
Since *Roe*: Access to Abortion in the United States and Policy Lessons from Western Europe

I. INTRODUCTION

Although it is a widely held belief that *Roe v. Wade*¹ legalized abortion on a federal level, the actual function of the decision only set a precedent invalidating most state laws restricting abortion.² The decision failed to declare abortion a “social right and need of all women” and, rather, was based upon broad concepts of “medical necessity” and rights to privacy.³ The language of the decision left open numerous exceptions by which states could legally limit access to abortion.⁴ This paper argues that the legal loopholes of *Roe* have allowed the government and the courts to infringe upon and increasingly limit women’s reproductive rights. Particular focus will be given to implementation of parental consent laws by states, as well as partial birth abortion bans on both state and federal levels. These measures will be compared to several nations abroad where fewer restrictions and more liberalized laws in these specific areas have achieved greater reproductive freedom for their citizens. By examining the implementation and success of greater reproductive freedoms internationally, this paper will conclude that such entitlements are warranted and feasible in the United States.

II. HISTORICAL OVERVIEW

The *Roe v. Wade* decision, although momentous, was a “logical extension” of the right to privacy deemed a constitutional right by previous Supreme Court decisions.⁵ The Court based its decision in *Roe* upon the legal

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1. *Roe v. Wade*, 410 U.S. 113 (1973).
 2. See Center for Reproductive Rights, *A Guide to the Supreme Court and Choice*, at http://www.reproductiverights.org/crt_roe_primer.html (Jan. 2004) [hereinafter *Supreme Court Guide*].
 3. ROSALIND POLLACK PETCHESKY, *ABORTION AND WOMAN’S CHOICE* 289 (1990).
 4. See *id.*
 5. See Center for Reproductive Rights, *Roe v. Wade: Then and Now*, (Jan. 2003) at

precedent that “personal decisions about procreation, marriage, and other aspects of family life” cannot be intruded upon by government regulation.⁶

The constitutional right to privacy was first applied in the context of reproductive health rights in *Griswold v. Connecticut* where the complainants challenged a state law criminalizing the dispensing of birth control devices to married couples.⁷ The *Griswold* Court recognized a “zone of privacy” implicitly guaranteed by various provisions of the Constitution and was inclusive of the marital relationship and decisions made within.⁸ The decision in *Griswold* was crucial to advocacy of modern abortion rights, conferred constitutional protection upon reproductive rights, legalized birth control, and provided legal authority for the “nearly unanimous acceptance of contraception.”⁹

The Supreme Court extended privacy rights established in *Griswold* to unmarried persons by striking down a Massachusetts law which criminalized the distribution of contraceptives to unmarried persons in *Eisenstadt v. Baird*.¹⁰ The *Eisenstadt* Court held that the statute violated “fundamental human rights” established in *Griswold*, as “denying contraception distribution to unmarried persons was equally impermissible” as denying such to married couples.¹¹

Although the holding in *Griswold* based the right to contraception upon privacy rights within the marital relationship, the “marital couple is not an independent entity” but is rather “an association of two individuals.”¹² This reasoning signified the Court’s recognition of the ability and right to control reproduction as a personal choice in which unmarried women were similarly entitled to be free from government intrusion.¹³ Also significant in *Eisenstadt* was the Court’s specific addressing of reproductive rights:

If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the include matters so fun-

http://www.reproductiverights.org/crt_roe_jbroe.html (last visited Apr. 19, 2004).

6. Planned Parenthood Federation of America, *Roe v. Wade: It's History and Impact*, (last modified Nov. 2002) at <http://www.plannedparenthood.org/library/ABORTION/Roe.html> (last visited Apr. 19, 2004).

7. See generally *Griswold v. Connecticut*, 381 U.S. 478 (1965).

8. See *id.* at 482-86.

9. Planned Parenthood Federation of America, *Griswold v. Connecticut: The Impact of Legal Birth Control and the Challenges that Remain*, (last modified May 2000) at <http://www.plannedparenthood.org/library/facts/griswolddone.html> (last visited Apr. 19, 2004).

10. See *Eisenstadt v. Baird*, 405 U.S. 438 (1972).

11. See *id.* at 443, 453.

12. *Id.* at 453.

