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2008

Built in Obsolescence: The Coming End to the Abortion Debate

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Built in Obsolescence: The Coming End to the Abortion Debate:¹
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Abstract

The current legal and political dispute is grounded in the misconception that the decision to have an abortion is one decision, a decision to terminate a fetus. In fact, in choosing an abortion, a woman is actually making two distinct choices: first, she is choosing to terminate her pregnancy, that is, remove the fetus from her body; and, second, she is choosing to terminate the fetus. Currently, a woman's decision to remove the fetus from her body (the "autonomy decision") is necessarily a medical decision to terminate the fetus (the "reproductive decision"). The current argument in favor of legalized abortion assumes that the woman's autonomy interest is inseparable from the reproductive decision. Over time, medicine will develop to the point where the decisions can be made separately with a live birth of a fetus creating no more risk to the woman than an ordinary abortion. Under those circumstances, the Supreme Court's current abortion jurisprudence offers no legal reason for a woman's interests to be given primacy in the reproductive choice over the reproductive interest of man or the state. For more than thirty years, one side of the abortion debate has argued about a right to life while the other side has argued about right to autonomy. The changing medical technology will allow the law to satisfy both sides. In the future, the law will be able to allow a woman to choose early in the pregnancy not to carry to term while making it illegal to terminate the life of a fetus. A change that will have significant consequences for all parties involved: women, men and the state.

Introduction

Opponents of unfettered access to abortion argue that the fetus enjoys, from the moment of its conception, the same inalienable "right to life," that any other human enjoys. Advocates of unfettered access to abortion argue that the right to an abortion is protected by the Constitution and based on a woman's right to privacy. This argument has played out repeatedly in the courts since *Roe v. Wade*⁴ and was repeated most recently when the Supreme Court considered a state ban on "partial birth" abortions. Amazingly, advocates on both sides have missed the true significance of "partial birth" abortion; that is, partial birth abortion is an example of the built-in

¹ Thanks 15th Annual Delaware Feminist Conference; Marina Angel; Andrea Seielstad; Kimberly O'Leary; The Feminist Conference; Wiedener University

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⁴ *Roe v. Wade*, 410 U.S. 113, 117-118 (1973).

obsolescence of the controversy over abortion, and foreshadows the end of the abortion debate. Both sides of the debate have all but ignored the impact of changing medical technology on the debate as it is currently framed, and, by extension, on reproductive rights.

The current legal and political dispute is grounded in the misconception that the decision to have an abortion is one decision, a decision to terminate a fetus. In fact, in choosing an abortion, a woman is actually making two distinct choices: first, she is choosing to terminate her pregnancy, that is, remove the fetus from her body; and, second, she is choosing to terminate the fetus. Currently, a woman's decision to remove the fetus from her body (the "autonomy decision") is necessarily a medical decision to terminate the fetus (the "reproductive decision"). The current argument in favor of legalized abortion assumes that the woman's autonomy interest is inseparable from the reproductive decision. However, as Laurence Tribe noted in 1973:

Once the fetus can be severed from the womb by a process which enables it to survive, leaving the abortion decision to private choice would confer not only a right to *remove* an unwanted fetus from one's body but also an entirely separate right to *ensure its death*.⁵

Currently, the first decision inevitably leads to the second, however, changing medical technology ensures that this will not always be the case. Over time, medicine will develop to the point where the decisions can be made separately with a live birth of a fetus creating no more risk to the woman than an ordinary abortion. Under those circumstances, the Supreme Court's current abortion jurisprudence offers no legal reason for a woman's interests to be given primacy in the reproductive choice. For more than thirty years, one side of the abortion debate has argued about a right to life while the other side has argued about right to autonomy. The changing medical technology will allow the law to satisfy both sides. In the future, the law will be able to allow a woman to choose not to carry to term while making it illegal to terminate the life of a fetus.

Legal Framework of the Abortion Debate

In the 1960's, Texas law criminalized all abortions except those undertaken on medical advice for the purpose of saving the mother's life.⁶ In the early part of 1970 a single pregnant woman, who at the time wished to remain anonymous, challenged the constitutionality of the Texas criminal laws.⁷ A three judge District Court panel declared the Texas laws violated the woman's Ninth and Fourteenth Amendment rights.⁸ The Supreme Court, in 1973, affirmed, in relevant part, the District Court's ruling.⁹ The Supreme Court's decision in Roe v. Wade had three central parts. The Court affirmed: (1) a woman's right to choose an abortion without undue influence from the state in the first two trimesters; (2) the state's power to restrict abortions in the third trimester; and, (3) the state's interest in the woman's health and the potential life of the fetus.¹⁰ The Court's decision was grounded in a right to privacy implicit in the Constitution.¹¹

⁵ The Supreme Court, 1972 Term-foreword: Towards a Model Roles in the Due Process of Life and Law, 87 Harv.L.Rev. 1, 27 (1973).

⁶ Roe v. Wade, 410 U.S. 113, 117-118 (1973).

⁷ Id.

⁸ Id. at 121-22.

⁹ Id. at 164-66.

¹⁰ Id. at 164.

Roe was not the final word on abortion, and since that decision the Court has been asked to address the issue on several occasions. Shortly after Roe, the Court reaffirmed and refined its decision.

In Planned Parenthood v. Danforth, the Supreme Court struck down a spousal notification provision that required a woman seeking an abortion to notify her spouse before an abortion could be performed in the first 12 weeks of a pregnancy¹². In its holding, the Court reasoned that a state could not “delegate to a spouse a veto power which the state itself is absolutely and totally prohibited from exercising during the first trimester of pregnancy.”¹³ Since the state could not regulate or proscribe abortion during the first stage, it could not delegate authority to any particular person to prevent abortion during that same period.¹⁴ Danforth, is as informative for what it does not say, as for what it does. The Court’s analysis in Danforth focused on a question of timing as much as anything else. The Danforth decision struck down a state law that regulated abortion pre-viability, and did so because the state had no authority to regulate abortion during that period. Implicit in Danforth is the understanding that the state may delegate its authority post-viability and may consider the father’s reproductive interests.

