal skull is perforated with surgical instruments. At that point, the contents of the fetal skull are removed by vacuum aspiration using a hollow cannula. Since the fetus is usually dead by this point, whether due to an induced abortion or miscarriage, and since the head is under great pressure, the cerebral contents are often extruded without any intervention by the surgeon. The head collapses, permitting delivery of the more or less intact fetus.

A variation of this procedure, which is usually preceded by several days of treatment to open the uterus so as to permit passage of the fetus, is decompression of the fetal skull as it presents first in the sequence of expulsion or delivery of the fetus. Again, the fetus is usually dead at the point at which this occurs. I think fetal death is often brought about by infarction (death) of the placenta as the result of other kinds of treatment such as those that cause uterine irritability.

A common approach to abortion by some obstetricians

for the fetus are secondary to the safety and welfare of the woman seeking the abortion.

The possible advantages of Intact D & E procedure include a reduction of the risk of perforation of the uterus. Since most women seeking abortions are young women who hope to reproduce in the future, having a safe abortion technique for late abortion is of paramount importance, aside from the prevention of complications.

Another advantage of the Intact D & E is that it eliminates the risk of embolism of cerebral tissue into the woman's blood stream. This catastrophe can be almost immediately fatal.

I support the right of my medical colleagues to use whatever methods they deem appropriate to protect the woman's safety during this difficult procedure. It is simply not possible for others to second guess the surgeon's judgment in the operating room. That would be dangerous and unacceptable.

Fetal Considerations

According to biologist Clifford Grobstein and others, fetal neurological development well into the early part of the third trimester is insufficient for the fetus to experience what we regard as "pain." In

which was desired. She was a diabetic and had developed hyperemesis gravidarum (uncontrollable vomiting from pregnancy). She was starving to death. Her doctors were having difficulty keeping her alive. Her blood chemical balance was severely altered to the point that her heart could stop at any time. She was profoundly dehydrated. She was critically ill and could barely speak. Since she and her husband wanted the pregnancy, they tried everything to get her through it, but she was finally advised that she must have the abortion. While being flown to Boulder so that I could see her, she almost died in the airplane. I began her treatment immediately and performed the abortion by one the techniques I have described here two days later. She recovered completely and felt healthy again the next day. Without this operation, she would have died.

Another woman with an advanced pregnancy was referred to me by a colleague in northern Colorado because her fetus had been found to have a severe genetic disorder. She and her husband both wanted the pregnancy to continue. The fetal disorder also caused a serious disease of the placenta, which, in turn, caused the woman's blood pressure to go up. When she arrived at my office, her blood pressure was starting to go up at an

anomalies. She was resting in my recovery room in preparation for her abortion, accompanied by her husband, when suddenly, without warning, the woman developed signs of shock, and I made a diagnosis of placental abruption. The placenta had torn away from the wall of the uterus and she was bleeding to death into the uterus. I carried her into my operating room without waiting for assistance, placed her on the operating table, and assembled my surgical team. My nurse held her fist on the patients aorta to keep her from bleeding to death while I did the abortion. As I began the procedure, two units of blood (about a quart) spurted out of her uterus, and she lost another unit during the operation. Without our preparations and my skill and experience, that woman would have died within minutes.

Mr. Chairman, I did not have time with any of these cases to consult the United States Senate on the proper method of performing the abortions.

Comparative risk of abortion and term birth

Without medical treatment, the risk of death due to pregnancy and childbirth is in the range of 1%. This is measured by the maternal mortality ratio, which is the proportion of women dying from pregnancy or its effects

published in the journal Obstetrics and Gynecology in February, 1993, I described the experience of 124 patients for whom I performed abortions in pregnancies complicated by severe fetal anomaly, diagnosed genetic disorder, or fetal death. The average length of pregnancy was 23 weeks with a few over 30 weeks. The major complication rate was less than 1% (one patient).

In another comparative study of mine published one year ago in the American Journal of Obstetrics and Gynecology, 1001 patients whose pregnancies ranged from 13 to 25 weeks in duration experienced a major complication rate of 0.3%. Only 3 of these patients experienced a major complication.

Implications of S. 939 for medical practice

Late abortion as currently practiced in the United States is a safe procedure that saves women's lives. The medical community has not determined the very best way to perform these procedures, and that cannot be determined by any legislature. That is a matter for scientific study and medical judgment.

If S. 939 is passed into law, any physician performing any second trimester or later abortion could be prosecuted by an aggressive public prosecutor. It

Hern, W.M.: The concept of quality care in abortion services. Advances in Planned Parenthood **13**:63-74, 1978.

Hern, W.M., W.A. Miller, L. Paine, and K.D. Moorhead: Correlation of sonographic cephalometry with clinical assessment of fetal age following early midtrimester D & E abortion. Advances in Planned Parenthood **13**:14-20, 1978.

Hern, W.M. and B. Corrigan: What about us? Staff reactions to D & E. Advances in Planned Parenthood 15:3-8, 1980.

Hern, W.M.: Outpatient second-trimester D & E abortion through 24 menstrual weeks' gestation. Advances in Planned Parenthood **16**:7-13, 1981.

Hern, W.M.: Correlation of fetal age and measurements between 10 and 26 weeks of gestation. Obstetrics and Gynecology **63**:26-32, 1984.

Hern, W.M.: Serial multiple laminaria and adjunctive urea in late out patient dilatation and evacuation abortion. Obstetrics and Gynecology 63:543-549, 1984.

Hern, W.M.: Cervical treatment with Dilapan prior to second trimester dilation and evacuation abortion: A pilot study of 64 patients. American Journal of Gynecologic Health 7(1):15-18, 1993.

Hern, W.M: Laminaria versus Dilapan osmotic cervical dilators for outpatient dilation and evacuation abortion: Randomized cohort comparison of 1001 patients. American Journal of Obstetrics and Gynecology 171:1324-1328, 1994.

Hern, W.M.: Abortion: Medical and Social Aspects. In Encyclopedia of Marriage and the Family, David Levinson, Ed. New York: Simon & Schuster MacMillan, 1995. pp 1-7.

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March 20, 1996

Representative Charles Canady
U.S. House of Representatives
Washington, D.C. 20515-0912

Dear Representative Canady:

I am writing to urge that your House Subcommittee on the Constitution oppose the passage of HR 1833. I am Associate Professor of Obstetrics and Gynecology at the University of Massachusetts Medical Center, as well as Medical Director of Preterm Health Services in Brookline, Massachusetts. In my opinion, passage of HR 1833 will result in an unprecendented Congressional intrusion into physicians' medical practice and will eliminate vital options for women whose tragic circumstances warrant later pregnancy termination.

Part of my responsibilities as a faculty member at the University of Massachusetts is to staff the Labor and Delivery Unit that serves as the high-risk referral center for the Central Massachusetts region. Our Department cares for pregnant women throughout the area who have serious, and often life-threatening, medical conditions. We also offer prenatal diagnosis of fetal conditions that, in some unfortunate cases, are incompatible with functional extrauterine life. Women with these medical problems or who are carrying these wanted, but affected, fetuses may choose to terminate the pregnancy - a decision which is among the most difficult and heart-wrenching that I have ever witnessed.

Although I am an abortion provider, neither I nor any of my colleagues in Central Massachusetts possess the requisite skills to perform D and X procedures. Most of our patients are poor and cannot afford to travel to avail themselves of the procedure through experienced practitioners in other areas. As a result, the only alternative that we can offer to women with indications for later pregnancy termination is induction of labor.

Please find it in your hearts for one moment to picture this scenario. Because women in these circumstances require careful monitoring and skilled nursing care, they must undergo their induction on the Labor and Delivery Unit of our hospital, where other women are delivering normal infants. They undergo hours and hours (sometimes days) of induced labor, a process which may exacerbate their medical illnesses and perhaps threaten their very lives. If the induction fails, they may require Cesarean section, which is major surgery and potentially risky, especially to women with underlying medical problems. Even if the induction succeeds and a

woman delivers vaginally, the placenta quite frequently fails to pass spontaneously, requiring uterine curettage under anesthesia. After suffering through this process, a woman may deliver an infant who is alive at birth, only to watch that infant die after a few minutes to hours of life due to serious chromosomal defects and anomalies. The emotional pain that these women endure is unspeakable, and the fact that we have no alternative to offer them feels cruel and unjust.

The D & X procedure offers a safe alternative to women in these tragic circumstances, one which would be seriously undermined through passage of HR 1833. Indeed, if Congress had the best interests of women in mind, it would, not only oppose HR 1833, but allocate resources to assure that more physicians are adequately educated and trained to offer the full range of treatment options to women who require later pregnancy terminations, including the D & X procedure. As a physician, I have dedicated my life to preserving and enhancing the health and lives of women through appropriate medical interventions. That a Congress untrained in the priniciples and practice of medicine should dictate how physicians practice, interfere with the doctor-patient relationship, and determine what treatment options will be available to patients is both ridiculous and dangerous.

Access to safe and legal abortion has had a dramatic impact on maternal mortality and morbidity in the United States. In 1965, reported illegal abortion deaths among American women accounted for over 17% of all pregnancy-related mortality that year (the real number of deaths is undoubtedly much higher, since many abortion-related deaths remained unreported as such); today, abortion-related deaths are almost unheard of, and complication rates are exceedingly low. The risk of dying from pregnancy, labor, and childbirth is, in fact, at least 12 times higher than the risk of dying from a legal abortion. HR 1833 is but one of a long line of tactics undertaken by abortion opponents to make abortion inaccessible to women. By eliminating safe abortion options, passage of HR 1833 will contribute to maternal morbidity and mortality for American women.

I urge your Subcommittee to stand squarely for public health principles by opposing HR 1833. I urge you to respect the law of the land that upholds women's right to reproductive choice, including later pregnancy termination in some circumstances, by opposing HR 1833. I urge your Subcommittee to preserve the sanctity of medical practice and the doctor-patient relationship by opposing HR 1833. The lives of women depend on it. Thank you.

Sincerely,

Maureen Paul, M.D., M.P.H.

John-

This is ~~the~~ opinion for a similar case in Ohio. Judge found ban unconstitutional. I marked pages where judge cites doctor's testimony in case you want them. Debbie

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO
WESTERN DIVISION

WOMEN'S MEDICAL PROFESSIONAL CORP.	:	
and	:	
MARTIN HASKELL, M.D.,	:	
Plaintiffs,	:	Case No. C-3-95-414
vs.	:	JUDGE WALTER HERBERT RICE
GEORGE VOINOVICH, GOVERNOR, STATE OF OHIO	:	
and	:	
BETTY MONTGOMERY, ATTORNEY GENERAL, STATE OF OHIO	:	
and	:	
MATTHIAS HECK, JR., PROSECUTING ATTORNEY, MONTGOMERY COUNTY, OHIO,	:	
Defendants.	:	

DECISION AND ENTRY GRANTING PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION (DOC. #2); DEFENDANTS, EMPLOYEES, AGENTS, SERVANTS PRELIMINARILY ENJOINED FROM ENFORCING ANY PROVISION OF HOUSE BILL 135, PENDING A FINAL DECISION ON THE MERITS; CONFERENCE CALL SET TO DETERMINE FURTHER PROCEDURES TO BE FOLLOWED IN THIS LITIGATION

Never, since the final shot of the Civil War, over a century and a quarter ago, has American society been faced with an issue so polarizing and, at the same time, so totally incapable of either rational discussion or compromise, as is

the ongoing controversy, of which this case is but the latest chapter, over the legality of attempts by the State to regulate abortion--the act of voluntarily terminating a pregnancy, prior to full term.[1]

[1] According to the Supreme Court's opinion in Roe v. Wade, 410 U.S. 113 (1973), until the last half of the nineteenth century, most states used the English common-law approach to abortion, which only criminalized abortion after the fetus "quickened," or moved in utero, which typically occurred during the sixteenth to eighteenth weeks of pregnancy. Id. at 132, 138. In the latter half of the nineteenth century, a number of states enacted statutes which criminalized abortion, at any stage of pregnancy. Id. at 139. By the end of the 1950s, most states banned all abortions except those necessary to preserve the life or health of the mother. Id.

In Roe, the Supreme Court held that a pregnant woman has a constitutional right to privacy, under the Due Process Clause of the Fourteenth Amendment to the United States Constitution, which prevents states from proscribing abortion before viability. 410 U.S. at 147-65. Roe also established a trimester framework: during the first trimester, the State could not interfere with the woman's decision to have an abortion; during the second trimester and until viability, the State could regulate abortion in ways that were reasonably related to the mother's health; after viability, the State could proscribe abortion, except where necessary to preserve the life or health of the mother. Id. at 163-65.

In Planned Parenthood v. Casey, 112 S.Ct. 2791 (1992), the Supreme Court reaffirmed Roe's "central holding" that, prior to viability, the State could not prohibit any woman from obtaining an abortion, because of the woman's liberty interest as protected by the Fourteenth Amendment to the United States Constitution. In contrast to Roe, however, the Court placed a greater emphasis on the State's interest in potential life throughout pregnancy. Accordingly, the Court discarded the trimester framework in Roe, and allowed the State to regulate pre-viability abortions as long as the regulation did not impose an "undue burden"; that is, as long as the regulation had neither "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus." Id. at 2820-21.

In the few years since Casey was decided, several states have enacted regulations on pre-viability abortions, and the constitutionality of some these regulations has been challenged. See, e.g., Planned Parenthood v. Miller, 63 F.3d 1452 (8th Cir. 1995) (striking down parental notification provisions, criminal provisions, and civil penalty provisions; upholding mandatory information requirements); Jane L. v. Bangerter, 61 F.3d 1493 (10th Cir. 1995) (striking down ban on abortions after 20 weeks, fetal experimentation ban, and choice of method requirement; upholding medical emergency exception); Fargo Women's Health Org. v. Schafer, 18 F.3d 526 (8th Cir. 1994) (upholding mandatory information requirement, 24-hour waiting period, and medical emergency definition); Barnes v. Mississippi, 992 F.2d 1335 (5th Cir.) (upholding parental consent requirement and judicial bypass mechanism), cert. denied, 114 S.Ct. 468 (1993); Barnes v. Moore, 970 F.2d 12 (5th Cir.) (upholding informational requirement and 24-hour waiting period), cert. denied, 113 S.Ct. 656 (1992); Utah Women's Clinic, Inc. v. Leavitt, 844 F. Supp. 1482 (D. Utah 1994) (upholding 24-hour waiting period and medical emergency exception); Planned Parenthood v. Neely, 804 F. Supp. 1210 (D. Ariz. 1992) (striking down medical emergency definition, and definition of medical procedures with respect to an abortion).

Over the course of six days of hearings, this Court has heard testimony from a number of medical practitioners, each expert in the field in which he or she testified. This Court believes that, regardless of the personal opinions of these professionals, whether pro-choice or pro-life, each testified, not in accordance with those personal opinions, but rather on the basis of his or her medical opinion. So, too, has this Court endeavored to put aside its personal opinion on the issues herein, in order to render an opinion which it believes is mandated by the present state of the law.

This case presents a challenge to the constitutionality of House Bill 135, which was enacted by the Ohio General Assembly on August 16, 1995, and was to have become effective on November 14, 1995. After hearing two days of testimony, this Court granted a ten-day Temporary Restraining Order on November 13, 1995, which was extended for an additional ten days, and was set to expire today, on December 13, 1995. Following four additional days of testimony, the Court now issues a preliminary injunction which enjoins enforcement of the three major portions of the Act: the ban on the use of the Dilation and Extraction ("D&X") abortion procedure; the ban on the performance of post-viability abortions, and the viability testing requirement. During the effective period of this preliminary injunction, no part of House Bill 135 may be enforced, as there is no part which appears to be either constitutional, or severable, from the remainder of the Act.

This Act creates two separate bans, and a separate requirement with regard to post-viability abortions. First, the Act bans the use of the Dilation and Extraction ("D&X") procedure[2] in all abortions, including those performed before viability. O.R.C. § 2919.15(B). Physicians who are criminally prosecuted or sued civilly for violating this ban may assert, as an affirmative defense, that all other available abortion procedures would pose a greater risk to the health of the pregnant woman. § 2919.15(C); § 2307.51(C). Second, the Act bans all post-viability abortions, except where necessary to prevent the pregnant woman's death, or to avoid a serious risk of substantial and irreversible impairment to a major bodily function.[3] § 2919.17(A). For purposes of the post-viability ban only, any unborn child of at least 24 weeks is presumed to be viable.[4] § 2919.17(C). Third, the Act also imposes a viability testing requirement before an abortion may be performed after the 22nd week of pregnancy. § 2919.18. Unless a medical emergency exists, any physician intending to perform a post-viability abortion must

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[2] The D&X procedure is defined as:

> The termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain. "Dilation and extraction procedure" does not include either the suction curettage procedure of abortion or the suction aspiration procedure of abortion.

O.R.C. § 2919.15(A).

[3] The determination that a post-viability abortion is necessary must be made in good faith, and in the exercise of reasonable medical judgment. O.R.C. § 2919.17(A).

[4] The gestational age is calculated from the first day of the last menstrual period of the pregnant woman. § 2919.16(B).

meet several requirements.[5] The Act creates civil and criminal liability for violations of the D&X ban or the post-viability ban, and criminal liability for violations of the viability testing requirement.[6]

Plaintiff Women's Medical Professional Corporation ("WMPC") operates clinics and provides abortion services in Montgomery, Hamilton, and Summit Counties (Doc. #1, ¶5). Plaintiff Haskell, a doctor affiliated with Plaintiff WMPC, formerly performed abortions after the 24th week, but no longer does so; he uses the D&X procedure for abortions during the 21st to 24th week of gestation (Id., ¶6). On October 27, 1995, Plaintiffs filed this suit for declaratory and injunctive relief from all provisions of the Act, on their own behalf and on behalf of their patients. Plaintiffs allege that this Act imposes an undue burden on the rights of their patients to choose an abortion, and, further, that the Act's

[5] The following requirements apply to post-viability abortions: (1) the physician must certify the necessity of the abortion in writing, (2) a second physician must certify the necessity of the abortion in writing, after reviewing the patient's medical records and tests, (3) the abortion must be performed in a health care facility which has access to neonatal services for premature infants, (4) the physician must choose the abortion method which provides the best opportunity for the fetus to survive, unless it would pose a significantly greater risk of death to the pregnant woman, or a serious risk of substantial and irreversible impairment to a major bodily function, and (5) a second physician must be present at the abortion to care for the unborn human. O.R.C. § 2919.17(B)(1). These conditions need not be complied with if the physician determines, in good faith and in the exercise of reasonable medical judgment, that a medical emergency exists and prevents compliance. § 2919.17(B)(2).