13. See *id.*

damentally a person as the decision whether to bear . . . a child.¹⁴

The right to privacy and the language of the *Eisenstadt* holding is perhaps the most significant legal doctrine supporting the right to choose abortion.¹⁵ However, despite the strong language governing reproductive rights, *Eisenstadt* did not make such rights absolute. By employing the word “unwarranted,” the possibility for justified “governmental intrusion” was left open.¹⁶

The *Roe v. Wade* decision in 1973 held state statutes criminalizing abortion unconstitutional, following the Court’s reasoning in *Griswold* and *Eisenstadt*.¹⁷ As noted in *Roe*, the right to privacy included a “woman’s decision whether . . . to terminate her pregnancy.”¹⁸ The Court limited this right, however, by defining the right to abort a pregnancy as not absolute, but rather subject to constraint by the State.¹⁹

Roe deemed state interests in protecting the health of pregnant women and potential human life as compelling, thereby allowing regulation of abortion to further these interests.²⁰ The protective interests are “separate and distinct” and do not become compelling until a specified point during pregnancy.²¹ The *Roe* decision set out a “trimester framework,” establishing different levels of state regulation of abortion during each stage of pregnancy.²²

The recognized aspect of the *Roe* holding deems state interference during the first trimester of pregnancy unconstitutional.²³ State interests in both the woman’s health and protection of the fetus are not compelling at this point.²⁴ Before compelling interests arise, the states have no constitutional authority by which to impose restrictions on abortion.²⁵ Therefore, during this first trimester, *Roe* held that the decision to terminate a preg-

14. PETCHESKY, *supra* note 3, at 290 (citing *Eisenstadt*, 405 U.S. at 453) (emphasis added).

15. *See id.*

16. *See id.*

17. *See generally Roe*, 410 U.S. 113 (holding that abortion was within the scope of personal liberties guaranteed by the United States Constitution).

18. *Id.* at 154.

19. *See id.*

20. *See id.* at 162.

21. *Id.* at 163.

22. *Supreme Court Guide, supra* note 2.

23. *See PETCHESKY, supra* note 3, at 291.

24. *See Roe*, 410 U.S. at 182 (stating that due to established medical fact, during the first trimester, the fetus is not viable, the mother faces a lower mortality rate in obtaining an abortion, and therefore, no compelling state interest exists in the first trimester of pregnancy).

25. *See generally id.*

nancy was to be made by “the attending physician,” using “his medical judgment,” in consultation with his patient, free from state regulation.²⁶

By implementing these terms, the *Roe* decision was not granting a woman’s right to determine whether to bear a child, but was, in fact, granting physicians the right to make a medical decision free from state interference.²⁷ The Court refused to declare it a “woman’s right to *have* this kind of medical care,” but rather was affirming the “autonomy of . . . physicians” to determine “when [and for whom] medical care is warranted.”²⁸ Framing abortion in a medical context rather than as an individual right provides the basis upon which reproductive freedoms can be legally stripped away.²⁹

States’ compelling interest in the “preservation and protection of maternal health” is only compelling after the first trimester.³⁰ During the second trimester, states have only the ability to regulate abortion as related to the compelling interest in protecting maternal health.³¹ Regulations may only come in the form of laws maintaining the medical safety of abortion procedures and may not infringe upon women’s access and right to obtain an abortion during the second trimester.³²

Roe recognized several permissible regulations of abortion procedures aimed at achieving the state interest in protecting maternal “life and health [from the] risks associated with abortion.”³³ States are to appropriately regulate the skill of the abortion provider,³⁴ the “environment in which the abortion is performed,”³⁵ and the authority to inquire as to, and medically determine, the “duration of the pregnancy.”³⁶ It is important to note that second trimester regulations must be promulgated in the interest of the pregnant woman. Any regulations impinging upon the right to obtain an abortion would necessitate a purpose of fetal protection, which the state does not have a “compelling interest” in the first or second trimester.³⁷

26. *Id.* at 183.

27. *See* PETCHESKY, *supra* note 3, at 291.

28. *Id.*

29. *See generally id.*

30. *Roe*, 410 U.S. at 182-83.

31. *See id.*

32. *See id.* (stating examples of permissible state regulation for protection of maternal health and welfare inclusive of licensure of persons performing abortions, what facilities abortions may be performed in, etc.).

33. *Id.* at 146.

34. *See id.* (specifying that abortions “should be performed by physicians or osteopaths who are licensed to practice and who have ‘adequate training.’”).

35. *Id.* (establishing standards for abortion facilities and suggesting length of hospital stay following receipt of the procedure).

36. *Id.*

37. *See generally Roe*, 410 U.S. 113.

The diversion between the two state interests defined in *Roe*, and the corresponding regulation, rests on the argument of “fetal viability” and the point at which human life is deemed to begin, thereby justifying state protection.³⁸ The point at which a fetus is capable of “meaningful life outside the mother’s womb” is considered the point of viability and when the state’s compelling interest in the protection of the fetus actualizes.³⁹ The Court refused to define when exactly “life begins” and concedes that its definition of “viability” is flexible.⁴⁰ This ambiguous definition implies that the state’s compelling interest in the protection of the fetus does not evolve until the third trimester of pregnancy.⁴¹