In Planned Parenthood v. Casey, the Supreme Court again reaffirmed its decisions in Roe and Danforth.¹⁵ However, the court also refined its jurisprudence regarding abortion. In Roe and Danforth, the Court talked about fetal viability without clearly defining it, instead discussing a trimester framework that relied on what was the then state of medicine which acknowledged that a fetus was viable after two trimesters of gestation. In Casey the Court departed from that definition, defining viability generally as, “that time when the fetus was potentially able to live outside the womb, albeit with artificial aid.” Casey allows for the use of technology in radically shrinking pre-viability.¹⁶

The Court’s jurisprudence on abortion makes one concept clear, that while a woman’s interest in terminating an unwanted pregnancy is given primacy pre-viability, the state’s interest is paramount post-viability. This concept was never clearer than in the Court’s 2007 ruling in Gonzales v. Carhart.¹⁷ In Carhart, the Court upheld a state’s ban on a late-term abortion procedure, reiterating the pre- and post-viability distinction.¹⁸ It is this distinction which raises serious concerns regarding the future of reproductive rights.

The Impact of Medical Technology

Each day brings medical advances that blurs the bright line third trimester rule of Roe v. Wade and turns back the viability clock established in Planned Parenthood v. Casey. To start, there is a significant difference in the survival rate of premature infants now compared to the early 1970s when Roe was decided. At the time of Roe v Wade, fetus/infants born before 24

¹¹ Id. at 155.

¹² Planned Parenthood of Central Missouri v. Danforth, 428 U.S. 52 (1976).

¹³ Id. at 69.

¹⁴ Id. at 70.

¹⁵ Planned Parenthood of Southeastern Pennsylvania v. Casey, 505 U.S. 833 (1992).

¹⁶ Id. at 860.

¹⁷ 127 S.Ct. 1610 (2007).

¹⁸ Id. at 1626-27.

weeks had very little chance of survival.¹⁹ By 1989, the age at which a fetus could be expected to have a reasonable shot at survival had moved below 24 weeks.²⁰ Today, over 50% of those infants survive, although some with seriously compromised health.²¹

Medical technology has always had a significant impact on the survival rates of preterm infants. For instances, the development of antibiotics and blood transfusions, advances in the prenatal and neonatal technology, increased understanding of the physiology and pathology of the newborns, and the development of the subspecialty in pediatrics of neonatologist significantly increased the survival rates of preterm infants.²² Perhaps the most significant development in the survival of preterm infants has been the medical specialty neonatologist and neonatal intensive care unit. Neonatal intensive care units developed in the 1950's and 1960's provide specialize care of ill or premature infants.²³ They provide better temperature support,

¹⁹ Roe v. Wade, *supra* at 160.

²⁰ See generally, Neonatal mortality and morbidity rates in late preterm births compared with births at term. McIntire Donald D; Leveno Kenneth J Department of Obstetrics and Gynecology, The University of Texas Southwestern Medical Center, Dallas, Texas 75235-9032, USA.; Webster v. Reproductive Health Services, 492 U.S. 490 (1989). Plaintiff's brought challenging the constitutionality of a Missouri statute which set forth in part: (1) that the life of each human being begins at conception, (2) that a physician, prior to performing an abortion on any woman whom he has reason to believe is 20 or more weeks pregnant, must ascertain whether the fetus is viable by performing medical tests to determine the fetus' gestational age, weight and lung maturity. See also Mo. Rev. Stat. ' 1.205(1), (2) (1986)

²¹ Cf., Louis JM, Ehrenberg HM, Collin MF, Mercer BM. 2004. Perinatal intervention and neonatal outcomes near the limit of viability. *Am. J. Obstet. Gynecol.* 191(4):1398-1402. (noting that obstetric intervention and aggressive neonatal resuscitation have increased for pregnancies delivered between 23 and 26 weeks of gestation ; that survival has increased over time and with advancing gestational age at delivery, short-term morbidity in survivors is similar, regardless of gestational age); McElrath, Thomas F., et al. 2002. Contemporary Trends in the Management of Delivery at 23 Weeks' Gestation. *American Journal of Perinatology* 19, no. 1:009-016(Reporting that most respondents underestimate the consensus in the most recent literature on survival of infants born at 23 to 24 weeks); Extreme prematurity effects the development of the fetus' lungs and invariably leaves the infant with severe respiratory problems. D. G. Jones *Manufacturing Humans* (1987) pp. 94-112; J. Bion *The Outcomes of Neonatal Intensive Care* (1995) 310 *British Medical Journal* pp.681-684; M.L. Lupton, *Artificial Wombs: Medical Miracle, Legal Nightmare*, 16 *Medicine and Law* 621, 623 (1997); Bartels Dorothee B; Wenzlaff Paul; Poets Christian F, *Obstetrical volume and early neonatal mortality in preterm infants*, 22(11) *European journal of epidemiology* 791-8 (2007)

²² See P.M. Dunn, *The Van Deventure Lecture. 'Prematurity: the changing scene'*. 33 *Eur. J. Obstetrics Gynecology Reprod. Biology* 33, 69 (1989); cf., *Trends in preterm-related infant mortality by race and ethnicity, United States, 1999-2004*. MacDorman Marian F; Callaghan William M; Mathews T J; Hoyert Donna L; Kochanek Kenneth D, 37(4) *International journal of health services - planning, administration, evaluation*, 635-41 (2007).

²³ Office of Technology Assessment, U.S. Congress, *The Implications of Cost-Effectiveness Analysis of Medical Technology, Background Paper No. 2: Case Studies of Medical Technologies, Case Study No. 10: The Costs and Effectiveness of Neonatal Intensive Care* 9 (1981)

isolation from infection risk, specialized feeding, respiratory support and access to specialized physicians, equipment and resources.²⁴ Over the next 10-20 years, premature infants will survive at increasingly younger development and at an increasingly higher rate.²⁵

In addition, during the next 20 years it is predicted that an artificial womb capable of sustaining a fetus to term will become reality.²⁶ There are many potential uses for an artificial womb including providing a drug/alcohol free environment during gestation; turning multiple pregnancies from fertility treatment to a single pregnancy; as an alternative to human surrogacy and, of course, as an alternative to fetal termination.²⁷