[6] Violation of the viability testing requirement is a fourth degree misdemeanor. O.R.C. § 2919.18(B). Violation of either the D&X ban or the post-viability ban is a fourth degree felony. § 2919.15(D), § 2919.17(D). A patient upon whom one of these procedures is performed or attempted to be performed is not criminally liable. § 2919.15(E), § 2919.17(E). She may, however, sue within one year of the procedure or attempted procedure for compensatory, punitive, and exemplary damages, as well as for costs and attorneys fees. § 2307.51(B), § 2307.52(B). Derivative claims for relief may also be brought. § 2305.11(D)(3)&(7).

provisions are unconstitutionally vague and fail to give physicians fair warning as to what actions will incur criminal and civil liability. Accordingly, they seek to enjoin the Act as a violation of Plaintiffs' rights to privacy, liberty, and due process, as guaranteed by the Fourteenth Amendment to the United States Constitution.

I. Jurisdiction, Ripeness, Standing, Preliminary Injunction Standard

Before addressing the merits of Plaintiffs' request for a preliminary injunction, this Court must address three issues relating to its jurisdiction over this action. First, because this case involves a challenge to the constitutionality of a state statute under the United States Constitution, federal question jurisdiction is proper under 28 U.S.C. § 1331. Second, even though Plaintiff Haskell has not yet been prosecuted for violating the Act, this case is ripe for decision because a doctor facing criminal penalties for performing abortions may sue for pre-enforcement review of the relevant statute. Doe v. Bolton, 410 U.S. 179, 188 (1973).

Third, Plaintiff Haskell has the necessary standing to raise both his own rights and the rights of his patients. Because Plaintiff Haskell has asserted that he intends to continue performing the D&X procedure after this law takes effect, he is at direct risk of prosecution, and has standing to seek pre-enforcement review of this statute. Doe, 410 U.S. at 188. Given the close relationship between Plaintiff Haskell and his patients, and given the obstacles which

prevent pregnant women from challenging this statute, including a desire for privacy and the imminent mootness of their claims, he may also assert third-party standing and raise the rights of his patients. Singleton v. Wulff, 428 U.S. 106 (1976) (plurality opinion) (allowing two doctors to sue for declaratory and injunctive relief from state statute taking away Medicaid funding for abortions), cited with approval in Planned Parenthood Ass'n v. Cincinnati, 822 F.2d 1390, 1396 (6th Cir. 1987). It is also noteworthy that in Planned Parenthood v. Casey, 112 S.Ct. 2791 (1992), an action for declaratory and injunctive relief from a state statute restricting the right to abortion was brought by similar plaintiffs: abortion clinics and a doctor. Based on the foregoing authority, Plaintiff Haskell has standing to bring this action, and to assert both his own rights and the rights of his patients. Although Defendants have argued that the Plaintiff must show that a particular woman will be impacted by the Act in order to have standing to raise her rights, this Court agrees with Plaintiff Haskell's argument that such a showing is unnecessary. It is sufficient that Plaintiff Haskell has alleged that he regularly has patients upon whom he performs the procedure, and that he will have such in the future.[7]

[7] In addition, this Court notes that one such patient, Jane Doe Number 2, testified in this hearing after her abortion was performed by Dr. Haskell on November 30, 1995--two weeks after the Act was to have taken effect.

Plaintiff Haskell also has standing to challenge the provisions of the Act which ban post-viability abortions, codified at O.R.C. § 2919.17, and the viability testing requirement in O.R.C. § 2919.18. Defendants have argued that he lacks standing to challenge these provisions, because he only performs the D&X procedure up through the 24th week of pregnancy (Defendant's Memorandum in Opposition, Doc. #11, p.27, 34). The ban on post-viability abortions, however, imposes a rebuttable presumption of viability at 24 weeks, O.R.C. § 2919.17(C), which will apply to Plaintiff Haskell. If, in certain cases, he is unable to rebut the presumption of viability, the remaining provisions relating to the ban on post-viability abortions will also apply to him. In addition, Plaintiff Haskell will have to satisfy the viability testing requirement for any patients he treats who are in or beyond their twenty-second week of pregnancy. Therefore, Plaintiff Haskell also has standing to challenge these provisions of House Bill 135.

Plaintiff WMPC sues on behalf of its physicians who are employed at its various affiliated locations, and on behalf of women who receive medical services, including abortions, at these locations. This Court does not now reach the issue of whether Plaintiff WMPC has standing to bring this action, due to an inadequately developed factual record.[8] This issue need

[8] For example, although Plaintiff WMPC has asserted that it has standing because it will incur civil liability under the Act, this Court does not now have facts sufficient to conclude that Plaintiff WMPC may be civilly liable.

not be reached at this time, because Plaintiff Haskell's standing is sufficient to allow this action to go forward. Accordingly, the remainder of this opinion will use "Plaintiff" in the singular, in reference to Plaintiff Haskell. This Court now turns to the merits of Plaintiff's Motion for a Preliminary Injunction.

When considering whether a preliminary injunction is proper, this Court must consider four factors: (1) the substantial likelihood of the Plaintiff's success on the merits; (2) whether the injunction will save the Plaintiff's patients from irreparable injury; (3) whether the injunction would harm others;[9] and (4) whether the public interest would be served by issuance of the injunction. International Longshoremen's Ass'n v. Norfolk Southern Corp., 927 F.2d 900, 903 (6th Cir. 1991), cert. denied, 112 S.Ct. 63 (citing In re DeLorean Motor Co., 755 F.2d 1223, 1228 (6th Cir. 1985)). This Court need not conclude that all four factors support its decision. Chrysler Corp. v. Franklin Mint Corp., 1994 U.S. App. LEXIS 18389, at *4 (6th Cir. 1994). Rather than being "rigid and unbending requirements" that must be satisfied, these factors are intended to guide this Court's discretion in balancing the equities. In re Eagle-Picher Industries, Inc., 963 F.2d 855, 859 (6th Cir. 1992). For example, the degree of likelihood of success which is required to issue a preliminary

[9] This third prong is also construed as a "balancing of equities"; to wit, whether the harm which would be suffered by the Plaintiff if the injunction were not granted, outweighs the harm which would be suffered by the Defendant if the injunction were to be granted.

injunction may vary according to the strength of the other factors. In re DeLorean Motor Co., 755 F.2d at 1229. This Court must make specific findings as to each of these factors, unless fewer are dispositive of the issue. International Longshoreman's Ass'n, 927 F.2d at 903.

II. Plaintiff's Substantial Likelihood of Success on the Merits

Plaintiff has asserted a number of arguments attacking the constitutionality of the D&X ban, the post-viability ban, and the viability testing requirement. Many of these arguments can be divided into two categories: first, those that assert that the Act either imposes an undue burden on a woman's right to an abortion, or jeopardizes the pregnant woman's health, and is thus unconstitutional under Casey; second, those that assert that the Act is unconstitutionally vague. Before addressing these arguments, this Court will briefly set forth the relevant law to be applied to each of these categories. This Court will then consider each of the three challenged statutory provisions in turn.

A. Standards for Challenging Abortion Regulations

1. The Substantive Law

In Planned Parenthood v. Casey, a plurality of the Supreme Court held that viability marks the point at which the State's interest in protecting the potential life of the fetus outweighs the pregnant woman's liberty interest in having an abortion, subject only to a medical determination that her own

life or health is at risk. 112 S.Ct. at 2816-17, 2819-2821. Before viability, states may not enact regulations which have "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion...." 112 S.Ct. at 2820. Such regulations constitute an "undue burden" on a pregnant woman's right to have an abortion, and are an unconstitutional violation of her liberty interest, as guaranteed by the Fourteenth Amendment to the United States Constitution. Id. at 2819. After viability, however, the State may regulate and proscribe abortions "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." Id. at 2821. Therefore, whereas regulations which affect pre-viability abortions are subject to an undue burden analysis, regulations which apply only to post-viability abortions are presumptively valid, unless they have an adverse impact on the life or health of the pregnant woman.

It has been suggested that "strict scrutiny" should be applied to the medical necessity exception to the ban on post-viability abortions, codified at O.R.C. § 2919.17(A)(1).[10] In the opinion of this Court, a strict scrutiny approach would be improper in this specific situation, because it might allow a state, in some circumstances, to proscribe a post-viability abortion even where such an abortion is necessary to preserve

[10] Quite obviously, such a level of scrutiny cannot be applied to the ban itself, for Casey instructs us that a state may ban abortions after viability, unless an abortion is necessary, in the appropriate medical judgment, to preserve the life or health of the mother.

the life or health of the mother. For example, in a situation where the mother is terminally ill, and is only expected to live for a maximum of six months following the post-viability abortion that saves her life, a state might attempt to argue that its interest in the fetus's life was actually more compelling than the mother's compelling interest in her own life, and that this interest should allow it to forbid an abortion in that circumstance.

This would force courts to decide when, and under what circumstances, an unborn child's life becomes more important, and more worthy of protection, than the life of its mother. In the opinion of this Court, this inquiry is beyond the realm of legal jurisprudence, and must be left to the discretion of the individuals involved. Neither the legislature, nor the courts, has either the legal or the moral authority to balance the interests and the lives involved, and to make this decision.

Therefore, this Court holds that although a state may ban most abortions subsequent to viability, it may not take away a pregnant woman's right, as recognized in Casey, to have a post-viability abortion which is necessary to preserve her life or health. A strict scrutiny analysis could have the effect of narrowing this exception, and should not be applied. Instead, any regulation which impinges upon or narrows this exception, must be declared to be unconstitutional.

2. Standard for Reviewing Facial Challenges to Abortion Regulations

There is some dispute as to the proper showing which Plaintiff must make in order to succeed in bringing this facial challenge.[11] Before the Supreme Court's decision in Casey, a plaintiff bringing a facial challenge to a statute imposing restrictions on abortion faced the difficult burden of establishing "that no set of circumstances exists under which the Act would be valid." United States v. Salerno, 481 U.S. 739, 745 (1987), followed by Rust v. Sullivan, 500 U.S. 173, 183 (1991) (applying Salerno to facial challenge to regulations prohibiting facilities which receive federal funds from counseling, referring, or advocating abortion as a method of family planning); Ohio v. Akron Center for Reproductive Health, 497 U.S. 502, 514 (1990) (applying Salerno to facial challenge to judicial bypass procedure for minors seeking abortions); cited in Webster v. Reproductive Health Services, 492 U.S. 490, 524 (O'Connor, J., concurring) (applying Salerno to facial challenge to state law prohibiting use of public

[11] The difference between challenging a statute "on its face," as in this case, or in challenging it "as applied," was recently explained by Justice Scalia:

> Statutes are ordinarily challenged ... "as applied"--that is, the plaintiff contends that application of the statute in the particular context in which he has acted, or in which he proposes to act, would be unconstitutional. The practical effect of holding a statute unconstitutional "as applied" is to prevent its future application in a similar context, but not to render it utterly inoperative. To achieve the latter result, the plaintiff must succeed in challenging the statute "on its face."

Ada v. Guam Society of Obstetricians & Gynecologists, 113 S.Ct. 633 (1992) (Scalia, J., dissenting from denial of cert.). In the instant case, Plaintiff Haskell seeks to have the entirety of House Bill 135 declared unconstitutional, and not only as it applies to his particular situation. Thus, he is bringing a facial challenge to the statute.

facilities to perform abortions except where necessary to save the mother's life). In Casey, however, the plurality employed a more relaxed standard in striking down the Pennsylvania spousal notification provision: the law was held to be invalid because "in a large fraction of the cases in which [it] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." 112 S.Ct. at 2830. Moreover, when examining the informed consent provision, the plurality specifically examined the record, and the facts contained therein, which related to the application of the challenged provision to specific persons and in specific circumstances. Id. at 2825-31. This appeared to signal a new approach to evaluating facial challenges to pre-viability abortion regulations.

Since Casey, a split has developed among the Circuits as to whether the Casey approach has replaced the Salerno standard. The Third and Eighth Circuits, joined by district courts in the Seventh (Indiana) and Tenth Circuits (Utah), have concluded that Casey did replace Salerno. Planned Parenthood, Sioux Falls Clinic v. Miller, 63 F.3d 1452, 1458 (8th Cir. 1995) ("we choose to follow what the Supreme Court actually did ... and apply the undue burden test"); Casey v. Planned Parenthood, 14 F.3d 848, 863 n.21 (3rd Cir. 1994) ("the Court has... set a new standard for facial challenges to pre-viability abortion laws"); A Woman's Choice-East Side Women's Clinic v. Newman, Cause No. IP 95-1148-C H/G, at 19-20 (S.D. Ind. 1995) (memorandum opinion on motion for preliminary

injunction) ("this court believes that Casey effectively displaced Salerno's application to abortion laws"); Utah Women's Clinic v. Leavitt, 844 F. Supp. 1482, 1489 (D. Utah 1994) ("to bring a facial challenge in good faith, one must reasonably believe that the statute is incapable of being applied constitutionally in a large fraction of the cases in which it is relevant."). The Fifth Circuit has disagreed, and continues to apply the Salerno standard when evaluating restrictions on abortion. Barnes v. Moore, 970 F.2d 12, 14 n.2 (5th Cir. 1992) ("we do not interpret Casey as having overruled, sub silentio, longstanding Supreme Court precedent governing challenges to the facial constitutionality of statutes").

The Supreme Court, itself, appears to be split on this issue. Compare Fargo Women' Health Org. v. Schafer, 113 S.Ct. 1668 (1993) (O'Connor, concurring with denial of application for stay and injunction) (stating that the Casey approach should be followed by lower courts), with Ada v. Guam Society of Obstetricians and Gynecologists, 113 S.Ct. 633 (1992) (Scalia, dissenting from denial of petition for writ of certiorari) (stating that Court did not change the Salerno standard in Casey).

Not surprisingly, whereas Plaintiff has urged this Court to adopt the Casey approach, Defendants have vigorously argued that the Salerno standard should be employed. Because the Sixth Circuit is silent on the issue of whether Salerno should

apply to pre-viability abortion regulations, it is a matter of first impression in this Circuit.

This Court concludes that for purposes of evaluating the ban on the D&X procedure, which is used in the weeks preceding viability, this Court will follow the approach actually undertaken in Casey, and employed by courts in the Third, Seventh, Eighth, and Tenth Circuits, and ask whether, "in a large fraction of the cases in which [the ban] is relevant, it will operate as a substantial obstacle to a woman's choice to undergo an abortion." This Court makes this decision for two reasons. First, because Casey did not require that every married woman be subject to physical abuse in striking down the spousal notification requirement, the plaintiffs in that case did not have to show that "no set of circumstances exist under which the law would be invalid" in order to successfully challenge it. Second, it seems that it would be impossible, as a practical matter, to evaluate whether a regulation will create an undue burden on the right to an abortion, without examining specific facts in the record, and evaluating the likely impact that a regulation will have on the specific group of women who are affected by it. For these reasons, this Court declines to apply Salerno to the challenged pre-viability regulations in this case.

Although this Court has concluded that it will not apply Salerno to the pre-viability regulations in House Bill 135, the issue of whether Salerno should apply to the post-viability regulations in House Bill 135 is a separate issue.

unconstitutionally threaten the life or health of even a few pregnant women. The Court so holds for three reasons. First, the cases which have applied Salerno have not involved laws which threaten to inflict, unconstitutionally, such severe and irreparable harm.[13] Second, because the Supreme Court signalled in Casey that an unconstitutional infringement of the liberty interests of some, but not all, pregnant women, is sufficient to justify application of a lesser standard where a pre-viability abortion is concerned, there is no reason why the Court would not similarly apply a lesser standard where a law threatens to deprive some, but not all, pregnant women of their greater constitutional interest in their own life and health. Finally, and most importantly, it would be unconscionable to hold that a pregnant woman--or her estate--may not challenge a post-viability regulation until after she is unconstitutionally deprived of her life or health. Therefore, this Court will allow Plaintiff to facially challenge this post-viability ban, even though he has not shown that "no set of circumstances" exists under which the ban would be valid.

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[13] In Rust, the Court applied Salerno to a facial challenge to regulations which restricted the ability of facilities receiving Title X funding to counsel, make referrals, or advocate, abortion. 500 U.S. at 183. In Akron Center for Reproductive Health, plaintiffs brought a facial challenge to a parental notification statute; in considering the judicial bypass procedure, the Court applied Salerno, rejecting arguments that the procedure's time requirements might be construed as "business days" instead of "calender days," and reasoning that the statute should not be invalidated "based on a worst-case analysis that may never occur." 502 U.S. at 514. Finally, in Webster, Justice O'Connor stated that Salerno should apply to a Missouri provision that prohibited the use of public facilities to perform abortions not necessary to save the life of the mother. 490 U.S. at 523.

For purposes of evaluating the ban on post-viability abortions, therefore, this Court must likewise consider whether it is bound to apply the more restrictive Salerno standard.[12]

Whether the Salerno standard for facial challenges should apply to post-viability regulations appears to be an issue of first impression before this, or any, Court. Casey is not dispositive, because the approach in that case is specifically designed to evaluate whether a law restricting access to pre-viability abortions would impose an "undue burden" on a large fraction of the relevant population; it does not evaluate whether a law restricting access to post-viability abortions is invalid simply because it may jeopardize the life or health of a few (or many) pregnant women who need such an abortion. Indeed, none of the cases cited above which followed the new Casey approach involved restrictions on post-viability abortions. Thus, this appears to be an issue of first impression in this, or any, Court.