Fetal “rights,” or even the consideration of the fetus as a human-being, which would entitle the fetus to rights and government protection, played a substantial role in the *Roe* decision, as well as modern abortion debate.⁴² In order to receive constitutional protections, one must be considered a “person” and although the Constitution uses the term frequently in the post-natal context, it fails to define personhood in a pre-natal sense.⁴³

The absence of a more concrete interpretation of when life is legally recognized is an additional loophole of *Roe*, posing the potential for increased fetal rights and deterioration of the affirmative guarantees to reproductive choice.⁴⁴ *Roe* authorizes state interference with women obtaining an abortion at the time when the fetus becomes “viable,” rather than specifically stating a gestational duration in terms of weeks.⁴⁵ This flexible definition, combined with fast-paced and continually progressive medical technology, poses the potential for viability, and therefore state interference at a point earlier than the third trimester.⁴⁶

Although the *Roe* decision provides substantial rights and protections to the unborn fetus, it specifically reiterated the important state interest and responsibility in protecting the life and health of the mother, even after fetal viability.⁴⁷ This important “pillar” of the *Roe* decision holds that after vi-

38. *Id.* at 163.

39. *Id.*

40. *Id.* at 181 (holding that beginning around twenty-four to twenty-eight weeks, a fetus has potential to live outside the mother).

41. *See* PETCHESKY, *supra* note 3, at 291.

42. *See Roe*, 410 U.S. at 181.

43. *See id.* at 157.

44. *See generally Roe*, 410 U.S. 113.

45. *See* PETCHESKY, *supra* note 3, at 322 n.11 (The *Roe* Court “associates viability with the third trimester,” rather than defining viability with any specificity. (citing *Roe*, 410 U.S. at 162-163)).

46. *See id.* (posing the realistic possibility that advancing “technology for sustaining a fetus outside the uterus” could restructure traditional assumptions regarding viability).

47. *See Roe*, 410 U.S. at 183.

ability, states may prohibit abortion, but such regulatory statutes must include an exception allowing abortion procedures when the life or health of the woman is threatened.⁴⁸

The principles *Roe* established in support of abortion rights, and the high level of judicial review have been eroded by subsequent court decisions and legislation.⁴⁹ The “steady decline in constitutional protection” of abortion rights culminated with the Supreme Court’s decision in *Planned Parenthood v. Casey* in 1992.⁵⁰ The *Casey* Court expressly stated that its purpose was not to overrule the “essential holdings” of *Roe v. Wade*, although this determination was made more for the purposes of stare decisis than for upholding principles of individual liberties.⁵¹

Casey vastly changed the analysis of state statutes regulating abortion by establishing a new legal test to replace the strict scrutiny test applied in *Roe*.⁵² The “undue burden” standard was introduced in the *Casey* opinion as “a state regulation [having] the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”⁵³ By stripping away the high level of scrutiny granted to abortion decisions in *Roe*, the new standard allowed for greater state interference during the once fully protected first trimester.⁵⁴

The *Casey* decision dismantled the trimester framework of *Roe*, expanding the states’ interest in the protection of potential life throughout the entire course of pregnancy.⁵⁵ The decision advocated and authorized further state regulation of abortion for the purpose of “persuading [women] to choose childbirth over abortion.”⁵⁶ The holding specifically undermines an important “constitutional pillar” of *Roe* mandating government neutrality and legislation which did not “push women into one decision or another” regarding abortion.⁵⁷

48. *Supreme Court Guide, supra note 2.*

49. *See id. See also Roe*, 410 U.S. at 155 (citing *Griswold v. Connecticut*, 381 U.S. 478, 485 (1965); *Aptheker v. Secretary of State*, 378 U.S. 500, 508 (1964); *Cantwell v. Connecticut*, 310 U.S. 296, 307-308 (1940); *Eisenstadt v. Baird*, 405 U.S. 438, 460, 463-464 (1972)). The *Roe* Court reviewed the state statute at issue under a strict scrutiny standard, requiring any state limitation upon “fundamental rights” be justified by a “compelling state interest” and regulations be “narrowly drawn to express only the legitimate state interests at stake.” *Roe*, 410 U.S. at 155.

50. *Supreme Court Guide, supra note 2.*

51. *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

52. *See generally Casey*, 505 U.S. 833.

53. *Id.* at 877.

54. *See Supreme Court Guide, supra note 2.*

55. *See Casey*, 505 U.S. at 878.

56. *Id.*

57. *Supreme Court Guide, supra note 2.*

Specifically, *Casey* evaluated several provisions restricting first trimester abortions included in the Pennsylvania Abortion Control Act of 1982.⁵⁸ In applying the lesser undue burden standard, the Court found three of the

58. See *Casey*, 505 U.S. at 844. See also 18 Pa.C.S. §§ 3203, 3205, 3206, 3209, as amended in 1988 and 1989 (1990):

§3205 reads:

(a) No abortion shall be provided or induced except with the voluntary and informed consent of the woman upon whom the abortion is to be performed or induced. Consent . . . is voluntary and informed if and only if:

(1) At least 24 hours prior to the abortion, the physician who is to perform the abortion. . . has orally informed the woman of:

- i. The nature of the proposed procedure. . . and risks and alternatives. . .
- ii. The probable gestational age of the unborn child at the time the abortion is to be performed.
- iii. The medical risks associated with carrying her child to term.