Professor Lui has already developed an artificial womb and brought rodents to term in the artificial womb.²⁸ This is significant because rodents' reproductive processes are very similar to those of humans²⁹. Similarly, Dr. Yoshinori Kuwabara, a Japanese Professor of Obstetrics at Juntendo University delivered goats from an artificial womb after just three weeks of gestation.³⁰ In fact, the researchers believe that they will have a functional artificial womb for humans in 10 to 20 years.³¹ Scientists are now developing the artificial womb for use in cases where the woman is ill and can no longer carry the fetus or where the fetus is ill and needs to be removed

²⁴ Office of Technology Assessment, U.S. Congress, *The Implications of Cost-Effectiveness Analysis of Medical Technology*, Background Paper No. 2: Case Studies of Medical Technologies, Case Study No. 10: The Costs and Effectiveness of Neonatal Intensive Care 9 (1981)

²⁵ But see, "Neonatal intensive care is a scarce and expensive resource which is often successful in the short term in that it prevents immediate death, only for the infant to die some months or years later"; *J Bion Rationing Intensive Care* (1995) 310 No 6981 *British Medical Journal* 682.

²⁶ Gretchen Reynolds, *Artificial Wombs: Will We Grow Babies Outside Their Mothers' Bodies*, *Popular Science* (2005); Hyun Jee Son, *14 Artificial Wombs, Frozen Embryos, and Abortion: Reconciling Viability's Doctrinal Ambiguity*. *UCLA Women's Law Journal* 213 (2005); M.L. Lupton. 1997. *Artificial Wombs: Medical Miracle, Legal Nightmare*. *Medicine and Law*. 16. 621; M.L. Lupton. 1999. *the Role of the Artificial Uterus in Embryo Adoption and Neonatal Intensive Care*. *Medicine and Law*. 18. 613-629

²⁷ M.L. Lupton, *Artificial Wombs: Medical Miracle, Legal Nightmare*, 16 *Medicine and Law* 621, 623-624 (1997); Robin Mckie, *Man Redundant? Now We Don't Need Women Either*. *Guardian Unlimited* (2002).

²⁸ Gretchen Reynolds, *Artificial Wombs: Will We Grow Babies Outside Their Mothers' Bodies*, *Popular Science* (2005); Hyun Jee Son, *Artificial Wombs, Frozen Embryos, and Abortion: Reconciling Viability's Doctrinal Ambiguity*, 14 *UCLA Women's Law Journal* 213 (2005);

²⁹ Gretchen Reynolds, *Artificial Wombs: Will We Grow Babies Outside Their Mothers' Bodies*, *Popular Science* (2005); Hyun Jee Son, *Artificial Wombs, Frozen Embryos, and Abortion: Reconciling Viability's Doctrinal Ambiguity*, 14 *UCLA Women's Law Journal* 213 (2005);

³⁰ Y. Kuwabara et al. *Artificial Placenta: long term extrauterine incubation of isolated goat fetuses* 13 *Artificial Organs* pp.527-31. (1989); Y. Kuwabara et al. *Artificial Placenta: long term extrauterine incubation of isolated goat fetuses* 13 *Artificial Organs* pp.527-31. (1989); Sacha Zimmerman, *Fetal Position - The Real Threat to Roe v. Wade*, *The New Rep.*, Aug. 18 & 25, 2003, at 14, 16; Jeremy Rifkin. 2002. *The End of Pregnancy*. *The Guardian of London*

³¹ Gretchen Reynolds, *Artificial Wombs: Will We Grow Babies Outside Their Mothers' Bodies*, *Popular Science* (2005);

from the woman's womb and cared for where it can be easily monitored.³² While the development of the artificial womb has focused on the health of mother and child, there is no reason an artificial womb could not be used to bring a child to term in cases where a woman wants to terminate her pregnancy and the father (or the state) wants the infant born alive.

Artificial wombs make it possible that viability will occur near the moment of conception. If a safe transfer technique is developed than even an embryo could gestate to full term outside the mother's womb and inside a separate and discrete man-made womb."³³ Finally, an artificial womb might not be required if scientist can develop a technique for transplanting a fetus from a birth mother to a surrogate.

Regardless of the final form it will take, developing neonatal technology including artificial wombs makes it inevitable that the fetal termination decision will be separated from the fetal extraction decision³⁴ and late term abortions is an example of the dilemma.

Late Term Abortions as a Current Example

The debate over Late-Term Abortions provides a current context demonstrating the coming dilemma. "Late Term" abortions are generally defined as abortions that occur at a state of fetal development that would give the fetus a high probability of survival if were born alive.³⁵ Using that definition, "Late-term" abortions exclude all first-trimester³⁶ abortions; include all

³² Gretchen Reynolds, *Artificial Wombs: Will We Grow Babies Outside Their Mothers' Bodies*, *Popular Science* (2005); Hyun Jee Son, *Artificial Wombs, Frozen Embryos, and Abortion: Reconciling Viability's Doctrinal Ambiguity*, 14 *UCLA Women's Law Journal* 213 (2005);

³³ Hyun Jee Son, *Artificial Wombs, Frozen Embryos, and Abortion: Reconciling Viability's Doctrinal Ambiguity*, 14 *UCLA Women's Law Journal* 213 (2005);

³⁴ Cf. . Ken Martyn, *Technological Advances and Roe v. Wade: The Need to Rethink Abortion Law*, 29 *UCLA L. Rev.* 1194, 1194 (1982) (arguing the artificialwomb technology shows a need to refocus viability away from technological advancements to the "more fruitful question of when human life begins"); Michael Buckley, *Current Technology Affecting Supreme Court Abortion Jurisprudence*, 27 *N.Y.L. Sch. L. Rev.* 1221, 1242 (1982) (discussing the need for the Court to clarify between the right to terminate a pregnancy with the right to destroy an embryo); Laurence Tribe, *Abortion: The Clash of the Absolutes* 220 (new ed. 1992) (noting the types of technology that were pondered included a wide array of possibilities such as the "artificial womb or placenta" or even the technology to allow men to become "pregnant").; Mark A. Goldstein, *Choice Rights and Abortion: The Begetting Choice Right and State Obstacles to Choice in Light of ArtificialWomb Technology*, 51 *S. CAL. L. REV.* 877, 882 (1978) (arguing the artificialwomb technology shows that a "state may proscribe first trimester feticidal abortions as long as none of the woman's fundamental rights are infringed").