After careful consideration of the interests involved, this Court concludes that the Salerno requirement that the plaintiff must show that "no set of circumstances exists under which the law would be valid," should not apply to facial challenges to post-viability abortion regulations which may

[12] Defendants have argued, for example, that the testimony given by Jane Doe Number One and Jane Doe Number Two--both of whom would have been adversely affected by this ban on post-viability abortions--should be disregarded by this Court, because Salerno requires that the law be unconstitutional in all of its applications, rather than in a few or many situations. Because this is a facial challenge, Defendants argue, such testimony as to how the law may affect specific individuals is irrelevant.

B. Standard for Vagueness Challenges

In addition to arguing that this Act is unconstitutional under Casey, Plaintiff argues that the Act is unconstitutionally vague. When determining whether a statute or regulation is sufficiently vague so as to violate due process, there are several relevant considerations. A statute or regulation may be vague if it fails to give fair warning as to what conduct is prohibited. Grayned v. City of Rockford, 408 U.S. 104, 108 (1972) ("we insist that laws give the person of ordinary intelligence a reasonable opportunity to know what is prohibited, so that he may act accordingly"), cited in Fleming v. United States Dept. of Agriculture, 713 F.2d 179, 184 (6th Cir. 1983). A statute or regulation may also be vague if it is subject to arbitrary and discriminatory enforcement, due to a failure to provide explicit standards for those who apply the law. Id. Finally, the lack of a mens rea requirement in a statute which imposes criminal liability may indicate that the statute is unconstitutionally vague. Colautti v. Franklin, 439 U.S. 379, 395 (1979) ("Because of the absence of a scienter requirement in the provision directing the physician to determine whether the fetus is or may be viable, the statute is little more than 'a trap for those who act in good faith.'").

A vague law is especially problematic in two situations. First, its potential to cause citizens to "'steer far wider of the unlawful zone' ... than if the boundaries of the forbidden areas were clearly marked," Id. (quoting Baggett v. Bullitt,

377 U.S. 360, 372 (1964)), is of particular concern where the exercise of constitutionally protected rights may be inhibited or "chilled." Colautti v. Franklin, 439 U.S. 379, 391 (1979) (applying to the right to an abortion); Baggett, 377 U.S. at 372 (applying to First Amendment rights). Second, a vague law which provides for criminal penalties is troubling because of the severe consequences which may result from violating the law. Hoffman Estates v. The Flipside, Hoffman Estates, Inc., 455 U.S. 489, 498-99 (1982). When determining whether a law is void for vagueness, this Court must examine the challenged law in light of all of the above considerations.

This Court now turns to Plaintiff's arguments challenging the constitutionality of the D&X ban, the post-viability ban, and the viability testing requirement, for purposes of gauging whether the likelihood of Plaintiff's success on the merits of these arguments is substantial.

C. Ban on Use of the D&X Procedure

1. Vagueness of the Definition of D&X

House Bill 135 bans the performance or attempted performance of any abortion, pre-viability or post-viability, by use of the Dilation and Extraction ("D&X") procedure, which is defined as follows:

> [T]he termination of a human pregnancy by purposely inserting a suction device into the skull of a fetus to remove the brain. 'Dilation and extraction procedure' does not include either the suction

curettage procedure of abortion or the suction aspiration procedure of abortion.

O.R.C. § 2919.15(A). Plaintiff argues that this definition is unconstitutionally vague, because it does not adequately distinguish the D&X procedure from a different procedure known as the Dilation and Evacuation ("D&E") procedure. Plaintiff further argues that this vagueness will chill physicians from performing abortions by use of the D&E method, which is the most common method used in the early to mid-second trimester. Defendants dispute this, arguing that the definition does not include or describe the D&E procedure, and so is not vague; further, Defendants argue that the D&E procedure is included in the definition of suction curettage, and so is excepted from the ban.

In order to address this vagueness argument, it is necessary to define and describe the various methods of abortion, based on the testimony in this case. When the procedures are described in detail, it becomes apparent that the statutory definition of the Dilation and Extraction procedure could be construed to include the more widespread Dilation and Evacuation ("D&E") procedure. It also becomes apparent that the D&E method is <u>not</u> included in any definition of suction curettage: although a D&E procedure does include suction curettage, it also includes additional steps, such as dismemberment, and additional instruments, such as forceps. Furthermore, suction curettage is a first-trimester procedure, whereas D&E is a second-trimester procedure. Accordingly,

Plaintiff has demonstrated a substantial likelihood of success of showing that the definition of a D&X procedure is unconstitutionally vague.

a. suction curettage/aspiration

Suction curettage and suction aspiration (also known as vacuum aspiration) are common methods of first-trimester abortions, and the terms are used interchangeably (Tr., 12/6, at 13, 115).[14] In a suction curettage procedure, the doctor mechanically dilates the opening to the uterus by the use of metal rods, inserts a vacuum apparatus into the uterus, and removes the products of conception by the use of negative suction (Tr., 12/5, at 33). There is no need to dilate the patient's cervix in the days before the procedure is performed (Id.). Suction curettage/aspiration can sometimes be performed up to the 15th week of pregnancy, but is typically a first-trimester procedure (Id.). Approximately ninety-five percent of the abortions which are performed in this country are performed during the first fifteen weeks of pregnancy[15] (Tr., 12/6, at 13).

[14] The transcripts of the hearing testimony are, for the most part, paginated separately for each day of testimony. Therefore, when referring to transcript testmony throughout this opinion, this Court will indicate the date of the transcript, as well as the page on which the specific reference may be found.

[15] The testimony indicates that some women who seek abortions in their second trimester are victims of rape or incest, and may have been psychologically unable to face their pregnancies at an earlier time (Tr., 11/8, at 27). Other women who seek abortions in the second trimester do so because it is only then that they discover that their fetus has developed severe anomalies, i.e., physical defects that call into question the ability of the fetus, once carried to term, to survive (Tr., 12/5, at 103-08).

b. Dilation & Evacuation (D&E)

In the second trimester, the fetus becomes too large to remove by use of suction curettage (Tr., 12/5, at 33-34). At that point, the most common abortion method is a Dilation and Evacuation (D&E) procedure; indeed, it is the only procedure which can be used from the thirteenth to sixteenth weeks of pregnancy (Tr., 11/8, at 51). Instead of using metal rods to dilate the cervix over a short period of time, the doctor inserts laminaria into the cervix during the one-to-two day period prior to the procedure, in order to slowly dilate the cervix. Then, a suction curette with a larger diameter is placed through the cervix, and the doctor removes some, or all, of the fetal tissue.

Frequently, however, the torso and the head cannot be removed in this manner (Tr., 12/5, at 35). The procedure typically results, therefore, in a dismemberment of the fetus, beginning with the extremities. This dismemberment is accomplished both by use of the suction curettage, and by the use of forceps (Id.).

Removing the head of the fetus from the uterus is typically the most difficult part of the D&E procedure, in part because the head is often too large to fit through the partially dilated cervix. It is important to remove the head as quickly as possible, because fetal neurologic tissue can negatively affect the mother's ability to clot, and lead to greater bleeding (Tr., 12/6, at 32). Physicians have

developed different methods of decompressing the head, in order to remove it.

Dr. Anthony Levatino testified that when he performed D&E abortions, he preferred to grasp the fetal head with a clamp, crush it, and remove it in pieces along with the skull contents (Tr., 12/7, at 190). Because he decompressed the skull by crushing it, he found it unnecessary to decompress the skull by purposely inserting a suction device into the skull and removing some of its contents (Id. at 192).

Dr. Paula Hillard testified that when the skull is too large to remove intact, she grasps the skull and suctions out its contents with a cannula--which may enter the skull--in order to decompress it and facilitate its removal (Tr., 11/8, at 77). She has never performed the procedure utilized by Dr. Haskell (Id. at 49).

Dr. Doe Number One testified that because the use of forceps can cause trauma to the mother's uterus, his preference is to collapse the head by the use of suction, prior to its removal. By making a small incision at the base of the skull and inserting a suction device into the brain--while the head is still within the uterus, and no longer attached to the body--he can collapse the head and easily remove it, without the use of forceps (Tr., 12/5, at 43). This method decreases injury to the cervix and uterus, and reduces operating room time, blood loss, and anesthesia time (Id. at 44). Dr. Doe describes his procedure as a D&E, and

performed from 15 to 18 weeks. Although he does not always collapse the head in this fashion, Dr. Doe Number One testified that the two procedures--D&E with collapse, and D&E without collapse--are on a continuum (Id. at 72). He has never performed the procedure utilized by Dr. Haskell (Id. at 84).

Dr. Mary Campbell has not performed second-trimester abortions, but has read about and observed various second-trimester methods, in preparation for setting up a second-trimester practice at her clinic. In describing the D&E procedure, she testified that the fetal skull is generally not intact following dismemberment of the body--the jaw is often removed with the neck--and "the edges of the fetal skull are sharp enough to lacerate the maternal uterine [blood] vessels..." (Tr., 12/6, at 35). The goal is therefore to place the suction cannula into the skull in order to remove its contents and make it smaller, thereby allowing it to be removed intact, in order to minimize lacerations (Id. at 33). In addition, removing the head intact is advantageous because it ensures that no parts of the skull are left behind in the woman's uterus (Id. at 35).

Dr. Harlan Giles, who performs D&E abortions up to the twentieth week of pregnancy, testified that he had never seen an instance in which the fetal head was too large to be removed without being crushed or somehow decompressed, but he admitted that such an occurrence was possible (Tr., 11/13, at 269-70; Tr., 12/8, at 41).

The D&E procedure appears to be preferable to other available procedures before the twentieth week; at thirteen to sixteen weeks, it is the only available procedure. The main alternative to a D&E procedure after sixteen weeks is an induction or instillation method, which involves either the injection of saline, urea, or prostaglandins into the amniotic cavity, or, the insertion of vaginal prostaglandin suppositories. These procedures result in labor, and are further described below. The D&E procedure appears to be less painful for the mother than induction procedures, because it does not require labor, and because the cervix is dilated slowly with laminaria rather than being dilated more forcefully by uterine contractions. In addition, the D&E procedure takes less time, generally between ten and twenty minutes, as opposed to twelve to thirty-six hours. Because the uterus is not under pressure over a long period of time, there is less of a risk of forcing fluids or fetal proteins into the maternal circulation (Tr., 12/6, at 31). Finally, there is a reduced risk of retained products of conception, infection, hemorrhage, and cervical injury (Id. at 39).

Although the D&E procedure appears to have a lower rate of complications than other methods of abortion in the early to mid-second trimester, it can be equally risky at later periods, when the fetus is larger. One serious complication of later D&Es is caused by the use of forceps, which results in uterine and cervical injuries, and increased blood loss (Tr., 12/5, at 41).

c. Dilation and Extraction (D&X)

In this section, the Court will describe Dr. Haskell's specific method of abortion, which has been described by various parties as either an "intact D&E," a "brain suction procedure," or a "Dilation and Extraction" procedure. It is typically used late in the second trimester, from twenty to twenty-four weeks.

Plaintiff Haskell described his procedure in a paper presented at the National Abortion Federation Conference in 1992 (Defendant's Exhibit A). The following description is taken from that paper.

On the first and second days of the procedure, Dr. Haskell inserts dilators into the patient's cervix. On the third day, the dilators are removed and the patient's membranes are ruptured.[16] Then, with the guidance of ultrasound, Haskell inserts forceps into the uterus, grasps a lower extremity, and pulls it into the vagina. With his fingers, Haskell then delivers the other lower extremity, the torso, shoulders, and the upper extremities. The skull, which is too big to be delivered, lodges in the internal cervical os.[17] Haskell uses his fingers to push the anterior cervical

[16] Defendants pointed out that, in the videotape in which Dr. Haskell demonstrates the procedure (Defendant's Exhibit R), the patient's membranes had ruptured (her "water had broken") prior to the procedure, on the very first day. Although this fact might be relevant if this were a medical malpractice action brought by that particular patient, it is not relevant to the issue of whether the D&X procedure is generally safe for the mother's health.

[17] Although Dr. Haskell does not state in his paper that he cuts the umbilical cord prior to penetrating the base of the skull with scissors, he testified that he routinely cuts the cord, and he did so on the

lip out of the way, then presses a pair of scissors against the base of the fetal skull. He then forces the scissors into the base of the skull, spreads them to enlarge the opening, removes the scissors, inserts a suction catheter, and evacuates the skull contents. With the head decompressed, he then removes the fetus completely from the patient.

The primary distinction between this D&X procedure and the D&E procedure previously described appears to be that, whereas the D&E procedure results in dismemberment and piece-by-piece removal of the fetus from the uterus--and, possibly, in removal of portions of the skull contents by the use of suction after the skull is crushed with forceps or otherwise invaded, and before the head is placed next to the opening to the uterus--the D&X procedure results in a fetus which is removed basically intact except for portions of the skull contents, which are suctioned out after the head is placed next to the opening to the uterus (and after the rest of the fetus is removed from the uterus), and before the fetus is fully removed from the mother's body.[18] The hallmark of the D&X procedure, therefore, is that the fetus is removed intact, rather than being dismembered prior to removal, as is done in a D&E procedure. In both procedures, the head usually must be

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minutes for the fetus to die, following the cutting of the umbilical cord, and that, on the videotape, Haskell waited only thirty seconds from the time he cut the cord to the time he inserted the scissors, this Court also notes that the fetus in the videotape appeared to be dead at the beginning of the procedure.

[18] If the skull could not be decompressed by suctioning out part of the contents, and yet was too big to pass through the cervix, it apparently would have to be crushed in order to remove it.

decompressed, either by crushing the skull, or by invading the skull and suctioning out its contents. In the D&X procedure, the suctioning is purposeful; in a D&E procedure, the suction may either be purposeful, or, given the inability to clearly see the fetus, even with ultrasound, and the consequent difficulty of knowing whether the surgical instrument is in, or simply near, the skull, it may be accidental.

The testimony indicates that the D&X procedure may be considered to be a variant of the D&E technique.[19] Indeed, doctors who use the procedure may not know which procedure they will perform until they encounter particular surgical variables and circumstances after they begin the procedure to terminate the pregnancy.[20] The doctor may intend to do a D&X in cases where the patient has requested an intact fetus for

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[19] The testimony indicates that each physician's surgical procedures may differ from similar procedures used by other physicians (Tr., 12/6, at 103). Indeed, physicians experiment with and develop their own variants of surgical techniques, and then use them, even if those variants are not specifically approved in a peer review journal (Id. at 104).

In this case, Dr. John Doe Number One testified that he developed a procedure which is similar to Haskell's D&X procedure for use in his D&E procedures at fifteen to eighteen weeks: after the extremities of the fetus are dismembered and removed, he collapses the head by making an incision and then using suction to decompress the skull, instead of crushing it with forceps, so that he can remove the skull intact (Tr., 12/5, at 42-44). Dr. John Doe Number Two, who uses Haskell's D&X procedure in situations where an intact fetus is requested, or if the fetus is breech (feet first), testified that he considers the D&X procedure to be a modification of the D&E procedure (Tr., 12/6, at 47-48).

[20] Dr. Doe Number Two testified, for example, that he uses the D&X procedure in the specific circumstance when the fetus is "double footling breech" and comes out feet first, resulting in a trapped head. At that point, he has "no room to work" because the head is trapped in the lower uterine segment, and must try to finish the procedure as quickly as possible to lower the risks to the mother. In that circumstance, the D&X procedure is the safest and fastest method. If he were prohibited from suctioning out the skull contents to decompress the head, he would have to dismember the head from the body, push the detached head back up into the uterus, crush the skull with the appropriate instruments, and then remove it in pieces (Tr., 12/7, at 76).

purposes of genetic testing, or, perhaps, where a patient has a history of Cesarean sections and a uterine scar, and thus is more vulnerable to uterine injury (Tr., 12/7, at 89).

Based on the testimony of various physicians, this Court further finds that in both the D&E and the D&X procedures, a suction device may be purposely inserted into the skull in order to remove the skull contents, to accomplish the goal of decompressing the fetal head, thereby facilitating its removal from the woman's body. Because the statutory definition of the prohibited "Dilation and Extraction Procedure" thereby appears to encompass the purportedly allowable D&E procedure as well, Plaintiff has demonstrated a substantial likelihood of success of showing that this definition is unconstitutionally vague, as it does not provide physicians with fair warning as to what conduct is permitted, and as to what conduct will expose them to criminal and civil liability.[21]

2. Constitutionality of Banning the Specific Abortion Procedure at Issue

As far as this Court is aware, only one case has considered the propriety of a ban on a specific abortion procedure. In Planned Parenthood of Missouri v. Danforth, 428 U.S. 52 (1976), the Supreme Court struck down a ban on the

[21] In addition, this Court notes that House Bill 135 bans not only the performance of D&X abortions, but also the attempted performance of D&X abortions. Given this Court's finding that the D&X procedure is on a continuum with the D&E procedure, this phrase adds confusion as to when a doctor, who is performing a D&E abortion, attempts to perform a D&X, and thus incurs criminal and civil liability.

second-trimester abortion method of saline amniocentisis. The Court reasoned that, because the method was commonly used and was safer than other available methods, it failed to serve the stated purpose of protecting maternal health. The Court concluded that, given that there were no safe, available alternatives to the banned method, the ban was "an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting, the vast majority" of second trimester abortions. Accordingly the ban was held to be unconstitutional. Id. at 75-79.