³⁵ See e.g., *Partial-Birth Abortion Ban Act of 2003*, Pub. L. No. 108-105, § 2(14)(I), 117 Stat. 1201, 1205.

³⁶ First trimester is generally considered between conception through 12 weeks. See, *Fetal development: What happens during the second trimester?*, (Mayo Foundation for Medical Education and Research), <http://www.mayoclinic.com/health/prenatal-care/PR00112/METHOD=print>, (Last visited: March 21, 2008)

third-trimester abortions³⁷; and include some second-trimester abortions³⁸ and exclude others.³⁹ Late-term abortions are seen as necessary when fetuses are discovered to have congenital defects or to save the life of the woman.⁴⁰ However, only a fraction of the late-term abortions performed are done for fetal anomalies or to save the life of the mother⁴¹, many are done for non-medical, elective reasons.⁴² Of the estimated 30,000 late-term abortions performed each year, as many as 80% of these may be 'elective.'⁴³, that is the vast majority of these late-term abortions are performed in the 20-plus week range on healthy fetuses and physically healthy mothers.⁴⁴ Even where the pregnancy poses a threat to the woman's life at gestational ages when late term abortions are typically performed, immediate delivery of the fetus with vigorous supportive care would result in survival of many fetuses.⁴⁵

³⁷ Third trimester is generally consider pregnancy from 28 weeks to birth. . See, Fetal development: What happens during the second trimester?, (Mayo Foundation for Medical Education and Research), <http://www.mayoclinic.com/health/fetal-development/PR00114/METHOD=print>, (Last visited: March 21, 2008)

³⁸ Second trimester is generally consider pregnancy from 13 weeks to 27 weeks. See, Fetal development: What happens during the second trimester?, (Mayo Foundation for Medical Education and Research), <http://www.mayoclinic.com/health/fetal-development/PR00113/METHOD=print>, (Last visited: March 21, 2008)

³⁹See, Scott A. Hodges, Constitutional Law: Beyond The Bounds of Roe: Does Stenberg V. Carhart Invalidate The Partial-birth Abortion Ban Act of 2003?, 57 Oklahoma Law Review 601-655 (2004); Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 2(14)(I), 117 Stat. 1201, 1205 (citing to a medical association discussing partial-birth abortion after twenty weeks).

⁴⁰Calhoun, Byron C.; Reitman, James S.; Hoeldtke, Nathan J., Perinatal hospice: a response to partial birth abortion for infants with congenital defects, 13(2) Issues in Law & Medicine 125-143 (Fall, 1997); Diane M. Gianelli, Medicine Adds to Debate on Late-Term Abortion: Abortion Rights Leader Urges End to 'Half truths', Am. Med. News, Mar. 3, 1997, at 3, 28-29.

⁴¹ Congenital defects severe enough to cause death still affect roughly 20% of all live births. Center for Disease Control, Birth Defects, <http://www.cdc.gov/ncbddd/bd/default.htm> (Last Visited: March 21, 2008). Late-Term Abortion are intended to ensure that fetus with severe congenital defect will not be born alive, to avoid the prolong suffering at birth when law and society recognize and protect the infant as a person. Joan Callahan, Ensuring a Stillborn: The Ethics of Fetal Lethal Injection in Late Abortion, 6 J. Clinical Ethics 254, 258-60 (1995).

⁴².Testimony of Dr. Curtis R. Cook, at a Joint Hearing Before the U.s. Senate Judiciary Committee and the Constitution Subcommittee of the U.S. House Judiciary Committee March 11, 1997, 14 Issues in Law & Medicine 65 (1998);

⁴³Testimony before the House Judiciary Committee referring to taped and transcribed interviews conducted by reporters from American Medical News with Martin Haskell, M.D. and James T. McMahan, M.D.

⁴⁴Testimony before the House Judiciary Committee referring to taped and transcribed interviews conducted by reporters from American Medical News with Martin Haskell, M.D. and James T. McMahan, M.D.

⁴⁵ See Edward J.Wolf et al., Do Survival and Morbidity of Very-Low-Birth-Weight Infants Vary According to the Primary Pregnancy Complication that Results in Preterm Delivery? 169 Am. J.

Whatever the reasons that prompt them, Late-Term abortions are intended to ensure that an unwanted fetus/infant is not born alive.⁴⁶ Because of the size of the fetus, more common abortion techniques such as “suction curettage”⁴⁷ are unsuitable in late term procedures. More common “Late Term” procedures include amino infusion⁴⁸ and “dilation and extraction”⁴⁹. However, some of these procedures have resulted in some undesired live births or serious complications.⁵⁰ All “late term” methods have the following in common: they require that a doctor induce labor to dilate the cervix, and terminate the fetus before delivery. Another procedures, “Dilation and Extraction” (D&X) or partial birth abortion was specifically

Obstetrics & Gynecology 1233 (1993); Walter J. Morales & Thomas Talley, Premature Rupture of Membranes at (is less than) 25 Weeks: A Management Dilemma, 168 Am. J. Obstetrics & Gynecology 503 (1993).

⁴⁶Joan Callahan, Ensuring a Stillborn: The Ethics of Fetal Lethal Injection in Late Abortion, 6 J. Clinical Ethics 254, 258-60 (1995); Bryon Calhoun, James Reitman and Nathan Hoeldtke, Perinatal hospice: a response to partial birth abortion for infants with congenital defects, 13 Issues in Law & Medicine 125-143 (1997);

⁴⁷Suction curettage, the most common first trimester abortion procedure, involves the physician dilating the cervix, inserting a suction tube into the uterus and removing the fetus with suction. See, e.g., Ann MacLean Massie, So-called “partial-birth abortion” Bans: Bad Medicine? Maybe. Bad Law? Definitely!, 59 University of Pittsburgh Law Review 301-380 (1998); 1998; [Carhart v. Stenberg](#), 11 F. Supp. 2d 1099, 1102 (D. Neb. 1998); [Jensen JT, Harvey SM, Beckman LJ.](#), Acceptability of suction curettage and mifepristone abortion in the United States: a prospective comparison study, 182 Am J Obstet Gynecol. 1292 (June 2000); [Planned Parenthood v. Doyle](#), 9 F. Supp. 2d 1033, 1036 (W.D. Wis. 1998), rev'd, 162 F.3d 463 (7th Cir. 1998).

⁴⁸.With amino infusion (or induction), the physician injects a solution of either saline or urea into the amniotic cavity of the uterus. After the fetus dies from the solution, labor is induced and the fetus is delivered dead. See, e.g. Ann MacLean Massie, So-called “partial-birth abortion” Bans: Bad Medicine? Maybe. Bad Law? Definitely!, 59 University of Pittsburgh Law Review 301-380 (1998); 1998 [Hooper TI, Smith RG, Pion RJ.](#), A midtrimester procedure, not without its risks... Saline abortion: a review of the experience at Kapiolani hospital., [Hawaii Med J.](#) 1973 Jul-Aug;32(4):222-5. ;Carhart v. Stenberg, 972 F. Supp. 507, 516-17 (D. Neb. 1997); Greene, Michael F.; Ecker, Jeffrey L., Abortion, Health, and the Law, 350(2) The New England Journal of Medicine 184-186 (Jan 8, 2004).

⁴⁹.Dilation and extraction involves dilation of the cervix and extraction of the uterine contents, the fetus, by surgical means. [Darney PD, Atkinson E, Hirabayashi K.](#), Uterine perforation during second-trimester abortion by cervical dilation and instrumental extraction: a review of 15 cases. 75 [Obstet Gynecol.](#) 441-4 (March, 1990)

⁵⁰ See e.g., Michele Kurs Frishman, Wisconsin Act 110: When an Infant Survives an Abortion, [20 Wis. Women's L.J. 101](#) (Spring 2005) Stroh G, Hinman AR., Reported live births following induced abortion: two and one-half years' experience in Upstate New York, 126 Am J Obstet Gynecol.. 83 (September 1976);

developed in response to the life birth problem.⁵¹ D & X involves inducing labor, rotating the fetus so that the feet and legs delivers first and causing the death of the fetus before it's head can be born. Thus, because labor is induced and the fetus is "born," a D & X or "partial birth abortion" involves no more physical risk to the woman than if she decided to have the fetus born alive.⁵² This technique is used when the fetus/infant is too large for an abortion by dilation and evacuation and to assure that there is not a failed abortion and the fetus/infant is burned alive.⁵³

In Gonzalez v. Carhart the Court focused on which procedure a state might legally ban⁵⁴, however, in line with the Court's previous rulings, a state might legally ban *all* late-term abortions that resulted in a dead fetus. The American College of Obstetricians & Gynecologists (ACOG) found no circumstances where D & X would be only option to save the life or preserve the health of the woman.⁵⁵ Because labor is induced and the fetus/infant is "born," a D & X or

⁵¹ The use of the term "Dilation and extraction" appeared as a response to the description of the procedure as a "partial birth" abortion

⁵² However, the term "partial birth abortion" is a political term and not a medical term. Medical professionals have referred to "partial birth abortion as "dilation and extraction," ("intact D&X"); "intact dilation and evacuation" ("intact D&E"); or "modified dilation and evacuation" ("modified D&E"). Ann MacLean Massie. 1998. So-called "partial-birth abortion" Bans: Bad Medicine? Maybe. Bad Law? Definitely!, 59 University of Pittsburgh Law Review 301-380, 313 (1998); American College of Obstetricians & Gynecologists, ACOG Statement of Policy, Statement of Intact Dilatation and Extraction (January 12, 1997)(noting that "partial-birth abortion" is not a medical term and electing to use the term "Intact Dilatation & Extraction" (Intact D&X)). Nancy Romer, The Medical Facts of Partial Birth Abortion, 3 Nexus 57, 58(1998).

⁵³ Ann MacLean Massie. 1998. So-called "partial-birth abortion" Bans: Bad Medicine? Maybe. Bad Law? Definitely!, 59 University of Pittsburgh Law Review 301-380, 311 (1998); Jill Stank, a nurse, testified to her experience of following a failed abortion procedure. She described holding child in her arms, waiting forty-five minutes for it to die. Born-Alive Infants Protection Act: Hearing on the Born Alive Infants Protection Act, H.R. 4292 Before the Constitution Subcommittee of the House Judiciary Comm., 106th Cong. (2000) (Testimony of Jill Stanek, R.N.); Kathleen M. Casagrande, Children Not Meant to Be: Protecting the Interests of the Child When Abortion Results in Live Birth, 6 Quinnipiac Health Law Journal 19-55, 33(2002); cf. Roger Byron, Children of a Lesser Law: The Failure of The Born-alive Infants Protection Act and a Plan for its Redemption, 19 Regent University Law Review, 275-302, 285 (2006-2007); Hilary White, Baby Girl Born Alive and Killed After Surviving Late-Term Abortion, LIFESITE, Nov. 2, 2006, <http://www.lifesite.net/ldn/2006/nov/06110205.html> (reporting the investigation and potential criminal prosecution for the death of a child reportedly killed after being born alive through an abortion attempt); Cf., Stills v. Gratton, 127 Cal. Rptr. 652, 658-59 (Ct. App. 1976) (plaintiff can recover all costs available for failed abortion); Wilczynski v. Goodman, 391 N.E.2d 479, 487-88 (Ill. 1979) (plaintiff allowed damages for medical expenses due to failed abortion, but cost of raising unwanted child disallowed); Speck v. Finegold, 408 A.2d 496, 508-09 (Pa. Super. Ct. 1979) (allowed medical expenses after failed abortion)

⁵⁴ See, supra note 17.

⁵⁵ American College of Obstetricians & Gynecologists, ACOG Statement of Policy, Abortion (1997); cf., Ann MacLean Massie. 1998. So-called "partial-birth abortion" Bans: Bad Medicine?