The reasoning in Danforth suggests that a state may act to prohibit a method of abortion, if there are safe and available alternatives. This reading comports with Casey, which dictates that if a ban on a specific method were to place a substantial obstacle in the path of a woman seeking a pre-viability abortion--for example, if there were no safe and available alternative method of abortion--the ban would be an undue burden and therefore unconstitutional. The issue before this Court, therefore, is whether, in Ohio, there are safe and available alternatives to the D&X procedure, which is typically performed during the twentieth to twenty-fourth weeks of pregnancy, such that there would be no undue burden if the procedure were banned.

a. D&E Procedure

Due to the larger size of the fetus in the mid to late-second trimester, when the fetus is not necessarily viable,

the D&E is no longer the procedure of choice to perform an abortion.[22] Therefore, in considering the safest method of abortion at this stage of pregnancy, this Court will compare the D&X procedure--which is typically performed from the twentieth to the twenty-fourth weeks of pregnancy--to other available procedures.

b. Instillation/Induction Procedures

The main alternative to the D&X procedure, in the late second trimester, is the use of an induction method of abortion. Induction methods are also known as "instillation" methods. In one type of induction method, the physician injects some substance--typically saline, or a combination of a prostaglandin and urea--into the amniotic cavity of the woman. In another type, the physician places prostaglandin suppositories into the patient's vagina. In both cases, the end result is labor: the substances cause the uterus to contract, resulting in the eventual expulsion of the fetus. This labor typically lasts between twelve and twenty-four hours (Tr., 12/6, at 25), but may last as long as thirty-six hours (Id. at 118).

The evidence suggests that induction methods were more frequently used in the 1970s, when the D&E procedure was just

[22] Additional obstacles to performing a D&E after the twenty-second week of pregnancy include: the presentation of the fetus, in which the spine is oriented toward the cervix, and the toughness of the fetal tissues; both of these factors make it more difficult to dismember the fetus (Tr., 11/8, at 177). Because the operating time is thereby increased, this can cause heavy blood loss (Id. at 178).

being developed. Also, induction procedures are more often used by less skilled physicians (Id. at 22). Finally, they must be performed in a hospital environment, and so cannot be done on an outpatient basis.

There appear to be two advantages which induction methods have over the D&E procedure: they require less skill to perform, and they do not involve the placement of any sharp instruments into the uterus (Id. at 29).

One obvious disadvantage of the induction method is that it results in labor, with all of its potential complications. These may include: fear, lack of control, mild to severe abdominal pain, nausea, and diarrhea, and extreme discomfort, over a lengthy period of time. The substances used, especially saline, may result in mild side effects--vomiting, diarrhea, and high fever--or in severe maternal complications. The fluids which are introduced may be forced into the maternal circulation, leading either to amniotic fluid embolus, which is generally fatal, or to disseminated intravascular coagulation (DIC), in which the clotting factors in the blood are used up, and bleeding cannot be stopped. Induction methods can also thin out the lower uterus to the point that the fetus comes through the uterine wall instead of through the vagina (Tr., 12/6, at 25-26). In addition, induction methods cannot be performed on women who have an active pelvic infection, or who are carrying dead fetuses (Id. at 26), and probably should not be performed on women who had previously had Cesarean sections, given the possibility of

rupturing the uterine scar (Id. at 28). Finally, induction methods may be ineffective in cases where the fetus is lying with its head on one side and its feet on the other, because there is no pressure against the cervix (Id. at 27), and the fetus will not be expelled from the uterus.

c. Hysterectomy/Hysterotomy

Another alternative to the D&X is a hysterotomy, which is essentially a Cesarean section performed before term, although it is potentially more dangerous because the uterus is thicker than it is at the end of term, and the incision causes more bleeding and may make future pregnancies more difficult. A more extreme alternative is a hysterectomy, which removes the uterus completely. Both of these methods entail the risks associated with major surgical procedures, and are rarely used today.

d. D&X Procedure

Before discussing the apparent benefits and risks of the D&X procedure, it is necessary to address Defendant's arguments that the procedure has no measurable benefits, for the reason that no peer review journal has published any studies measuring these benefits. The Court acknowledges that if there were a statistical study, published in a peer review journal, which demonstrated the benefits of the D&X procedure, this would make the asserted benefits more credible. Nevertheless, the lack of a study in a peer review journal

does not, ipso facto, mean that there are no benefits, or no risks. Indeed, in this situation, there are a number of factors which help to explain the lack of such a statistical study.

First, the D&X procedure is relatively new--it apparently was first described in 1992--and it will take time for other practitioners to begin using and evaluating the procedure. Second, given the security concerns which must be considered by doctors who perform abortions, physicians who use the D&X procedure may be understandably reluctant to publicly acknowledge that they use this procedure, and may be even more reluctant to participate in a study and publish the results. Finally, as was testified to by Dr. Mary Campbell, funding for studies of abortion methods was cut drastically in the early 1980s, and there have been no large-scale abortion studies since that time (Tr., 12/6, at 74, 76). Given these obstacles to performing and publishing statistically valid studies on new abortion methods, this Court is not persuaded that the absence of a study on D&X abortions in the medical literature means that the procedure has no benefits.[23]

Dr. George Goler, the Ohio Section Chief of the American College of Obstetricians and Gynecologists, testified that he

[23] In addition, and for similar reasoning, this Court is unpersuaded by the Defendant's argument that the D&X procedure is not within the accepted medical standards. This is a new, controversial procedure. As Dr. Goler testified: "I don't think enough people know about it to really say its within the accepted standards of practice. I think, as it gets to be better known and the results [are] published, it will be." (Tr., 12/6, at 133-34). Given the recent development of the D&X procedure, the fact that no publication has concluded, to date, that it is within acceptable medical standards, is not dispositive.

views Dr. Haskell's procedure as an improvement over the traditional D&E procedure, because it causes less trauma to the maternal tissues (by avoiding the break up of bones, and the possible laceration caused by their raw edges), less blood loss, and results in an intact fetus that can be studied for genetic reasons (Tr., 12/6, at 136). Dr. Haynes Robinson, a pathologist and geneticist, testified that it is sometimes desirable to obtain an intact fetus in order to confirm the presence of fetal anomalies, and to predict the likely recurrence in future pregnancies (Tr., 12/5, at 118). Although an intact fetus can be obtained following an induction or instillation procedure--and such a method might be preferable where the brain needs to be studied intact--the use of various substances to induce labor can cause autolysis, or the breaking down of tissue, which may make the fetal tissue less useful for such studies (Tr., 12/6, at 34). A further advantage over induction or instillation procedures is that the D&X procedure takes far less time--ten to twenty minutes--than the twelve to thirty-six hours in which a woman must be in labor following an induction or instillation procedure.[24]

Plaintiff Haskell testified that, in approximately 1,000 D&E procedures performed after the twentieth week of

[24] This Court rejects Defendant's claim that the D&X procedure takes longer, because it requires the insertion of laminaria one or two days before the procedure. Dr. Doe Number Two testified that the insertion of laminaria does not impair the woman's ability to function in any way, nor does it cause major discomfort, although it may cause some cramping. This does not compare to the more traumatic experience of going through labor.

pregnancy, two patients had serious complications (Tr., 11/8, at 149). In approximately 1,000 D&X procedures performed after the twentieth week of pregnancy, there were no serious complications (Id. at 150-51). Although this is anecdotal, not statistical, evidence, this Court finds that it is both uncontradicted and plausible.

Dr. Levatino, who has performed D&E but not D&X abortions, predicted that the D&X procedure would have greater complications than the induction methods, because there is an increased possibility of perforating the patient's uterus when the abortion is performed in the late second trimester (Tr., 12/7, at 198, 205). This testimony appears, however, to have been based less on his analysis of the specific procedure then on his estimate of the risks of performing late-term D&E abortions, generally. As noted earlier, the D&E procedure can be risky in the late-second trimester, because the fetus is larger and more difficult to dismember, and the use of forceps in the uterus becomes more dangerous. The D&X procedure mitigates this risk by delivering the fetus intact--except for a decompression of the head after it has been placed next to the opening to the uterus--and thus would not appear to bear an increased risk of uterine perforation. Although forceps are still used, their use appears to be minimized.

Dr. Giles testified that the procedure is not new, but is rather a resurrection of an obstetric method discarded in the 1960s, which was used to deliver dead fetuses, and known as craniotomy (Tr., 12/8, at 18-23). His criticisms of the D&X

procedure on this ground are not persuasive. First, the reason for the abandonment of the craniotomy procedure--which required the use of sharp instruments, and caused uterine lacerations and perforations--does not appear to be relevant to the D&X procedure, which reduces the risk of uterine lacerations (in comparison to the D&E procedure) by delivering all but the head of the fetus intact, which is then decompressed by the use of scissors and suction. Second, unlike the situation in the 1960s, ultrasound can now be utilized to help to avoid injury when sharp instruments are introduced into the uterus.

Finally, in regard to the availability of the D&X procedure, it can be performed on an outpatient basis, and does not require hospitalization. Although the procedure requires three separate visits to the clinic, the insertion of laminaria on days one and two takes less than an hour (Tr., 12/5, at 22), and the D&X procedure itself, which is performed on the third day, requires a total time of less than two hours (Id.). At least three doctors in Ohio perform some variation of the D&X procedure: Plaintiff Haskell (Tr., 11/8, at 109-10); Dr. John Doe Number One (Tr., 12/5, at 43); and Dr. John Doe Number Two (Tr., 12/7, at 47-48).

e. Conclusion

After viewing all of the evidence, and hearing all of the testimony, this Court finds that use of the D&X procedure in the late second trimester appears to pose less of a risk to

maternal health than does the D&E procedure, because it is less invasive--that is, it does not require sharp instruments to be inserted into the uterus with the same frequency or extent--and does not pose the same degree of risk of uterine and cervical lacerations, due to the reduced use of forceps in the uterus, and due to the removal of any need to crush the skull and remove it in pieces, which can injure maternal tissue.

This Court also finds that the D&X procedure appears to pose less of a risk to maternal health than the use of induction procedures, which require the woman to go through labor, pose additional risks resulting from the injection of fluids into the mother, and cannot be used for every woman needing an abortion.

Finally, the Court finds that the D&X procedure appears to pose less of a risk to maternal health than either a hysterotomy or a hysterectomy, both of which are major, traumatic surgeries.

Because the D&X procedure appears to have the potential of being a safer procedure than all other available abortion procedures, this Court holds that the Plaintiff has demonstrated a substantial likelihood of success of showing that the state is not constitutionally permitted to ban the procedure. If this abortion procedure, which appears to pose less of a risk to maternal health than any other alternative, were banned, and women were forced to use riskier and more deleterious abortion procedures, the ban could have the effect

of placing a substantial obstacle in the path of women seeking pre-viability abortions, which would be an undue burden and thus unconstitutional under Casey.

Even if induction procedures were as safe as the D&X procedure--and this Court does not find, on the evidence, that they are as safe--the requirement that a pregnant woman be hospitalized in order to undergo an induction procedure may also have a negative impact on the practical availability of abortions for women seeking pre-viability abortions. First, hospitals may refuse to allow induction procedures on an elective basis,[25] including those situations in which a woman wishes to abort a fetus with severe anomalies. Second, it may be psychologically daunting to undergo the induction procedure in the hospital environment.[26] These practical problems may discourage women in their second trimester from exercising

[25] For example, Miami Valley Hospital, in Dayton, Ohio, only permits therapeutic abortions, and does not allow their performance on an elective basis (Defendant's Exhibit F). Dr. George Goler, the Ohio Section Chief of the American College of Obstetricians and Gynecologists, also testified that "it's gotten to the point now where many of the hospitals do not have facilities" to perform abortions by use of induction methods (Tr., 12/6 at 118). Although Dr. Harlan Giles, a Pennsylvania physician, testified that it was his opinion that several Ohio facilities allowed the performance of elective abortions (Tr., 11/13, at 237), this Court is more inclined to rely on the testimony of Dr. Goler, who practices in Ohio, and whose testimony was specifically directed toward second-trimester abortions. This Court concludes that the preponderance of the evidence is that few Ohio hospitals allow non-therapeutic, second-trimester abortions.

[26] Dr. Doe Number One, who used to perform induction procedures but now performs a version of the D&X procedure, testified that hospitals and hospital personnel view induction procedures as a "second-class procedure" performed on "second-class patients," and that the problem is exacerbated by the practice of locating the woman obtaining the abortion in close proximity to women giving birth (Tr., 12/5, at 37-38). Dr. Mary Campbell also testified that it's depressing for the patient to undergo an abortion procedure in the labor and delivery area of a hospital: "These are families often with wanted pregnancies gone awry who in the course of their time in the hospital ... get to hear several other families through closed doors ... shouting rather happily ... it's a boy or it's a girl." (Tr., 12/6, at 28-29).

their right of seeking elective, pre-viability abortions, or make it practically impossible to do so, thereby amounting to an undue burden on the right to seek a pre-viability abortion. In contrast, the D&X procedure can be performed on an outpatient basis within a much shorter period of time, and is not limited by either of these practical problems.

For both of these reasons--because the D&X procedure appears to be the safest method of terminating a pregnancy in the late second trimester, and because the D&X procedure is more available than induction methods, which require the woman to be hospitalized--this Court holds that Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on the D&X procedure is unconstitutional under Danforth and Casey.[27]

3. Legitimacy of the State's Asserted Interest in Banning the D&X Procedure

Next, this Court turns to the state's asserted interest in enacting the ban on the D&X procedure, and to the constitutional legitimacy of that interest. The Ohio General

[27] Defendants have argued that the affirmative defense, codified at O.R.C. § 2919.15(C), saves the ban from being an undue burden. Under the affirmative defense, if a physician who is prosecuted for performing a D&X procedure can present prima facie evidence that all other procedures would have posed a greater risk to the mother's health, then the prosecutor has the burden of proving, beyond a reasonable doubt, that at least one other abortion method would not have posed a greater risk to the mother's health.

Defendants' argument is unpersuasive, for two reasons. First, the certainty of arrest and prosecution is certain to chill physicians from performing the D&X procedure, even where it is the least risky method of abortion. Second, even if there were no chilling effect, the challenged law restricts the availability of D&X procedures to situations where it is obviously and irrefutably the safest method. Given this Court's findings that the D&X procedure may be safer and more available than other methods of abortion, this would still amount to an undue burden.

Assembly declared that its intent in banning the D&X procedure was: "to prevent the unnecessary use of a specific procedure used in performing an abortion. This intent is based on a state interest in preventing unnecessary cruelty to the human fetus." House Bill 135, Sec. 3 (emphasis added).

In Casey, the Supreme Court recognized two specific interests which the state has in regulating abortions prior to viability. First, "to promote the State's profound interest in potential life throughout pregnancy the State may take measures to ensure that the woman's choice is informed, and [these] will not be invalidated as long as their purpose is to persuade the woman to choose childbirth over abortion." 112 S.Ct. at 2821. Second, "the State may enact regulations to further the health or safety of a woman seeking an abortion." Id. Neither of these interests, however, justify regulations which impose an undue burden on the right to seek a pre-viability abortion.

Because Casey only specifically mentioned these two interests, Plaintiff argues that any other interest--such as that of preventing unnecessary cruelty to the fetus during the abortion--is neither proper nor legitimate. Defendants argue that the interest is justified by the "State's profound interest in potential life throughout pregnancy," and that it would be contrary to logic and common sense to hold that this interest is not legitimate. The State further argues that if it is permitted to impose regulations which prevent cruelty to

animals, then surely, it should be permitted to impose regulations which prevent cruelty to fetuses.

Again, this appears to be an issue of first impression before this, or any, Court. To this Court's knowledge, no abortion regulation has heretofore been justified by an interest in preventing unnecessary cruelty to the fetus. Moreover, this Court has no precedent to directly guide and inform its decision. There are, however, a few observations which help its analysis.

First, and foremost, this Court is mindful of Casey's strong recognition of the State's interest in potential life throughout the pregnancy. Second, although Casey only specifically delineated a few interests which the state has which justify regulation, nowhere in the opinion did the Court hold that no other state interest could justify regulations on pre-viability abortions. These observations, taken together, suggest that the state may impose regulations which vindicate its interest in the potential life of the fetus, based on interests other than those of persuading the woman to choose childbirth over abortion, or of protecting her health and safety. Finally, the Court agrees with Defendants that it would be contrary to all logic and common sense, to hold that a state has no interest in preventing unnecessary cruelty to fetuses.

Assuming arguendo that the interest is legitimate, however, Casey is clear in holding that regulations enacted to further legitimate interests may not impose an undue burden on

the right to seek a pre-viability abortion. Because Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on D&X abortions would impose an undue burden on the right, the legitimacy of the state's interest, no matter how legitimate or compelling, will, in all likelihood, once the merits of this litigation are determined, not save the ban from being unconstitutional.

Although the Court need not, at this point, address the testimony concerning the cruelty of the D&X procedure--given that Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on the procedure is an undue burden and therefore is unconstitutional--it is in the public interest to discuss the issue of cruelty. Therefore, this Court now turns to the relevant testimony.

Defendants called two experts to testify to the pain felt by the fetus during the D&X procedure.[28]

Dr. Joseph Conomy is a professor of clinical neurology at Case Western Reserve University, and is involved in the issue of medical ethics. He has studied the formation of the nervous system, and has worked on problems of the nervous system in fetuses and newborn infants.

In regard to fetal neurology, Dr. Conomy testified that, at the age of twenty to twenty-four weeks, many of the neural

[28] Plaintiff Haskell testified that he didn't believe that fetal neurological development at twenty-four weeks would allow pain impulses to be transmitted to the brain (Tr., 11/8, at 179), and that a fetus of the same age lacked the cognitive ability to perceive pain (Id. at 180). Because Dr. Haskell was not qualified as an expert in the area of fetal neurology, this Court will not consider this testimony.

pathways which transmit pain to the brain are established, although the cortical projections from the lower level of the brain, the thalamus, are not yet established (Tr., 11/13, at 301). It is his opinion, therefore, that pain can be transmitted to at least the lower levels of the brain at that age (Id. at 302).

Dr. Conomy further testified that fetuses at the age of twenty to twenty-four weeks respond to nurturing stimuli, such as stroking the face, and noxious stimuli, such as pricking the skin, in different ways. Nurturing stimuli may cause a turning of the head, or pursing of the lips. Noxious stimuli will cause flexion and withdrawal (Id. at 300-302).