"partial birth abortion" involves no more *physical risk* to the woman than if she decided to have the fetus/infant born alive.⁵⁶ There is, of course, some danger to the fetus/infant of a pre-term delivery. At less than 24 weeks, fetal/infant survival is about 30 percent, between 24 and 26 weeks gestation fetal/infant survival is between 50 and 75 percent.⁵⁷

The problem with "intact D&E/partial birth abortion" debate specifically, and the abortion debate in general, is that it is based on the false presumption that the full authority on whether to reproduce is housed solely in the woman. Thus, "partial birth abortion" allows the woman to make both the decision to remove the fetus/infant from her body and the decision to kill the fetus/infant.⁵⁸ While commentators argue that "intact D&X"/Partial Birth Abortion are the lesser of several evils because they are substantially safer for the mother than the other leading methods of late-term abortion;⁵⁹ they make no assertion about the comparative safety between "intact D&X"/"partial birth abortion" and giving birth to a live fetus/infant.⁶⁰ In fact, they

Maybe. Bad Law? Definitely!, 59 University of Pittsburgh Law Review 301-380, 305 (1998).

⁵⁶ cf. Testimony of Dr. Curtis R. Cook, at a Joint Hearing Before the U.s. Senate Judiciary Committee and the Constitution Subcommittee of the U.S. House Judiciary Committee March 11, 1997, 14 Issues in Law & Medicine 65, 67 (1998); "Before performing the actual delivery, there is a two day period of cervical dilation that involves forcing up to twenty-five dilators into the cervix at one time. This can cause great cramping and nausea for the women, who are then sent to their home or to a hotel room overnight while their cervix dilates. After returning to the clinic, their bag of water is broken, the baby is forced into a feet first position by grasping the legs and pulling it down through the cervix and into the vagina. This form of internal rotation, or version, is a technique largely abandoned in modern obstetrics because of the unacceptable risk associated with it. These techniques place the women at greater risk for both immediate (bleeding) and delayed (infection) complications. In fact, there may also be longer repercussions of cervical manipulation leading to an inherent weakness of the cervix and the inability to carry pregnancies to term." Id.

⁵⁷.Nancy Romer, The Medical Facts of Partial Birth Abortion, 3 Nexus 57, 63 (1998).

⁵⁸.cf. Bryon Calhoun, James Reitman and Nathan Hoeldtke, Perinatal hospice: a response to partial birth abortion for infants with congenital defects, 13 Issues in Law & Medicine 125-143 (1997); (arguing that the real problem with "partial birth abortion" is that it is based on the false presumption that parents have the capacity and full authority to determine which infants shall live, how long, and with what 'quality of life.')

⁵⁹.Better Late Than Never. 214 The New Republic 8-9 (1996); Testimony of Dr. Curtis R. Cook, at a Joint Hearing Before the U.s. Senate Judiciary Committee and the Constitution Subcommittee of the U.S. House Judiciary Committee March 11, 1997, 14 Issues in Law & Medicine 65, 67 (1998)(asserting that "there are and always have been safer techniques for partial birth abortion").

⁶⁰.cf. Testimony of Dr. Curtis R. Cook, at a Joint Hearing Before the U.s. Senate Judiciary Committee and the Constitution Subcommittee of the U.S. House Judiciary Committee March 11, 1997, 14 Issues in Law & Medicine 65, 67 (1998).

cannot make that assertion; intact D&E/Partial-birth abortion carry inherent health risks more significant than childbirth.⁶¹ In *Gonzales*, the state law banned a particular procedure, when the state might have just as easily, and more successfully, chosen to ban all post-viability procedures that result in a terminated fetus.

The Future of Reproductive Rights

There are more interests at stake in the abortion decision than those of the pregnant woman. The government has a legitimate interest in protecting both the unborn child and the health of the mother . . . , and the father of the child has a personal interest in the pregnant woman's decision. Thus, unlike the condition of being pregnant, the "right" to have an abortion is not a fact that is specific to one gender. Instead, it is a legal right as to which the law can properly assign different interests to various parties.⁶²

Over the last 30 years, the abortion debate has focused on the tension between a woman's right to choose an abortion without undue interference from the state and the state's interest in the life of the fetus and the health of the mother. However, the reproductive decision, in truth, involves three parties with sometimes competing interests: the woman's interest, the man's interest and the state's interest. A woman's right to abortion has been anchored in her right to privacy and her interests in individual autonomy. Specifically, a woman has the right to control what happens to her body (autonomy) which leads to the right to decide whether or not to reproduce. That is, under the current law, once pregnant, a woman can decide to terminate the fetus or give birth.

Theoretically, a man's interests in the abortion decision are similar to the woman's – a right to privacy, autonomy and reproductive rights. Because men have no autonomy interest in the abortion decision, their reproductive interest has been limited because of the primacy given to the woman's autonomy interest. Even though a man may not want to reproduce he cannot force a woman to have an abortion; by the same token, a man who wants to reproduce cannot stop a woman from having an abortion.

The state has an interest in protecting potential life throughout the pregnancy. However, the current balancing of the state's interest versus the woman's interest is centered on viability. The state has little ability to protect the life of fetus if it is not viable. Essentially, pre-viability, the woman's interest in autonomy and right to control her body trumps the state interest in the

⁶¹.Nancy Romer, *The Medical Facts of Partial Birth Abortion*, 3 *Nexus* 57, 61 (1998). The artificial dilation cervix may result cervical incompetence and complications during future pregnancy. Women can have problems in future pregnancies if the cervix opens spontaneously and the fetus/infant is delivered prematurely. Nancy Romer, *The Medical Facts of Partial Birth Abortion*, 3 *Nexus* 57, 61(1998). Furthermore, turning the fetus/infant into the feet first position requires use of instruments inside the woman's uterus and can result in injury to the uterus, maternal hemorrhaging, and infection. *Id.*

⁶² Chief Justice Roberts while Deputy Solicitor General, in a brief authored on behalf of the government in *Bray v. Alexandria Women's Health Clinic*, 506 U.S. 263 (1993).

potential life of the fetus. However, once the fetus is viable, the state can protect the potential life by outlawing abortion in all cases except for when the health of the woman is at stake. As has been discussed, changing medical technology will have a significant impact on how the courts view the primacy of the state and the woman's interest. In addition, the same changes in technology will impact the balance between the woman and the man's interests.

Currently, the constitutional basis for the right to choose an abortion is grounded in the woman's autonomy interest, an interest that does not necessarily implicate reproductive rights. As Tribe observed, the abortion decision involves two separate medical decisions: the decision to remove the fetus from the woman's body (Fetal Extraction) and the decision to kill the fetus (Fetal Termination). While, historically, and currently during most stages of pregnancy, the first decision inevitably leads to the second, changing medical technology insures that this will not always be the case. Over time, medicine will develop to the point where, the decisions can be made separately with a live birth of a fetus creating no more risk to the woman than an ordinary abortion. Under those circumstances, there is no legal reason that a woman's interests should be given primacy in the reproductive choice. Taking into consideration the changing technology, the reproductive interest could be balanced as a private decision between a man and woman based on their potential responses to the pregnancy. It is also possible that the state's interest in the potential life of the fetus might be exercised in a way that makes all abortions illegal and provides recognition of men's reproductive interest.

Up until this point, a woman's reproductive interest has consistently prevailed over the man's. Not because the law gave greater protection to the woman's reproductive interest, but because the woman's autonomy interest gave her decisions regarding reproduction primacy. In fact, it is a fair statement to assert that courts and legislatures have generally not recognized any reproductive interest of men and only indirectly recognized the reproductive interest of women. In the future, the courts and legislatures will have to address directly reproductive rights. Whose reproductive interest will prevail may depend on whether there is reproductive conflict and whether there are viability concerns. Where there is reproductive conflict, the legislatures will most likely give priority to the person who wants life. However, that priority for the man will only occur if the conflict arises post-viability.

If both the woman and man want to reproduce (or does not care), there is no reproductive conflict. In this situation there are no viability concerns and no reason for the state to assert its interest, thus both parties reproductive interest prevails and the result will be pregnancy and live birth. If the woman wants to reproduce and the man does not, there is a reproductive conflict. Because the woman wants life there are no viability concerns. Thus, the woman's reproductive interest prevails and the result will be pregnancy and live birth. If the woman does not want to reproduce and man wants to reproduce, there is reproductive conflict and there are viability concerns. In this situation, a man's reproductive interest will prevail but only if the decision is post-viability. If the decision is post-viability, then the man's reproductive interest prevails and there will be fetal extraction and not fetal termination, however, if the decision is pre-viability, then the woman's reproductive interest prevails and fetal termination will occur.⁶³ If both the woman and man do not want to reproduce (or do not care), there is no reproductive conflict. In this situation, there are no viability concerns, thus both parties reproductive interest might prevail

⁶³ At least one commenter has asked whether requiring a woman to wait until viability to exercise her autonomy interest might be constitutionally permissible. Bruce Ching, Inverting the Viability Test for Abortion Law, 22 Women's Rts. L. Rep. 37, 44-45 (2000).

and the result would be fetal termination. However, it is possible that some states will exercise their interest in life and ban all fetal terminations. In this case a woman would be able to exercise her autonomy interest by having fetal extraction, but would not be allowed to choose fetal termination. In such a case, neither party's reproductive interest prevails.

Woman's Desire	Man's Desire	Reproductive Conflict	Viability Concerns	Prevailing Reproductive Interest	Result
Woman wants to reproduce or does not care	Man wants to reproduce or does not care	No	No	Both Parties' Reproductive Interest prevails	Pregnancy and live birth
Woman wants to reproduce	Man does not want to reproduce	Yes	No	Woman's Reproductive Interest prevails	Pregnancy and live birth
Woman does not want to reproduce	Man wants to reproduce	Yes	Yes, decision is pre-viability	Woman's Reproductive Interest prevails -	Fetal Termination (fetal death)
			Yes, decision is post-viability	Man's Reproductive Interest prevails -	Fetal Extraction (live birth)
Woman does not want to reproduce or does not care	Man does not want to reproduce or does not care	No	No	Both parties Reproductive Interest prevails -	Fetal Termination (death of fetus)
			Yes, Must be post-viability	Neither parties Reproductive Interest prevails; State's interest prevails	Fetal Extraction (live birth)

Regardless of the approach adopted by states, there will be collateral consequences which will need to be addressed in subsequent research. In this section, it is only our intention to point out some of the potential consequences. If changing medical technology results in the recognition of men's reproductive interest this would essentially be an equalization of reproductive rights and responsibilities. As in most things in the law, this equalization of gender rights does not necessarily mean this change would be entirely equitable in result.

The social impact of being able to extract the fetus from the woman's uterus will be significant. Both states and fathers could exercise their interest in having a live fetus. States could require all women to have fetal extraction. This would place a significant financial and emotional burden on men and women who do not want children. Men who did not want to reproduce have always borne this burden when a woman decided to carry the fetus to term. However, the number of men who will be required to reproduce will increase substantially. For women, the burden of having a child they did not want is one that most women have not had to bear since the legalization of abortion.

If a state was to choose to require fetal extraction in all feasible cases, it could have a disproportionately negative impact on poor women and women of color. Poor women may be forced to have children they cannot afford. While this is no different from the situation for poor men, poor women are not in the same place as poor men.⁶⁴ Women earn less⁶⁵ and where children are involved, women are more likely to be the primary caregiver.⁶⁶ As a result of women's financial status the new reproductive reality may cause more illegal terminations. However, it may also increase interest in pregnancy prevention and early stage abortion before "fetal extraction" is a viable alternative. However, science could eventually make extraction a viable alternative even for embryos.

If extraction is required by the state and neither the woman or the man wants to exercise their reproductive rights, we may see the establishment of fetal adoptions. If the extracted fetuses are placed for "fetal adoption" there will be an increase in the already high number of

⁶⁴Cf., Audrey Rowe, THE FEMINIZATION OF POVERTY: AN ISSUE FOR THE 90'S, 4 [Yale J.L. & Feminism](#) 73 (1991); But cf., Athena Mutua WHY RETIRE THE FEMINIZATION OF POVERTY CONSTRUCT?, 78 [Denv. U. L. Rev.](#) 1179 (2001)

⁶⁵ See, e.g. Joni Hersch, Sex Discrimination in the Labor Market, 2(4) *Found. & Trends in Microecon.* 1, 80 (2006). "Women earn less than men, and no matter how extensively regressions control for market characteristics, working conditions, individual characteristics, children, housework time, and observed productivity, an unexplained gender pay gap remains for all but the most inexperienced of workers." *Id.* "If the unexplained pay disparity sometimes favored women and sometimes favored men there would be no reason for concern. . . . But systematically and without exception finding that women earn less than men raises some questions. . . . [I]t is hard to continue to attribute the remaining disparity to unmeasurables and intangibles like effort and motivation and to ignore the possibility that discrimination remains a factor in the gender pay disparity." *Id.*

⁶⁶See e.g., LENORE J. WEITZMAN, THE DIVORCE REVOLUTION: THE UNEXPECTED SOCIAL AND ECONOMIC CONSEQUENCES FOR WOMEN AND CHILDREN IN AMERICA 70-109 (1985); Karen Czapanik, *Gender Bias in the Courts: Social Change Strategies*, 4 *GEO. J. LEGAL ETHICS* 1, 3 (1990).