In reference to the D&X procedure, Dr. Conomy testified that it is his opinion that the procedure would prompt an unpleasurable stimulus to the fetus (Id. at 303). He also testified, however, that it would be "speculative" to try to "get inside the mind of a fetus, if there is one." (Id. at 301). Indeed, Dr. Conomy specifically refused to testify that a fetus can feel pain: although the fetus does "exhibit a class of responses that are characteristic of reflex response to obnoxious stimulation.... feeling is very much beyond that because it involves perception, designation, locality, and things that are far too speculative for me to assure you that a fetus feels." (Id. at 305). Thus, although Dr. Conomy testified that a fetus at the age of twenty to twenty-four weeks may physically respond to noxious stimuli, he did not

testify that the fetus has a conscious, mindful awareness of the pain it is experiencing.

Finally, Dr. Conomy testified that a fetus who is aborted by the D&E procedure, which involves dismemberment, might experience as much discomfort as a fetus who is aborted by the D&X procedure (Id. at 307).

Defendants' second expert was Dr. Robert White, who is a professor of neurosurgery at Case Western Reserve University. He has been the director of a brain research laboratory for thirty years, but has not specifically studied pain or its mechanisms.

In his testimony, Dr. White defined "pain" as a physiological, or perhaps behavioral, expression resulting from the appreciation of a noxious stimulus (Tr., 12/7, at 119-120).

In particular reference to the mechanics of the D&X procedure, Dr. White testified that two maneuvers would cause pain to the fetus. First, the act of compressing, rotating, and pulling the fetus down into the birth canal--which also occurs during childbirth, at a more advanced age--must cause pain to the fetus (Id. at 131). Second, it was his opinion that the act of making an incision in the back of the neck and enlarging it--without, apparently, cutting any part of the nervous system--and then inserting a suction tube and evacuating the skull contents, must be painful (Id.).

Initially, Dr. White testified that it was his opinion that the fetus may feel pain during the D&X procedure; this

answer was stricken from the record because it did not indicate an opinion within reasonable medical probability (Id. at 110-11). Later in his testimony, and after viewing a videotape of the procedure being performed on a dead fetus, Dr. White amended his opinion to state that the fetus can feel pain (Id. at 124). He based this opinion partly on the small size of the infant, which means that pain travels a much shorter distance than in adults, and partly on his opinion that chemicals in the brain which suppress pain are not established in fetuses, whereas, chemicals which reinforce pain are so established (Id. at 126-27). He also disputed Dr. Conomy's opinion that the cortical projections from the thalamus are not established at twenty-four weeks (Id. at 158-59).

In regard to whether a fetus at twenty-four weeks can consciously experience pain, Dr. White noted that the problem is "what we consider consciousness." (Id. at 162). He did admit, however, that he did not know "at what particular stage in the gestational [age] ... that an infant is conscious." (Id. at 163).

Finally, Dr. White testified that the D&E procedure would also be painful for the fetus, although the nervous system is more formed at twenty to twenty-four weeks, when the D&E procedure is used on a less frequent basis (Id. at 164).

Based on this testimony, this Court concludes the following: first, there is evidence that a fetus of age twenty to twenty-four weeks will react, physiologically, to noxious

stimuli. Second, the evidence is inconclusive as to whether the pain impulses are transmitted to the higher levels of the brain at that age. Third, the evidence is inconclusive as to whether the D&X procedure is more painful than the D&E procedure.[29]

Finally, and most importantly, neither Dr. Conomy nor Dr. White testified that a fetus at age twenty to twenty-four weeks experiences a conscious awareness of pain. Although Defendants have suggested that there needn't be a conscious awareness of pain in order to conclude that the D&X procedure is "cruel," a finding that there is such a conscious awareness of pain on the part of the fetus does appear to be relevant to this Court; so, too, is the inability of the Court to make such a finding. Some might argue that abortion is always

[29] The parties stipulated that at the beginning of the D&X procedure, some fetuses are dead, and some are alive. An exact definition of the term "alive" was neither stipulated, nor clarified by the evidence. Indeed, in some basic, elemental sense, the fetus is "alive" from the moment of conception. What is clear, however, is that "alive" does not mean "viable." Were alive to mean viable, the stipulation arguably would be transformed into an acknowledgment that the D&X procedure is more cruel than either the D&E procedure, or any other form of mid-second trimester pregnancy terminations.

Assuming arguendo that the fetus does feel pain, one factor which suggests that the D&X procedure might be more painful than the D&X procedure--the physical act of dismembering the fetus in the D&E, as opposed to a relatively quick incision and suctioning process in the D&X--is balanced by the younger age of the fetus during the D&E procedure, which is performed earlier in the second trimester, when the nervous system is not as fully developed.

Assuming that the D&X procedure is "cruel," however, this Court fails to see how it is more cruel than the D&E procedure--which involves the dismemberment of the fetus and, sometimes, the crushing of its skull--or how it is always cruel, given that the fetus may already be dead (see Defendant's Exhibit R). The State's banning of the D&X procedure thus raises a question of whether its purpose in so doing was to prevent unnecessary cruelty, as stated, or, rather, was to place a significant obstacle in the path of a woman seeking a pre-viability abortion in the mid-second trimester. Casey, 112 S.Ct. at 2820. Cf. Danforth, 428 U.S. at 78 (discussing "the anomaly inherent in [the ban on saline amniocentesis] when it proscribes the use of saline but does not prohibit techniques that are many times more likely to result in maternal death").

cruel because it ends in the death of the fetus; this, however, does not provide a basis for distinguishing between different methods of abortion. If the fetus does not perceive or experience the pain, then it is hard to see how the D&X procedure could be any more cruel than any other abortion method.

This Court recognizes that the subject of when a fetus attains consciousness is a matter of great debate, and that reasonable minds can differ on the issue. As the Supreme Court stated in Casey:

> Men and women of good conscience can disagree, and we suppose some always shall disagree, about the profound moral and spiritual implications of terminating a pregnancy, even in its earliest stage. Some of us as individuals find abortion offensive to our most basic principles of morality, but that cannot control our decision. Our obligation is to define the liberty of all, not to mandate our own moral code.

112 S.Ct. at 2806. Until medical science advances to a point at which the determination of when a fetus becomes "conscious" can be made within a reasonable degree of certainty, neither doctors nor judges nor legislators can definitively state when an abortion procedure becomes "cruel," in the sense of when the fetus becomes aware of pain. That judgment must be made by each individual member of society.

Given that there is no reliable evidence that the D&X procedure is more cruel than other methods of abortion, this Court is unable to conclude that the ban on the use of the D&X procedure serves the stated interest of preventing unnecessary

cruelty to the fetus.[30] As in Danforth, the ban on the D&X procedure therefore "comes into focus, instead, as an unreasonable or arbitrary regulation designed to inhibit, and having the effect of inhibiting," second-trimester abortions prior to viability. 428 U.S. at 79.

This conclusion does not, however, mean that the state cannot regulate the D&X procedure, short of an absolute ban. As discussed above, Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on the D&X procedure is unconstitutional, because it imposes an undue burden on the right to seek a pre-viability abortion, and because the definition of D&X is vague. Assuming, however, that the fetus is conscious of the pain involved in the D&X procedure, it appears to this Court that the state could still seek to vindicate its asserted interest in preventing arguably unnecessary cruelty to the fetus, by regulating the procedure without banning it outright.

Although the testimony on this issue was not conclusive, one such possible regulation may require the physician to cut the umbilical cord prior to making an incision in the base of

[30] Before Casey, the State would have had to show that the ban on the D&X procedure was necessary to achieve a compelling state interest, under a strict scrutiny standard. After Casey, the State need only show that it has a legitimate interest, and that the challenged regulation "cannot be said [to] serve no purpose other than to make abortions more difficult." 112 S.Ct. at 2833. This new approach appears to require courts to examine whether the challenged regulation serves the stated, legitimate purpose. See, e.g., Barnes v. Mississippi, 992 F.2d 1335, 1340 (5th Cir.) (holding that because the challenged two-parent consent statute helped to safeguard the interests of both parents and the family, it could not be said to serve no purpose other than to make abortions more difficult), cert. denied, 114 S.Ct. 468 (1993). Accordingly, this Court must examine whether the ban on the D&X procedure serves the purpose of preventing unnecessary cruelty to the fetus.

the skull, and to wait until the fetus dies as a result. Another possible regulation might require the use of local or general anesthetic, on the fetus or the mother. By use of such regulations, states could prevent arguably unnecessary cruelty in the abortion procedure, without taking away the right to seek a pre-viability abortion. In enacting any regulation on the D&X procedure, however, states must bear in mind that they cannot reduce either the safety or the availability of the procedure. Such an effect would render the regulation unconstitutional under both Danforth and Casey.

D. The Ban on Post-Viability Abortions

1. Description of the Statute

Because the challenged ban on post-viability abortions is particularly complex, it is advisable to provide a detailed overview of all of the provisions before proceeding to analyze them individually.

House Bill 135 bans the performance of all post-viability abortions, unless:

> (1) the physician determines, in good faith and in the exercise of reasonable medical judgment, that the abortion is necessary to prevent the death of the pregnant woman or [medically necessary to prevent] a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman, [or]
>
> (2) the physician determines, in good faith and in the exercise of reasonable medical judgment, after making a determination relative to the viability of the unborn human in conformity with [§ 2919.18(A)], that the unborn human is not viable.

O.R.C. § 2919.17(A)(1-2). The statute defines a serious risk of the substantial and irreversible impairment of a major bodily function as follows:

> [A]ny medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function, including, but not limited to, the following conditions: (1) pre-eclampsia; (2) inevitable abortion; (3) prematurely ruptured membrane; (4) diabetes; (5) multiple sclerosis.

O.R.C. § 2919.16(J). This definition appears to limit the legality of post-viability abortions to situations where an abortion is required to preserve the woman's physical health, as opposed to her emotional or psychological health.

If the first exception applies (the abortion is medically necessary), the physician must conform with a number of requirements governing the performance of the abortion, unless a medical emergency exists. The statute sets forth five specific conditions which must be satisfied:

> (a) the physician who performs ... the abortion certifies in writing that that physician has determined, in good faith and in the exercise of reasonable medical judgment, that the abortion is necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.
>
> (b) the determination of [that] physician ... is concurred in by at least one other physician who certifies in writing that the concurring physician has determined, in good faith, in the exercise of reasonable medical judgment, and following a review of the available medical records of and any available tests pertaining to the pregnant woman, that the abortion is necessary to prevent the death of the pregnant woman or a serious risk of the

> substantial and irreversible impairment of a major bodily function of the pregnant woman.
>
> (c) the abortion is performed ... in a health care facility that has or has access to appropriate neonatal services for premature infants.
>
> (d) the physician ... terminate[s] the pregnancy in the manner that provides the best opportunity for the unborn human to survive, unless that physician determines, in good faith and in the exercise of reasonable medical judgment, that the termination of the pregnancy in that manner poses a significantly greater risk of the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman than would other available methods of abortion.
>
> (e) the physician ... has arranged for the attendance in the same room in which the abortion is to be performed ... of at least one other physician who is to take control of, provide immediate medical care for, and take all reasonable steps necessary to preserve the life and health of the unborn human immediately upon the unborn human's complete expulsion or extraction from the pregnant woman.

O.R.C. § 2919.17(B)(1)(a-e). These requirements may be summarized as follows: (1) the certification requirement, (2) the second physician concurrence requirement, (3) the neonatal facility requirement, (4) the choice of method requirement, and (5) the second physician attendance requirement.

In the event of a medical emergency, some or all of these requirements may be waived. The statute defines a medical emergency as:

> [A] condition that a pregnant woman's physician determines, in good faith and in the exercise of reasonable medical judgment, so complicates the woman's pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman

> that delay in the performance or inducement of the abortion would create.

O.R.C. § 2919.16(F). If a medical emergency exists, and is such that the physician cannot comply with one or more of the conditions, the physician may perform the abortion without fulfilling those statutory requirements.

The statute also creates a rebuttable presumption of viability at twenty-four weeks of gestational age. O.R.C. § 2919.17(C). The statute defines gestational age as:

> [T]he age of an unborn human as calculated from the first day of the last menstrual period of a pregnant woman.

O.R.C. § 2919.16(B).

A person who violates any of the above provisions is guilty of the crime of terminating a human pregnancy after viability, a fourth-degree felony. O.R.C. § 2919.17(D). In addition, that person may be civilly liable for compensatory and punitive damages. O.R.C. § 2307.52(B).

Plaintiffs have challenged seven separate provisions of this ban: (1) the determination of non-viability, (2) the definition of serious risk of the substantial and irreversible impairment of a major bodily function, (3) the definition of medical emergency, (4) the second physician concurrence requirement, (5) the choice of method requirement, (6) the second physician attendance requirement, and (7) the presumption of viability, including the statutory definition of gestational age. This Court will consider each of these challenges separately.

2. Determination of Non-viability

As noted, one exception to the ban on post-viability abortions allows a performance of a late-term abortion if the fetus is determined not to be viable. House Bill 135 defines viable as:

> [T]he stage of development of a human fetus at which in the determination of a physician, based on the particular facts of a woman's pregnancy that are known to the physician and in light of medical technology and information reasonably available to the physician, there is a realistic possibility of the maintaining and nourishing of a life outside of the womb with or without temporary artificial life-sustaining support.

O.R.C. § 2919.16(L) (emphasis added). This definition appears to allow the physician to rely on his own best clinical judgment in determining whether a fetus is viable.

The statute directs, however, that the physician cannot perform a late-term abortion unless the fetus is non-viable, as determined in the following manner:

> [T]he physician determines, in good faith and in the exercise of reasonable medical judgment, that the unborn human is not viable, and the physician makes that determination after performing a medical examination of the pregnant woman and after performing or causing the performing of gestational age, weight, lung maturity, or other tests of the unborn human that a reasonable physician making a determination as to whether an unborn human is or is not viable would perform or cause to be performed.

O.R.C. § 2919.18(A)(1) (emphasis added). Under this provision, it appears that the physician cannot rely solely on his or her own best clinical judgment in determining whether a fetus is viable; instead, that determination must be objectively reasonable as well, that is, reasonable to other

physicians, as well as to the physician making the determination.[31]

Plaintiff argues that because one provision (the definition of "viable") suggests that a viability determination may be made based on a physician's own best clinical judgment, whereas another provision (the determination of non-viability) requires that determination to be reasonable to other physicians as well, the statute is unclear as to what standard will be applied, and, thus, is unconstitutionally vague. This Court agrees that the quoted provisions of the statute set forth different standards for judging the legality of the physician's determination, and, thus, that Plaintiff has demonstrated a substantial likelihood of success of showing that the determination of non-viability, as required to satisfy one exception to the post-viability ban, at O.R.C. § 2919.17(A)(2), is unconstitutionally vague,

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[31] The Court draws this conclusion for two reasons. First, if the term "in the exercise of reasonable medical judgment" were a subjective standard, referring to the physician's own judgment, there would be no need to also require the physician to act "in good faith." It is a maxim of statutory construction that no word or words should be construed in such a way that they are surplusage.

Second, the term "reasonable," as it is used in the law generally, almost always incorporates an objective standard. The term "reasonable belief," for example, is commonly used to indicate both that the actor himself holds a belief, and that a reasonable man would hold that belief under the same circumstances. Black's Law Dictionary 874 (6th ed. 1991). The term "reasonable care" means "that degree of care which a person of ordinary prudence would exercise in the same or similar circumstances." Id. at 875. The term "reasonable cause" refers to the "basis for arrest without warrant, [with] such state of facts as would lead a man of ordinary care and prudence to believe ... that the person sought to be arrested is guilty of committing a crime." Id. These examples, which are not exhaustive, demonstrate that the term "reasonable" generally indicates a requirement that the action be reasonable to others. Absent a clear statutory intent to the contrary, this Court must construe the term "in the exercise of reasonable medical judgment" as incorporating an objective standard.

because it fails to provide the physician with fair warning of what legal standard will be applied, and, therefore, of what conduct will incur criminal and civil liability.[32]

3. Definition of "Serious Risk of Substantial and Irreversible Impairment of a Major Bodily Function"

The other exception to the post-viability ban requires a determination that the abortion is necessary to avert the death of the pregnant woman, or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function. The statute defines the term "serious risk of the substantial and irreversible impairment of a major bodily function" as follows:

> [A]ny medically diagnosed condition that so complicates the pregnancy of the woman as to directly or indirectly cause the substantial and irreversible impairment of a major bodily function, including, but not limited to, the following conditions: (1) pre-eclampsia; (2) inevitable abortion; (3) prematurely ruptured membrane; (4) diabetes; (5) multiple sclerosis.

O.R.C. § 2919.16(J). This definition appears to limit the legality of post-viability abortions to situations where an abortion is required to preserve the woman's physical health.

Plaintiff argues that this definition is too narrow, and does not allow the physician to consider other factors which

[32] Standing alone, the statute's definition of viable would appear to be unobjectionable, because it contains a purely subjective standard. In contrast, it could be argued that the determination of viability is void, either because its lack of a scientar requirement creates vagueness, or because the objective reasonableness standard will chill the physician's determination of non-viability, and create an undue burden. For this reason, this Court holds that the determination of non-viability, but not the definition of viable, is unconstitutional.

relate to the woman's health, including psychological and emotional factors. Plaintiff cites to a Supreme Court abortion case decided before abortion was legalized in Roe v. Wade, which discussed a statute that outlawed abortions except where a doctor determined that the abortion was necessary to preserve the mother's life or health:

> We agree ... 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.

Doe v. Bolton, 410 U.S. 179, 192 (1973). Plaintiff argues that House Bill 135 impermissibly limits the physician's discretion to determine whether an abortion is necessary to preserve the woman's health, because it limits the physician's consideration to medical factors relating to physical health.[33]

Defendant, however, cites to the Supreme Court's more recent decision in Casey, which upheld a similar definition of serious risk of the substantial and irreversible impairment of a major bodily function, that also limited the physician's

[33] The testimony in this case indicates that physicians do routinely consider non-medical factors that relate to health, when counseling women about having an abortion. Dr. Paula Hillard testified that she "takes into account the circumstances of the pregnancy which may be a result of rape or incest. So, I take into account the psychological health of the individual." (Tr., 11/8, at 29). Dr. John Doe Number Two testified that he deals with his patients "in a holistic approach, encompassing not only the physical consequences of the patient's particular situation, but encompassing her psychological well-being, both short and long term." (Tr., 12/7, at 22).

determination to consideration of medical factors. 112 S.Ct. at 2822. Defendant argues that the Supreme Court's decision in Casey governs here.

Plaintiff responds by pointing out that the challenged definition in Casey did not have the effect of preventing the performance of an abortion, altogether; instead, it merely allowed for an exception to the informed consent requirement, the 24-hour waiting period, and the parental consent provision. Thus, Plaintiff argues, the application of this definition to the challenged ban on post-viability abortions will have a more severe impact than it did in Casey, because it will completely prevent, and not merely delay, abortions that may be necessary to preserve the mother's overall health.

The testimony of Jane Doe Number Two is illustrative of how severe this impact may be. This witness testified to the pain and suffering she and her husband experienced when they discovered, during her twenty-second week of pregnancy, that their baby lacked a spine, had malfunctioning kidneys, and a clubbed foot (Tr., 12/6, at 151-53). A neonatal specialist advised them that after the baby was born, it would be paralyzed, at least from the waist down, would require immediate kidney dialysis, would need major surgery within thirty minutes of birth, and would probably be hydrocephalic (have water on the brain) (Id. at 154). Before this discovery, the witness testified that all indications pointed to an uneventful pregnancy (Id. at 155).

Jane Doe Number Two and her husband decided to terminate the pregnancy, rather than carry the baby to term. She explained their decision as follows:

> Just finding out about this, mentally, it just -- it crushed both of us. We were excited. We wanted a baby very badly. We had prayed for a girl, and I guess there was guilt involved because maybe we didn't pray for [the baby to be] healthy. And you felt selfish.
>
> I kept thinking, What did I do? You know, I didn't smoke. I didn't drink. I was eating right. This has to be one of our fault's. It has to be somebody's fault in some way that we're going through this....
>
> I couldn't imagine mentally going to term. When I found this out, it was on a Friday, and I had my [abortion] procedure scheduled for Tuesday; and just, during that time, all we did was cry, we beat ourselves up about what could we have done differently, when there was nothing we could have done.
>
> I just -- if I had to carry that baby to term, I am not sure I would have chosen to have children again.

Id. at 155-56. Jane Doe Number Two terminated her pregnancy by use of the D&X procedure, which was performed by Dr. Haskell. She testified that it was important to her that the fetus be intact, in order have an autopsy performed, and thereby to determine whether a genetic defect had caused the fetal anomalies (Id. at 158). The autopsy results indicated that the defect was not genetic. She and her husband have since had twin girls.

Under House Bill 135, it seems probable that a physician would have been forced to determine that Jane Doe Number Two's fetus had a realistic possibility of living after birth with life-sustaining support, although its prognosis was dismal. Therefore, if this Act had been in effect, Jane Doe Number Two

would have been forced to carry her baby to term, because there was no threat to her physical health, even though it seems clear that this would have been very damaging to her mental and emotional health.

It is also possible that a pregnant woman who is faced with such a law, and who is carrying a fetus with severe anomalies, might feel forced to abort her pregnancy before her twenty-fourth week of pregnancy merely in order to avoid the ban, even if she would prefer to try some measure, such as fetal surgery, to mitigate or cure the anomaly.

This possibility is suggested by the testimony of another of Dr. Haskell's patients, Jane Doe Number One, who terminated her most recent pregnancy on November 30, 1995. She first learned that there was a problem in her sixteenth week of pregnancy, when it was discovered that her baby had a bladder obstruction and could not urinate (Tr., 12/5, at 16-17). Once it was determined that the kidneys were functioning and that the baby was making good urine, this witness traveled to Detroit and underwent surgery to alleviate the bladder obstruction, in her eighteenth week (Id. at 17-18). That surgery was successful; however, the baby's ureter did not function properly, and the baby's right kidney failed as a consequence (Id.).

In her twentieth week of pregnancy, Jane Doe Number One traveled back to Detroit, and learned that her baby suffered from "prune belly syndrome." (Id. at 19). After reading about the syndrome and consulting with their physician, the witness

and her husband learned that their baby only had a twenty percent chance of survival at birth, that he would need a kidney transplant, and that he would probably die before the age of two (Id. at 19-20).

Jane Doe Number One was now in her twenty-second week of pregnancy. She and her husband consulted with their own doctor and a pediatric urologist, and then decided to terminate the pregnancy. She explained why they decided to have an abortion:

> Because the prognosis was so poor. We had seen that the left kidney had already become involved, and the left ureter was dilated. So, we felt certain that that kidney was going to fail, and we felt that the baby was not going to survive.... It's terribly agonizing to have a baby growing inside of you and to feel him kick and to know that he won't live. It's terrible.

Id. at 21. During her twenty-fourth week of pregnancy, Jane Doe Number One received an abortion by use of the D&X procedure, which was performed by Dr. Haskell. She compared her experience with the D&X procedure to a previous abortion by use of an induction procedure, by which she terminated another pregnancy with severe fetal anomalies:

> Physically ... there is no comparison. There was minimal pain. I was alert the entire time, and the procedure took, I would say, about an hour to an hour and a half. Physically, the [D&X] procedure is much -- it's terrible to say it was easier or better, but the procedure was much easier to endure.

Id. at 22-23. She testified that it was definitely helpful to have the D&X procedure available to her (Id. at 24).

In addition, Jane Doe Number One expressed concern that House Bill 135 would have forced her to make a decision to

terminate the baby before she had the opportunity to do everything possible to save it:

> In our situation, the kidneys were involved, and ... the baby's kidneys don't function until week sixteen or eighteen. So, therefore, we would not have known, or couldn't know, that there was a problem and totally tried to help the baby and make him a viable baby prior to that time. We'd have lost the opportunity .... We wouldn't have had a choice, or as many choices.

Id. Because her physical health would not have been threatened by carrying the baby to term, Jane Doe Number One would not, under House Bill 135, have been permitted to terminate her pregnancy after her baby was deemed to be viable.

The testimony of these two witnesses demonstrates the problems with House Bill 135's narrow definition of "serious risk of the substantial and irreversible impairment of a major bodily function," and its limitation to strictly medical factors. First, as in the case of Jane Doe Number Two, this definition will force women to carry babies to term which are likely to die before birth or immediately thereafter, or which have a prognosis so poor that its parents feel it would be best to terminate the pregnancy. This result could have a severe, negative impact on the mental and emotional health of the pregnant woman, as well as on the mental and emotional health of the baby's father. Second, as in the case of Jane Doe Number One, the possibility of being required to carry a severely deformed fetus to term might prompt pregnant women who are carrying fetuses with severe anomalies to abort before

their twenty-fourth week, simply in order to avoid the ban, even if they would prefer first to attempt some measures to improve their baby's chances of survival.

Finally, although there was no direct testimony from a victim of rape or incest, Dr. Hillard did testify about an eleven-year-old victim of incest, whose pregnancy was not diagnosed until approximately her twenty-second week, at which time legal charges were brought against her father (Tr., 11/8, at 52). The girl and her mother then requested that the pregnancy be terminated, and Dr. Hillard performed the procedure. Under House Bill 135, Dr. Hillard would have had to perform viability testing before terminating the pregnancy; if the fetus had been adjudged to be viable, and there were no physical threat to the girl's health, she would have been forced to carry her pregnancy to term. In this Court's view, it is inconceivable that the act of being forced to bear her father's child, could have failed to have a severe, negative, and lasting impact on this girl's emotional and psychological health.

The issue of whether a state may ban post-viability abortions except where necessary to preserve the woman's physical health, even if carrying the baby to term would cause her to suffer severe mental or emotional harm, appears to be an issue of first impression before this, or any, Court.

Under the authority of Doe v. Bolton, discussed above, this Court holds that a state may not constitutionally limit the provision of abortions only to those situations in which a

pregnant woman's physical health is threatened, because this impermissibly limits the physician's discretion to determine what measures are necessary to preserve her health.[34] Casey is not dispositive of this issue, because it only considered restrictions which delayed, but did not prevent, pre-viability abortions; whereas, in this case, the statute will completely prevent the performance of post-viability abortions that may, in appropriate medical judgment, be necessary to preserve the health of the pregnant woman. Under Casey, such a regulation is clearly unconstitutional. 112 S.Ct. at 2821. Accordingly, Plaintiff has demonstrated a substantial likelihood of success of showing that the Act's definition of "serious risk of the substantial and irreversible impairment of a major bodily function," which is limited to strictly medical factors in application to the ban on post-viability abortions, is unconstitutional.[35]

4. Definition of "Medical Emergency"

In its explanation of its Temporary Restraining Order, granted on November 13, 1995, this Court stated that Plaintiff had demonstrated a substantial likelihood of success of

[34] In addition, as highlighted by Jane Doe Number One's testimony, an exception which is limited only to preserving the pregnant woman's physical health may run the risk of impermissibly limiting the physician's discretion--and the mother's decision--to take whatever steps may be helpful (surgical or otherwise) in dealing with the specific problems facing that unborn child.

[35] As discussed in an earlier part of the opinion, this Court concludes that it need not apply the Salerno standard to restrictions on post-viability abortions, and that a pregnant woman may therefore succeed in a facial challenge to such a regulation, even if she cannot show that "no set of circumstances exists under which the law would be valid."

showing that the medical emergency definition was unconstitutional on two grounds: first, it lacked a mens rea, or scienter, requirement, and therefore was vague; second, it did not allow physicians to rely solely on their own best clinical judgment in determining that a medical emergency existed, and so would chill physicians from exercising their best medical judgment in deciding whether such an emergency exists.[36] Most of that discussion will be repeated here. In addition, the Court will address the effect of O.R.C. § 2901.21, which could potentially allow this Court to import a scienter requirement of "recklessness" into the medical emergency definition.

Before turning to the Act itself, it is advisable to define the meaning of the terms "scienter" and "mens rea", and to describe their importance in the law. The term "scienter" means "knowingly" and is "frequently used to signify the defendant's guilty knowledge." Black's Law Dictionary 1207 (5th ed. 1979). The term "mens rea" refers to a "guilty mind, a guilty or wrongful purpose, a criminal intent." Id. at 889. Both of these terms require that a defendant have some degree of guilty knowledge, or some degree of blameworthiness or

[36] On this point, it is significant that, as far as this Court is aware, no other court has been confronted with a medical emergency definition that includes an objective requirement, and therefore does not permit the physician to rely solely on his or her best clinical judgment.

This objective requirement seems certain to create a chilling effect--particularly given the lack of a scienter requirement. Even if the statute had a scienter requirement, it might still have a chilling effect, though to a lesser extent, given that the physician would still be subject to prosecution if other physicians disagreed with his or her determination. This Court therefore takes no position on whether an objective requirement in a medical emergency definition, with or without a scienter requirement, is also void for vagueness.

culpability, in order to be criminally liable. Statutes which do not contain such a requirement, and which impose criminal liability even if the defendant did not knowingly violate the law, or did not have a culpable state of mind, are known as "strict liability" statutes.

There is a strong presumption in our law favoring a mens rea or scienter requirement in statutes which create criminal liability. See Staples v. United States, 114 S.Ct. 1793, 1797 (1994) ("we must construe the statute in light of the background rules of common law ... in which the requirement of some mens rea for a crime is firmly embedded"); United States v. United States Gypsum Co., 438 U.S. 422, 437-38 (1978) ("the limited circumstances in which Congress has created and this Court has recognized [strict-liability] offenses... attest to their generally disfavored status"); Dennis v. United States, 341 U.S. 494, 500 (1951) ("the existence of a mens rea is the rule of, rather than the exception to, the principles of Anglo-American criminal jurisprudence"). The rationale for this presumption was eloquently set forth by Justice Jackson:

> The contention that an injury can amount to a crime only when inflicted by intention is no provincial or transient notion. It is as universal and persistent in mature systems of law as belief in freedom of the human will and a consequent ability and duty of the normal individual to choose between good and evil. A relation between some mental element and punishment for a harmful act is almost as instinctive as the child's familiar exculpatory "But I didn't mean to"....
>
> The unanimity with which [courts] have adhered to the central thought that wrongdoing must be conscious to be criminal is emphasized by the variety, disparity and confusion of their definitions of the requisite but elusive mental element... [including] such terms as "felonious

> intent," "criminal intent," "malice aforethought," "guilty knowledge," "fraudulent intent," "willfulness," "scienter," to denote guilty knowledge, or "mens rea," to signify an evil purpose or mental culpability. By use or combination of these various tokens, they have sought to protect those who were not blameworthy in mind from conviction of infamous common-law crimes.

Morissette v. United States, 342 U.S. 246, 250-52 (1952) (emphasis added). Although the presumption favoring a mens rea requirement is not as strong in statutes creating civil liability, because House Bill 135 imposes civil and criminal liability for the same actions, this Court must analyze the provisions of the Act in light of the presumption of a mens rea requirement. Having described the meaning and importance of a "guilty knowledge" requirement in laws creating criminal liability, this Court now turns to House Bill 135.

The medical emergency exception, which is defined in Ohio Revised Code section 2919.16(F), is employed in the ban on post-viability abortions. This Court concludes that because, under the definition of medical emergency, a physician may not rely alone on his own good-faith clinical judgment in determining that a medical emergency exists, and because both the medical emergency definition and provisions imposing criminal liability for violations of section 2919.17 lack scienter requirements, Plaintiff has demonstrated a substantial likelihood of success of showing that the medical emergency definition in the Act is unconstitutional.

House Bill 135 defines a medical emergency as follows:

> "Medical emergency" means a condition that a pregnant woman's physician determines, in good faith and in the exercise of reasonable medical judgment,

> so complicates the woman's pregnancy as to necessitate the immediate performance or inducement of an abortion in order to prevent the death of the pregnant woman or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman that delay in the performance or inducement of the abortion would create.

O.R.C. § 2919.16(F) (emphasis added). This definition includes subjective and objective requirements: the physician must believe, himself, that the abortion is necessary, and his belief must be objectively reasonable to other physicians. Under this definition, a finding that the physician failed to act in good faith is therefore not necessary to impose civil and criminal liability. One could act in good faith and according to one's own best medical judgment, and yet incur civil and criminal liability if, after the fact, the exercise of that medical judgment is determined by others to have been not objectively reasonable. In other words, physicians need not act willfully or recklessly in determining that a medical emergency exists in order to incur criminal liability; instead, they face liability even if they act in good faith, and according to their own best (albeit, in the later opinion of others, mistaken) medical judgment. Thus, this definition appears to create strict liability, that is, liability even if the physician acts in good faith, and without a culpable mental state, to comply with the statute.

Although this Court is unaware of any case which has considered the constitutionality of a similar provision, there are three cases which this Court finds to be relevant. In

Colautti v. Franklin, 439 U.S. 379, 396 (1979), the Supreme Court held unconstitutional a Pennsylvania provision which required physicians to determine non-viability before performing an abortion. If a physician failed to abide by specific requirements where there was "sufficient reason" to believe that the fetus "may be viable," he was civilly and criminally liable. Id. at 394. No language in the statute indicated that liability was to be predicated on a culpable state of mind. Id. at 380, n.1. The determination of non-viability was to be based on the physician's "experience, judgment, or professional competence." Id. at 380 n.1.

In concluding that the provision did not contain a scienter requirement, the Court found that neither Pennsylvania criminal law nor the Act itself "requires that the physician be culpable in failing to find sufficient reason to believe that the fetus may be viable." Id. at 394-95. The Court also noted that the subjective standard in the Act which is "keyed to the physician's individual skills and abilities ... is different from a requirement that the physician be culpable or blameworthy for his performance...." Id. at 395 n.12. The Supreme Court then held the provision void for vagueness due to its lack of a mens rea requirement:

> This Court has long recognized that the constitutionality of a vague statutory standard is closely related to whether that standard incorporates a requirement of mens rea. Because of the absence of a scienter requirement in the provision directing the physician to determine whether the fetus is or may be viable, the statute is little more than a 'trap for those who act in good faith.'

> The perils of strict criminal liability are particularly acute here because of the uncertainty of the viability determination itself. As the record in this case indicates, a physician determines whether or not a fetus is viable after considering a number of variables .... In the face of these uncertainties, it is not unlikely that experts will disagree .... The prospect of such disagreement, in conjunction with a statute imposing strict civil and criminal liability for an erroneous determination of viability, could have a profound chilling effect on the willingness of physicians to perform abortions ... in the manner indicated by their best medical judgment.

Id. at 395-96 (citations omitted) (emphasis added).

Colautti is directly applicable to this case, insofar as the determination of whether a medical emergency exists is similarly fraught with uncertainty, and is therefore equally susceptible to being disputed by experts at a later date, thereby resulting in criminal liability even where the physician acted in good faith. As noted, the medical emergency exception in House Bill 135 contains both a subjective and an objective requirement. Because both of these requirements must be met in order for the physician to avoid liability, and because there is no scienter requirement in this provision, a physician who performs a post-viability abortion under the medical emergency exception may be held liable even if he or she acted in good faith, as long as the physician was later determined, in the eyes of others, using 20/20 hindsight, to have acted unreasonably. Plaintiffs have demonstrated a substantial likelihood of success of showing that, given the short amount of time in which every decision regarding a medical emergency must be made, and given the

varying, highly individual factors which must be considered for each case, it is not unlikely that even where a physician acts in good faith, experts may later disagree as to the existence, immediacy, or extent of a medical emergency. As in Colautti, this prospect of disagreement, combined with the strict civil and criminal liability for even good-faith determinations, could chill physicians from performing post-viability abortions even where it is their best medical judgment that an abortion is required to preserve the life or health of a patient.