”unadoptable“ minority and disabled babies, particularly black babies.⁶⁷ This may result in a significant portion of a generation being raised as wards of the state.⁶⁸

Finally, even though men and women may relinquish their parental rights to the state, because of the significant financial burden on the state resulting from such a decision, states may take physical custody of the ”extracted baby“ but require both parents to continue to provide financial support; again, placing an inequitable burden on those least able to afford it. Thus, while abortion as we understand it might be radically altered because of the new reproductive rights reality, gender, class and race issues will persist and in many instances may worsen.

Conclusion

Technology is changing in ways that will have a significant impact on the current abortion debate, and our understanding of reproductive rights. There are three potential state responses to this changing medical technology. First, states may outlaw abortion and force women to use an artificial womb and/or fetal adoption.⁶⁹ Under Roe v Wade states can restrict access to abortion in the third trimester and many states already outlaw abortion post-viability.⁷⁰ Furthermore, many states have implemented unconstitutional and unenforceable bans which changing medical technology might make acceptable. However, some states may continue to see the abortion decision as a private decision giving the father more rights and the mother more responsibilities under the equal protection clause. Finally, a state could decide that the fetus is an extension of the woman’s body and that anything done to the fetus must be done with the

⁶⁷ Cf., Robert A. Frietas Jr., *Fetal Adoption: A Technological Solution to the Problem of Abortion Ethics*, *The Humanist* 22 (May/June 1980); Lydia A. Nayo, IN NOBODY'S BEST INTERESTS: A CONSIDERATION OF ABSOLUTE BANS ON SEXUAL MINORITY ADOPTION FROM THE PERSPECTIVE OF THE UNADOPTED CHILD, [35 U. Louisville J. Fam. L. 25](#) (1996-97); Twila L. Perry, TRANSRACIAL ADOPTION AND GENTRIFICATION: AN ESSAY ON RACE, POWER, FAMILY AND COMMUNITY , [26 B.C. Third World L.J. 25](#) (Winter, 2006)

⁶⁸ See, Minn. Stat. § 145.415.3 (making a child born alive after an attempted abortion a ward of the state unless either parent asserts parental rights within 30 days).

⁶⁹ Cf., Dr. W. David Hager, the head of the George W. Bush’s administration’s Reproductive Health Drugs Advisory Committee stated, “Roe v. Wade should be repealed anyway. But if we had the technology to be able to placentize or incubate in a placental environment, then I would say that would be an argument in favor of repeal.” Hyun Jee Son, Artificial Wombs, Frozen Embryos, and Abortion: Reconciling Viability’s Doctrinal Ambiguity, 14 *UCLA Women’s Law Journal* 213 (2005) citing Sacha Zimmerman, Fetal Position - The Real Threat to Roe v. Wade, *The New Rep.*, Aug. 18 & 25, 2003, at 14, 16.

⁷⁰ see also Sally Sheldon, Unwilling Fathers and Abortion: Terminating Men’s Child Support Obligations?, 66 *Mod. L. Rev.* 175 (2003) (examining the basis of paternal obligation where women retain sole control over the abortion decision; Cf. Scott Altman, [A Theory of Child Support](#), 17 *Int’l J.L. Pol’y & Fam.* 173 (2003) (reviewing arguments that can be offered for the support obligation); Tracey S. Pachman, DISPUTES OVER FROZEN PREEMBRYOS & THE “RIGHT NOT TO BE A PARENT” , [12 Colum. J. Gender & L.](#) 128 (2003)” (discussing the “right not to be a parent,” the controlling standard by which several courts have decided disputes over frozen preembryos)

mother's consent to protect her privacy.

None of these options require the Supreme Court to overturn Roe v Wade and subsequent rulings. The Supreme Court's current abortion jurisprudence stands for the proposition that the woman's autonomy interest outweighs the state's interest in life until viability, after viability the state may exercise its interest so long as the health and welfare of the mother are provided for in any laws enacted. At the time Roe was decided, viability was the third trimester: 24 weeks. Over the next 20 years, viability will move back earlier and earlier in the pregnancy, until, conceivably, an embryo will be viable at conception. With changing medical technology, the state's interest in potential life could take precedence over the woman's reproductive interest. The woman's reproductive interest would still exist, but the state could limit her right to exercise it by choosing a procedure that would not result in fetal termination if a living fetal extraction is available. Further, the father's reproductive interest, which has received little support under the current law, would have to become part of any abortion discussion.

In offering this analysis, we are not taking a position on either "pro-choice" or "right to life". It is clear that our prediction could have serious negative impact on women. The current abortion paradigm gives women power in a society where they have little. Further, the personal consequences of having a child exist in the world being raised by another may be different for women than for men. Even after decades of progress, we are still conditioned to believe that "a woman's place is in the home," and that there is a special bond between mother and child. While the law may be shaped to allow men and women equal parts in any reproductive decision, those decisions may not have equal consequences. Giving women this choice - both reproductive and autonomy - is one of the few places in our society where women actually have more power than men, in a profound way. If changing medical technology takes that away, the other pulls society gives men may end up leading women to coercive choices. This is true not only in the US, but around the world as other women look to our system as a model for empowerment. We are not suggesting this argument as a reason to continue to give the woman's decision primacy over the man's when the woman doesn't want to reproduce but the man does. However, not withstanding this, changing medical technology will require a reassessment of the respective rights and responsibilities. One side of the abortion debate argues that the Constitution protects a woman's right to choose an abortion; the other side argues that the fetus has a right to life that the law must recognize. New medical technology will allow the law to satisfy both. In the future, the law will be able to allow a woman to choose not to carry to term while making it illegal to terminate the life of a fetus.