In so finding, this Court acknowledges that the "undue burden" analysis in Planned Parenthood v. Casey, 112 S.Ct. 2791 (1992), applies only to pre-viability abortions, and therefore does not apply to this provision governing the performance of post-viability abortions. Although it may seem that this would render any "chilling effect" irrelevant, this is manifestly not the case. In Casey, the Supreme Court recognized that the State's interest in the life of the fetus allows it to regulate or proscribe abortions after viability, except "where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother." 112 S.Ct. at 2821. Such is the situation here. If physicians were chilled from acting according to their own best medical judgment when determining whether a post-viability abortion is necessary to save the life of the mother, and were forced to resolve even the smallest doubt in favor of a refusal to act, this could have a profound,

negative impact on the State's interest in preserving the life and health of the mother, and on the pregnant woman's interest in her own life and health. It is this Court's belief that such a situation would offend the Constitution to an even greater degree than those situations in which a chilling effect precludes the performance of elective pre-viability abortions, which are not necessary to preserve the mother's life or health. Therefore, the analysis in Colautti is applicable to this case.

A more recent case which addresses this issue is Planned Parenthood, Sioux Falls Clinic v. Miller, 63 F.3d 1452 (8th Cir. 1995). In that case, the Court invalidated provisions regarding the performance of abortions which created civil and criminal liability for violations of South Dakota's parental-notice, mandatory-information, and medical-emergency requirements. The medical emergency provision in that case did not require the physician either to act in good faith, or to apply reasonable medical judgment; instead, it merely provided:

> If a medical emergency compels the performance of an abortion, the physician shall inform the female, prior to the abortion if possible, of the medical indications supporting his judgment that an abortion is necessary to avert her death or that delay will create serious risk of substantial and irreversible impairment of a major bodily function.

Id. at 1455 n.4. Other provisions imposed civil and criminal liability for violation of the medical emergency provision:

> [§ 34-23A-22] If an abortion occurs which is not in compliance with [the medical emergency provision], the person upon whom such an abortion has been

> performed ... may maintain an action against the person who performed the abortion for ten thousand dollars in punitive damages and treble whatever actual damages the plaintiff may have sustained.
>
> [34-23A-10.2] A physician who violates [the medical emergency provision] is guilty of a Class 2 misdemeanor.

Id. at 1455-56 n.5-6. None of these provisions contained a scienter or mens rea requirement on their face.

The District Court found that the provision creating criminal liability lacked a mens rea requirement, which "made it unconstitutionally vague, creating a 'chilling effect' so that physicians, who cannot guess the standard under which the courts will judge their conduct, would choose not to act at all." Id. at 1463. The District Court also invalidated the civil liability provision on similar grounds, after concluding that strict civil liability created an undue burden because it made it unlikely that any physician would perform abortions. Id.

The Eighth Circuit affirmed the lower court's decision, due to the statute's lack of a scienter requirement. It agreed that the provision creating criminal liability would create an undue burden by chilling the willingness of physicians to perform abortions. Id. at 1465. It further agreed that the provision creating civil liability--which did not require a finding that the defendant acted willfully, wantonly, or maliciously, before awarding punitive damages--was invalid:

> The potential civil liability for even good-faith, reasonable mistakes is more than enough to chill the willingness of physicians to perform abortions in

> South Dakota. We therefore hold that [this provision] is an undue burden on a woman's right to choose whether to terminate her pre-viability pregnancy.

Id. at 1467.

As noted, the medical emergency exception in House Bill 135 could impose civil and criminal liability even where the physician acted in good faith. Plaintiffs have demonstrated a substantial likelihood of success of showing that, given the fact that reasonable physicians might disagree as to the existence or immediacy of a medical emergency, this provision would create liability even for good-faith, reasonable mistakes. As in Miller, this result would chill the willingness of physicians to perform post-viability abortions even where they are necessary, in a medical emergency, to preserve the life and health of the mother.

A third case which supports this Court's findings is the Eighth Circuit's decision to uphold the North Dakota definition of a medical emergency, because it allowed the physician to rely on his or her own "best clinical judgment" in determining whether an emergency existed, and because the statute contained a scienter requirement. Fargo Women's Health Org. v. Schafer, 18 F.3d 526, 534 (8th Cir. 1994) ("It is the exercise of clinical judgment that saves the statute from vagueness... In addition, the North Dakota Act contains a scienter requirement that we believe prevents a finding of vagueness."). Accord Barnes v. Moore, 970 F.2d 12, 15 (5th Cir. 1992) (upholding medical emergency definition which allowed physician to rely on "best clinical judgment" and

contained scienter requirement for imposition of criminal liability). The statute at issue in Schafer defined a "medical emergency" as:

> that condition which, on the basis of the physician's best clinical judgment, so complicates a pregnancy as to necessitate an immediate abortion to avert the death of the mother or for which a twenty-four hour delay will create grave peril of immediate and irreversible loss of major bodily function.

Id. at 527, n.3 (emphasis added). Although the North Dakota statute did not expressly contain a scienter requirement, North Dakota criminal statutes which neither specify culpability, nor explicitly provide that culpability is not required, are construed as requiring a "willful" violation of the statute, which is further defined as conduct done "intentionally, knowingly, or recklessly." Id. at 534-35. Thus, although the statute containing the medical emergency definition was silent on the question of intent, the Eighth Circuit imported a scienter requirement into the statute.

The medical emergency definition in House Bill 135 differs in two significant respects from the definition in Schafer. First, the definition in House Bill 135 does not allow the physician to rely solely on his or her own best, good-faith medical judgment; instead, in addition to requiring that he or she act in good faith, it requires the physician to apply "reasonable medical judgment," which is an objective requirement, subject to second-guessing by other physicians. Second, the medical emergency provision creates strict liability because it lacks a scienter requirement; in

addition, the provisions creating criminal liability for violations of the ban on post-viability abortions, and of the viability testing requirement--both of which apply the medical emergency exception--lack scienter requirements. Therefore, the medical emergency exception in House Bill 135 appears to fail both of the tests upon which the North Dakota definition was held to be valid.

In its earlier opinion which explained its Temporary Restraining Order, this Court incorrectly stated that Ohio law does not allow courts to import a scienter requirement into criminal statutes that are silent on the issue of whether intent is a required element, relying on State v. Curry, 43 Ohio St.2d 66; 330 N.E.2d 720 (Ohio 1975) ("If the statute is silent on the question of intent, intent is not an element of the crime."). Plaintiff correctly pointed out that an Ohio law enacted immediately prior to Curry (although inapplicable to the facts in Curry, which arose prior to the effective date of the statute) might, however, allow this Court to import a scienter requirement into the medical emergency definition, even though that definition does not include any intent requirement. Section 2901.21(B) of the Ohio Revised Code provides that:

> When the section defining an offense does not specify any degree of culpability, and plainly indicates a purpose to impose strict criminal liability for the conduct described in such section, then culpability is not required for a person to be guilty of the offense. When the section neither specifies culpability nor plainly indicates a purpose to impose strict liability, recklessness is sufficient culpability to commit the offense.

Thus, if the statute does not plainly indicate an intent to impose strict liability, Ohio courts could import a scienter requirement of recklessness into the statute.

For two reasons, it is this Court's opinion that Ohio courts would decline to import a recklessness standard into the statute's requirement that a physician act "in the exercise of reasonable medical judgment" when determining whether a medical emergency exists.

First, both sections of the statute which apply the medical emergency definition--the ban on post-viability abortions, and the viability testing requirement, discussed infra--plainly indicate an intention to impose strict liability. Both of these sections state that "no person shall" perform the proscribed acts, and fail to specify any mental state. Ohio courts have held that similar laws which lack culpable mental states, and contain the term "no person shall...," plainly indicate an intention to impose strict liability. State v. Cheraso, 43 Ohio App. 3d 221, 223; 540 N.E.2d 326 (Ohio 1988); Village of Bridgeport v. Bowen, 1995 Ohio App. LEXIS 3892, at *6 (Ohio Ct. App. 1995). In addition, it is significant that although the post-viability ban and the viability testing requirement lack scienter requirements, the ban on use of the D&X procedure does contain a scienter requirement.[37] Ohio courts have held if portions

[37] O.R.C. § 2919.15(B) provides: "No person shall knowingly perform or attempt to perform a Dilation and Extraction procedure upon a pregnant

of a statute specify a culpable mental state, whereas other portions of the statute are silent as to the culpable mental state, this is a plain indication of an intent to impose strict liability in the latter sections or portions. State v. Wac, 68 Ohio St. 2d 84, 87; 428 N.E.2d 428 (Ohio 1981); City of Brecksville v. Marchetti, 1995 Ohio App. LEXIS 5164 (Ohio Ct. App. 1995). Based on the foregoing, this Court finds that the ban on post-viability abortions, and the viability testing requirement, "plainly indicate" an intention to create strict liability.

Even if this were not the case, however, Ohio courts would be unable to import a recklessness requirement without, in effect, rewriting the statute. This is because the statute's standard of "reasonableness," which imposes criminal liability if a physician acts unreasonably in determining that a medical emergency exists, is a lower standard for incurring criminal liability, from the perspective of the actor, than the standard of "recklessness."[38] If courts were to import a recklessness requirement into the medical emergency definition per the above-quoted section 2901.21(B), physicians would no

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woman." (emphasis added). This demonstrates that the General Assembly knows how to include a scienter requirement when that is its intention.

[38] The difference between the two standards is most easily discernible in the area of tort law. As an example, a physician who commits medical malpractice may be found guilty of negligence if he acts unreasonably. If he acts recklessly, however, he may be found guilty of gross negligence, which is a more serious offense, and exposes the physician to a greater degree of liability. See, e.g., Gearhart v. Angeloff, 17 Ohio App. 2d 143; 244 N.E.2d 802 (Ohio 1969) ("Punitive damages may be recovered in an action for negligence where such negligence is so gross as to show a reckless indifference to the rights and safety of other persons.") (quoting syllabus).

longer be liable if they acted unreasonably, i.e., negligently; instead, they would have to act recklessly in order to be liable. This would contradict the legislature's intent to create liability if a physician fails to act "in the exercise of reasonable medical judgment," and would amount to rewriting the statute, which courts may not do. Therefore, this Court concludes that a scienter requirement may not be imported into the definition of medical emergency.

On the basis of the foregoing, this Court concludes that the Plaintiffs have shown a substantial likelihood of demonstrating that the medical emergency exception in O.R.C. § 2919.16(F) is unconstitutional on two grounds: first, it appears to be vague, because both the definition of medical emergency, and the provisions imposing criminal (and civil) liability for violations of the post-viability ban and the viability testing requirement, lack scienter requirements; second, the requirement that a physician's determination be objectively reasonable--that is, reasonable to other physicians--would appear to create a chilling effect that would prevent physicians from performing post-viability abortions where, in their own best judgment, an abortion is necessary to preserve the life or health of the mother.

5. Second Physician Concurrence Requirement

If it is determined that a post-viability abortion is necessary to save the life of the mother, or to avoid a serious risk of the substantial and irreversible impairment of a major bodily function of the mother, the physician who

performs the abortion must comply with a number of conditions governing the performance of the abortion. One of these provisions requires that at least one other doctor concur, in writing, as to the necessity of the abortion:

> The determination of the physician who performs ... the abortion ... is concurred in by at least one other physician who certifies in writing that the concurring physician has determined, in good faith, in the exercise of reasonable medical judgment, and following a review of the available medical records of and any available tests [sic] results pertaining to the pregnant woman, that the abortion is necessary to prevent the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman.

O.R.C. § 2919.17(B)(1)(b). Plaintiff argues that this requirement is unconstitutional because it undermines the physician's judgment, imposes unnecessary and cumbersome delays, and will be difficult to satisfy because few physicians will be willing to concur, in writing, to an abortion's necessity.[39]

In Doe v. Bolton, the Supreme Court struck down a Georgia statute which required a physician to obtain confirmation of his decision to perform an abortion, from two other doctors. The Court reasoned that this requirement interfered with the physician's clinical judgment and discretion:

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[39] The testimony by doctors who perform late-term abortions indicates that this may be a valid concern. Dr. John Doe Number One testified that it would be "virtually impossible" to find a second physician who would be willing to certify in writing that an abortion is necessary: "No one wants to involve themselves in the issue. I think ... whether it would be fear of personal harm, whether it would be fear of being ostracized, fear of picketing, who would want to involve themselves in this issue. It would be much easier to ignore it rather than to have your name on that chart." (Tr., 12/5, at 51).

> The statute's emphasis ... is on the attending physician's 'best clinical judgment that an abortion is necessary.' That should be sufficient. The reasons for the presence of the confirmation step in the statute are perhaps apparent, but they are insufficient to withstand constitutional challenge.... If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment. If he fails in this, professional censure and deprivation of his license are available remedies. Required acquiescence by co-practitioners has no rational connection with a patient's needs and unduly infringes on the physician's right to practice.

410 U.S. at 199. This holding by the Supreme Court appears to govern the analysis of the concurrence requirement in this case, and Defendants have made no argument as to why it should not so apply. Accordingly, this Court finds that Plaintiff has demonstrated a substantial likelihood of success of showing that the second physician concurrence requirement in House Bill 135 is unconstitutional, because it impermissibly interferes with the physician's discretion.

Additionally, it appears to this Court that this requirement may be unconstitutional for the same reasons which render the medical emergency definition likely to be unconstitutional; to wit, the requirement that a second physician concur "in good faith [and] in the exercise of reasonable medical judgment" imposes criminal and civil liability on such concurring physicians who act according to their own best clinical judgment, without any criminal intent. This is likely to create a chilling effect which will deter physicians from concurring, in writing, that an abortion is medically necessary; this will chill the performance of

abortions which are necessary to preserve the life or health of the mother. Accordingly, this Court finds that Plaintiff has demonstrated a substantial likelihood of success of showing that the second physician concurrence requirement in House Bill 135 is unconstitutional, because it is likely to chill the performance of post-viability abortions which are necessary to preserve the life or health of the mother.

6. Choice of Method Requirement

Under House Bill 135, another condition which must be satisfied by a doctor performing a post-viability abortion is the so-called "choice of method" requirement:

> The physician who performs ... the abortion terminates ... the pregnancy in the manner that provides the best opportunity for the unborn human to survive, unless that physician determines, in good faith and in the exercise of reasonable medical judgment, that the termination of the pregnancy in that manner poses a significantly greater risk of the death of the pregnant woman or a serious risk of the substantial and irreversible impairment of a major bodily function of the pregnant woman than would other available methods of abortion.

O.R.C. § 2919.17(B)(1)(d) (emphasis added). Plaintiff argues that the requirement that a particular method of abortion be used unless it would pose a significantly greater risk of harm to the woman, is unconstitutional, because it requires the physician to "trade off" the woman's health for that of the fetus.

In Colautti v. Franklin, 439 U.S. 379, 400 (1979) the Supreme Court held that a statute which "requires the

physician to make a 'trade-off' between the woman's health and additional percentage points of fetal survival" posed serious ethical and constitutional difficulties.

Later, in Thornburgh v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 769 (1986), the Supreme Court invalidated a "choice of method" provision which was remarkably similar to the challenged provision in House Bill 135, reasoning that the words "significantly greater medical risk" required the woman to bear an additional, increased risk to her health, and so was unconstitutional. The provision at issue in Thornburgh read:

> Every person who performs or induces an abortion after an unborn child has been determined to be viable shall exercise that degree of professional skill, care and diligence ... and the abortion technique employed shall be that which would provide the best opportunity for the unborn child to be aborted alive unless, in the good faith judgment of the physician, that method or technique would present a significantly greater medical risk to the life or health of the pregnant woman .... Any person who intentionally, knowingly, or recklessly violates that provisions of this subsection commits a felony of the third degree.

476 U.S. at 768 n.13 (emphasis added). The only differences between this statute and the one at issue in the present case are: first, that the provision in Thornburgh allowed the physician to rely solely on his best clinical judgment, whereas the provision in House Bill 135 does not; second, that the statute in Thornburgh required a culpable mental state in order to impose criminal liability, whereas House Bill 135 does not require any criminal intent. The Thornburgh provision therefore seems far less egregious than that in

House Bill 135, which, because it does not allow the physician to rely solely on his or her best clinical judgment, and imposes criminal liability even if there were no criminal intent, seems likely to have a chilling effect on the physician's exercise of discretion in determining which abortion method may be used without causing a "significantly" greater risk to the woman's health. This chilling effect would negatively impact the woman's life and health. Accordingly, this Court finds that Plaintiff has demonstrated a substantial likelihood of success of showing that the choice of method provision in House Bill 135 is unconstitutional, because it will impermissibly interfere with the physician's exercise of discretion, to the detriment of the pregnant woman's health.

Given the similarity between the provision in Thornburgh and the challenged provision in this case, this Court further finds that Plaintiff has demonstrated a substantial likelihood of success of showing that the choice of method requirement is unconstitutional, because it "trades off" the health of the mother for that of the fetus, and requires her to bear an increased medical risk.

7. Second Physician Attendance Requirement

Another requirement in House Bill 135 pertaining to the provision of post-viability abortions requires that a second physician be present when the abortion is performed, to care for the fetus:

> The physician who performs ... the abortion has arranged for the attendance in the same room in which the abortion is to be performed ... of at least one other physician who is to take control of, provide immediate medical care for, and take all reasonable steps necessary to preserve the life and health of the unborn human immediately upon the unborn human's complete expulsion or extraction from the pregnant woman.

O.R.C. § 2919.17(B)(1)(e). Plaintiff also challenges the constitutionality of this provision.

The Supreme Court has considered similar provisions in two cases. In Planned Parenthood Ass'n of Kansas City v. Ashcroft, 462 U.S. 476, 485-86 (1983), the Supreme Court upheld a second physician attendance requirement because it served the state's compelling interest in preserving the life of the fetus. Although there was no clear medical emergency exception in that statute, the Court construed the requirement as allowing for an exception in medical emergencies. 462 U.S. at 485 n.8. In Thornburgh, however, the Court struck down a second physician attendance requirement, because it did not contain a valid medical emergency exception. 476 U.S. at 771. Therefore, the constitutionality of the second physician attendance requirement in House Bill 135 appears to depend upon the validity of the statute's medical emergency exception.

As discussed above, this Court has found that Plaintiff has demonstrated a substantial likelihood of success of showing that the medical emergency exception in House Bill 135 is unconstitutional, because it lacks a scienter requirement, and is thus vague, and because its objective reasonableness

standard will chill physicians from determining that a medical emergency exists. For that reason, this Court finds that Plaintiff has also demonstrated a substantial likelihood of success of showing that the second physician attendance requirement in House Bill 135 is unconstitutional.[40]

8. Rebuttable Presumption of Viability

For purposes of the ban on post-viability abortions, House Bill 135 creates a rebuttable presumption "that an unborn child of at least twenty-four weeks of gestational age is viable." O.R.C. § 2919.17(C). The statute defines gestational age as "the age of an unborn human as calculated from the first day of the last menstrual period of a pregnant woman." O.R.C. § 2919.16(B).

Plaintiff challenges this requirement on three grounds. First, Plaintiff argues that a rebuttable presumption of viability impermissibly limits the physician's discretion to determine viability. Second, Plaintiff argues that because the last menstrual period (LMP) method of calculating gestational age generally produces an age that is two weeks earlier than the age from conception, the presumption actually attaches at twenty-two weeks, when fetuses are not viable, and so is necessarily invalid. Finally, Plaintiff argues that

[40] In this Court's opinion, the chilling argument which applied to the second physician concurrence requirement would not apply to this requirement, which does not require the second physician to give a written endorsement of the abortion, and merely requires him or her to perform the arguably laudable role of caring for the fetus.

because the presumption can only be rebutted after the physician is arrested and prosecuted, it will chill physicians from determining that fetuses of a gestational age of twenty-four or more weeks are not viable, and will constitute an undue burden on the right to seek a pre-viability abortion.

This Court declines to consider the likelihood of success of any of these arguments. Although the Supreme Court's decision in Webster v. Reproductive Health Services, 492 U.S. 490 (1989), indicates that it may be constitutionally permissible for a state to impose a rebuttable presumption of viability,[41] this Court finds it unnecessary to reach this issue at this time, because, as was discussed supra, Plaintiff has demonstrated a substantial likelihood of success of showing that the determination of non-viability in House Bill 135 is unconstitutionally vague, as the objective standard in that determination conflicts with the purely subjective standard in the statute's definition of viable in O.R.C. § 2919.16(L). If this Court determines, after a hearing on the merits, that the determination of non-viability is unconstitutional, then any portion of the statute which requires a physician to either determine viability, or rebut a presumption of viability, must, likewise, be invalidated.

[41] In Webster, a five-member majority of the Supreme Court upheld a viability testing requirement that attached at the twentieth week of pregnancy. Although the challenged statute also imposed "what is essentially a presumption of viability at 20 weeks," id. at 515, Justice O'Connor pointed out in her concurring opinion that the constitutionality of that presumption was not an issue before the Court. Id. at 526. Justice O'Connor did state, however, that, in her opinion, an argument that this presumption of viability impermissibly restricted the judgment of the physician would probably be unsuccessful. Id. at 527.

Accordingly, the Court finds it unnecessary to reach any of Plaintiff's arguments, in order to find that Plaintiff has demonstrated a substantial likelihood of success of showing that the rebuttable presumption of viability is unconstitutional, for the reason that the statute's mandated determination of non-viability is invalid.

E. Viability Testing Requirement

The third major portion of House Bill 135 creates a viability testing requirement at the twenty-second week of pregnancy, which must be complied with before an abortion after that time may be performed:

> Except as provided in [the medical emergency exception], no physician shall perform ... an abortion upon a pregnant woman after the beginning of her twenty-second week of pregnancy unless, prior to the performance [of] ... the abortion, the physician determines, in good faith and in the exercise of reasonable medical judgment, that the unborn human is not viable, and the physician makes that determination after performing a medical examination of the pregnant woman and after performing or causing the performing of gestational age, weight, lung maturity, or other tests of the unborn human that a reasonable physician making a determination as to whether an unborn human is or is not viable would perform or cause to be performed.

O.R.C. § 2919.18(A)(1). In addition to performing these tests, the physician may not perform the abortion "without first entering the determination ... and the associated findings of the medical examination and tests described ... in the medical records of the pregnant woman." § 2919.18(A)(2). The physician need not comply with either of these requirements if a medical emergency exists. § 2919.18(A)(3).

Violation of this section of the Act is a fourth degree misdemeanor. § 2919.18(B).

Although a viability testing requirement was upheld in Webster, 492 U.S. at 490, the viability testing requirement in House Bill 135 appears to be unconstitutional for two reasons. First, for the reasons given in an earlier part of this opinion, the statute's determination of non-viability appears to be unconstitutionally vague. Second, for the reasons also given in an earlier part of this opinion, the definition of medical emergency appears to lack a mens rea requirement, which creates vagueness, and also appears likely to create a chilling effect that would unconstitutionally jeopardize the life or health of pregnant women needing an abortion, due to its requirement that a physician's determination that a medical emergency exists be objectively reasonable.

Accordingly, Plaintiff has demonstrated a substantial likelihood of success of showing that the challenged viability testing requirement is unconstitutional, for two reasons. First, it lacks a valid medical emergency exception. Second, the definition of viable in O.R.C. § 2919.16(L), which applies to this viability testing requirement,[42] allows the physician to rely solely on his or her own best clinical judgment, whereas this mandated determination of non-viability also imposes a requirement that the physician's determination be

[42] The definitions in O.R.C. § 2919.16 apply both to the post-viability ban in § 2919.17, and to the viability testing requirement in § 2919.18. If the definition is flawed, then a regulation or requirement based on that definition is also flawed.

objectively reasonable; this conflict creates an ambiguity which appears to render this portion of the Act unconstitutionally vague, because the physician has no clear guidance as to what standard will be applied in judging whether he or she is criminally and civilly liable.

III. Whether Issuance of an Injunction Will Save Plaintiff from Irreparable Injury

Having considered the substantial likelihood of Plaintiff's success on the merits, this Court now turns to the remaining prongs governing the issuance of a preliminary injunction. The second prong of the preliminary injunction standard requires the Court to make findings as to whether the issuance of an injunction is necessary to save the plaintiff from irreparable injury.

Importantly, Plaintiff Haskell has standing in this lawsuit not only to raise his own rights, but also to raise the rights of his patients. Therefore, this Court need not decide whether the harm which Plaintiff Haskell will suffer if prosecuted criminally or sued civilly under the Act, is irreparable. Instead, this Court will focus on the harm which will be suffered by his patients.

Both Jane Doe Number One and Jane Doe Number Two testified that they chose to terminate their pregnancies, late in the second trimester, after discovering that their unborn children had severe anomalies. If this Act had been in effect, either or both of these women may have been prevented

from terminating their pregnancies, under either the provisions of the viability testing requirement, or the provisions of the post-viability ban. In both cases, the fetus may well have been determined to have been viable, and would not have been able to be aborted.

In this Court's opinion, the cost of being forced by the state to carry to term a child without a spine, or functioning kidneys, or with other such severe defects, is beyond description. It is difficult to imagine how horrible it would be to knowingly carry a child to term who is dying, or who has no reasonable chance of normal physical development.[43]

In addition, it is impossible to calculate the harm which would be suffered by a pregnant woman who, though she would prefer to try surgery or other methods to mitigate her unborn child's severe defects, is compelled by this ban on post-viability abortions--which only allows an abortion if her physical health is in danger--to terminate her pregnancy before the ban can apply to her, instead of taking measures to help her unborn child, because she feared the emotional and mental cost of carrying a child to term who had such severe defects. It is difficult to imagine a clearer example of irreparable harm, than is evidenced by these two scenarios.

[43] Although it may seem that a child who was certain to die, and had no reasonable chance for normal development, would not be considered to be viable, the testimony in this case indicates otherwise. Dr. Harlan Giles, for example, testified that babies with certain chromosomal defects are considered to be viable "even though these children have no reasonable chance for normal mental motor development.... even though it's a very serious defect, [and] even though it usually leads to death in the nursery." (Tr., 11/13, at 286).

As for the harm suffered by pregnant women who are unable to terminate their pregnancies by means of the D&X procedure, Jane Doe Number Two testified that the procedure was helpful to her because it allowed her fetus to be aborted intact, which was necessary for the performance of an autopsy. After learning that the defect was not genetic, she and her husband had more children. Jane Doe Number One testified that the D&X procedure was much easier to endure than an earlier abortion performed by use of an induction procedure. In addition, this Court has held that Plaintiff has demonstrated a substantial likelihood of success of showing that the alternatives to the D&X procedure--induction methods, hysterotomies, and hysterectomies--are neither as safe to the mother's health, nor as available to women seeking non-therapeutic abortions. Pregnant women in this state who are unable to terminate their pregnancies by means of the D&X procedure may therefore suffer irreparable harm, either because other abortion methods are not as safe for their health, or because other abortion methods are not as available to them.

Based on the above, this Court concludes that a preliminary injunction would serve to prevent irreparable injury to the patients of Plaintiff Haskell.

IV. Whether Issuance of an Injunction Would Harm Others

The third prong of the preliminary injunction standard traditionally requires this Court to "balance the equities" in considering whether the harm to the Defendant resulting from issuing the injunction, would outweigh the harm to the Plaintiff resulting from denying the injunction.

As far as the Defendants' interests are concerned, a preliminary injunction will merely maintain the status quo while the constitutionality of this legislation is decided. The potential for irreparable injury to some of Plaintiff's patients has already been discussed; in addition, other pregnant women may be harmed by specific provisions of the Act. For example, the objective reasonableness standard in the medical emergency definition may chill the discretion of a pregnant woman's physician in determining that a medical emergency exists, to the detriment of her health. As another example, the apparent vagueness of the determination of non-viability may chill physicians from determining that certain fetuses are not viable, and, therefore, may place an undue burden in the path of a woman seeking a pre-viability abortion. In this Court's opinion, therefore, the harm to the patients whom Plaintiff represents, should the preliminary injunction be denied, would be greater than the harm to the Defendants, if the injunction were granted.

V. Whether Issuance of an Injunction Would Serve the Public Interest

The final prong of the preliminary injunction standard requires this Court to determine whether the issuance of an injunction would serve the public interest.

In this Court's opinion, the public interest is best served by a full and fair hearing on the merits of the constitutionality of this legislation, particularly in view of the fact that the Plaintiff has demonstrated a substantial likelihood of success of showing that numerous provisions in House Bill 135 are unconstitutional. Accordingly, the Court concludes that the public interest would be served by the issuance of a preliminary injunction.

VI. Conclusion/Conclusions of Law

To summarize, this Court has held that all four prongs of the preliminary injunction standard weigh in favor of granting a preliminary injunction, which enjoins enforcement of all provisions of House Bill 135. In addition, this Court has held:

(1) it has federal question jurisdiction, under 28 U.S.C. § 1331, over this constitutional challenge to a state statute,

(2) Plaintiff Haskell may seek pre-enforcement review of House Bill 135, and this lawsuit is therefore ripe;

(3) Plaintiff Haskell has standing to bring this action, and may assert both his own rights and the rights of his patients;

(4) the Salerno standard no longer applies to a facial challenge to pre-viability abortion regulations;

(5) the Salerno standard does not apply to a facial challenge to post-viability abortion regulations;

(6) although a state may proscribe most abortions subsequent to viability, the state may not take away a pregnant woman's right to have a post-viability abortion where, in appropriate medical judgment, such an abortion is necessary to preserve her life or health--accordingly, strict scrutiny should not be utilized in this analysis;

(7) Plaintiff has demonstrated a substantial likelihood of success of showing that the definition of "Dilation and Extraction procedure" in O.R.C. § 2919.15(A) is unconstitutional, because of vagueness;

(8) Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on use of the D&X procedure in § 2919.15(B) is unconstitutional, because the state may not ban an abortion procedure unless there are safe and available alternatives, and because this ban may chill the exercise of a woman's right to a pre-viability abortion;

(9) Plaintiff has demonstrated a substantial likelihood of success of showing that the ban on use of the D&X procedure does not serve the stated interest of preventing unnecessary cruelty to the fetus;

(10) Plaintiff has demonstrated a substantial likelihood of success of showing that the mandated determination of non-viability in § 2919.18(A)(1), as applied to the post-viability ban (§ 2919.17(A)(2)) and the viability testing requirement (§ 2919.18), is unconstitutional, because the objective

standard in that determination is inconsistent with the purely subjective standard in the definition of viable in § 2919.16(L);

(11) Plaintiff has demonstrated a substantial likelihood of success of showing that the definition of serious risk of the substantial and irreversible impairment of a major bodily function in § 2919.16(J), as it applies to one allowable exception to the ban on post viability abortions, in § 2919.17(A)(1), is unconstitutional, because its limitation to factors relating solely to physical health impermissibly restricts the physician's determination of whether an abortion is necessary to preserve the health of the pregnant woman;

(12) Plaintiff has demonstrated a substantial likelihood of success of showing that the definition of medical emergency in § 2919.16(F), as it applies to the post-viability ban (§ 2919.17) and the viability testing requirement (§ 2919.18), is unconstitutional, because it lacks a scienter requirement, and thus is vague, and because it does not allow the physician to rely on his or her own best clinical judgment that a medical emergency exists, and so may chill physicians from determining that a medical emergency exists even where necessary to preserve the pregnant woman's life or health;

(13) Plaintiff has demonstrated a substantial likelihood of success of showing that the second physician concurrence requirement in § 2919.17(B)(1)(b) is unconstitutional, because it impermissibly limits the primary physician's discretion, and because it may chill the performance of post-viability

abortions that are necessary to preserve the life or health of the mother;

(14) Plaintiff has demonstrated a substantial likelihood of success of showing that the choice of method requirement in § 2919.17(B)(1)(d) is unconstitutional, because it requires the woman to bear an increased medical risk, forces the physician to "trade off" the pregnant woman's health for that of the fetus, and impermissibly interferes with the physician's exercise of discretion, to the detriment of the pregnant woman's health;

(15) Plaintiff has demonstrated a substantial likelihood of success of showing that the second physician attendance requirement in § 2919.17(B)(1)(e) is unconstitutional, because the medical emergency exception appears to be unconstitutional;

(16) Plaintiff has demonstrated a substantial likelihood of success of showing that the rebuttable presumption of viability in § 2919.17(C) is unconstitutional, because the mandated determination of non-viability in House Bill 135 appears to be unconstitutional;

(17) Plaintiff has demonstrated a substantial likelihood of success of showing that the viability testing requirement in § 2919.18(A)(1) is unconstitutional, because the medical emergency definition appears to be unconstitutional, and because the mandated determination of non-viability appears to be unconstitutional.

This Court further concludes that the issuance of an injunction will prevent irreparable injury to the patients of Plaintiff Haskell, that such injury outweighs the injury which will be suffered by Defendants if this injunction is issued, and that the public interest would be served by the issuance of this preliminary injunction.[44]

WHEREFORE, based upon the aforesaid, this Court orders that the Plaintiff's Motion for a Preliminary Injunction be GRANTED, effective as of the filing of this opinion. Accordingly, Defendants, their employees, agents, and servants are preliminarily enjoined from enforcing any provision of House Bill 135. Having considered the issue of bond as is required by Rule 65 of the Federal Rules of Civil Procedure,

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[44] This Court adopts the findings set forth within this Opinion as its Findings of Fact, for purposes of Rule 52(a) of the Federal Rules of Civil Procedure. This Court finds support for its lack of separate findings of fact in the Supreme Court's holding "that there must be findings, stated either in the court's opinion or separately, which are sufficient to indicate the factual basis for the ultimate conclusion." Kelley v. Everglades Drainage Dist., 319 U.S. 415, 422 (1943), quoted with approval in B.F. Goodrich Co. v. Rubber Latex Prod., Inc., 400 F.2d 401, 402 (6th Cir. 1968); see also Slanco v. United Counties, No. 82-3115 (6th Cir. 1983) (allowing district court to adopt oral opinion as findings of fact and conclusions of law for purposes of Rule 52); Craggett v. Bd. of Educ. of Cleveland City Sch. Dist., 338 F.2d 941 (6th Cir. 1964) (allowing district court to adopt written memorandum as findings of fact and conclusions of law for purposes of Rule 52).

However, this Court assures Counsel for the Plaintiff and the state Defendants that their detailed, proposed Findings of Fact and Conclusions of Law were thoroughly reviewed and form the basis of much of the discussion contained herein. This includes the submissions of the state Defendants which were not fully delivered to this Court's chambers, by facsimile, until 3:45 a.m., this date. In short, the diligent efforts of Counsel have not been in vain.

For purposes of completing the record, this Court also renders the following evidentiary rulings: Plaintiff's Exhibit 24 is admitted, for the limited purpose of showing the position of the American College of Obstetricians and Gynecologists on the federal Partial Birth Abortion Act of 1995, but not for the truth of the statements asserted therein. Plaintiff's Exhibit 25 is excluded, as hearsay.

this Court concludes that no bond should be required of the Plaintiff.

Counsel listed below will note that a brief telephone conference will be held, between Court and Counsel, beginning at 4:00 p.m., Eastern time, on Friday, December 22, 1995, for the express purpose of determining further procedures to be followed in this litigation. Specifically, Counsel should be prepared to discuss whether they wish to proceed to trial upon the merits of the captioned cause, at a date in mid-1996, or whether, in the alternative, Defendants wish to take an immediate appeal of this decision to the Sixth Circuit Court of Appeals, pursuant to 28 U.S.C. § 1292(a)(1).

December 13, 1995

WALTER HERBERT RICE
UNITED STATES DISTRICT JUDGE

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