(2) . . .

- i. The department published printed materials which describe the unborn child and list agencies which offer alternatives to abortion . . . and a copy will be provided to her free of charge if she chooses to review (the materials).
- ii. Medical assistance benefits may be available for prenatal care, child-birth and neonatal care . . .”

§3206 reads:

(a) If a pregnant woman is less than 18 years of age and not emancipated. . . a physician shall not perform an abortion on her unless he first obtains the informed consent both of the pregnant woman and of one of her parents.

(b) . . .

(c) If both of the parents . . . of the pregnant woman refuse to consent to the performance of an abortion or if she elects not to seek the consent of either of her parents . . . the Court of Common Pleas . . . in which the abortion sought shall, after an appropriate hearing, authorize a physician to perform the abortion if the Court determines that the pregnant woman is mature and capable of giving such informed consent . . .

(d) If the Court determines that the pregnant woman is not mature and capable of giving informed consent . . . the Court shall determine whether the performance of an abortion upon her would be in her best interests. If the Court determines that the performance of an abortion would be in the best interests of the woman, it shall authorize a physician to perform the abortion.

§3209 reads:

(a) [N]o physician shall perform an abortion on a married woman . . . unless he or she has received a signed statement . . . from the woman upon whom the abortion is to be performed, that she has notified her spouse that she is about to undergo an abortion. The statement shall bear a notice that any false statement made therein is punishable by law.

four challenged restrictions constitutional.⁵⁹ Informed consent counseling, mandatory waiting periods, and parental consent for minors were approved as not amounting to an “undue burden” for women seeking abortions.⁶⁰

The “informed consent” statute was challenged not only due to the biased content of the information proffered to women seeking treatment, but also due to the inclusion of a mandatory twenty-four hour waiting period before an abortion could be obtained.⁶¹ The Court reasoned that the state had a valid interest in informing women as to health risks associated with abortion and childbirth.⁶² The mandatory information required by the statute, however, was not without bias and attempts at persuasion, differentiating abortion from comparable medical procedures.⁶³ The Court held that the mandatory information regarding the consequences of abortion upon the fetus was not unduly burdensome, although admitting this information has “no direct relation” to the health, and purported state purpose for this legislation, of the woman.⁶⁴

The *Casey* Court demonstrated its weak interpretation of what governmental intrusions constituted a “substantial obstacle” and further departed from first trimester reproductive rights established in *Roe* by upholding the Pennsylvania statute’s twenty-four hour “waiting period” before an abortion would be performed.⁶⁵ The Court determined these waiting periods did not constitute an undue burden to women seeking an abortion, despite the fact that these delays would often require a woman to make two trips to a doctor’s office and increase exposure to harassment from anti-abortion protestors outside of treatment facilities.⁶⁶ The Court rejected the district court’s finding that waiting periods would result in an undue burden to “women who have the fewest financial resources, those who must travel long distances, and those who have difficulty explaining their whereabouts to husbands, employers, or others,” stating that although these factors were “troubling” they did not amount to “substantial obstacles.”⁶⁷

The *Casey* holding placed significant impediments upon women under the age of eighteen seeking abortions.⁶⁸ *Casey* reaffirmed the decisions in *Bellotti v. Baird*, qualifying the Pennsylvania statute requiring the informed

59. See generally *Casey*, 505 U.S. 833.

60. See generally *Roe*, 410 U.S. 113; *Casey*, 505 U.S. 833.

61. See *Casey*, 505 U.S. at 881.

62. See *id.* at 882.

63. See generally 18 Pa.C.S. § 3205 (1990).

64. *Casey*, 505 U.S. at 882-83.

65. *Id.* at 885-86. See also generally *Roe*, 410 U.S. 313.

66. See *Casey*, 505 U.S. at 885-86.

67. *Id.* at 886.

68. See *id.* at 899.

consent of one parent as not unduly burdensome.⁶⁹ This specific provision mandated minors to obtain the consent of at least one parent and that this consent is “informed,” in compliance with the statutory definition, inclusive of the twenty-four hour waiting period.⁷⁰

In concluding the discussion of *Roe* and *Casey*, it is important to recognize the legal precedents each set and maintains as applicable to current attempts at state and federal regulation of, and interference with, reproductive choice. *Roe*'s establishment of the state interest in protecting the health and life of women, which remains binding precedent, requires federal and state statutes regulating abortion to include deregulatory health and life exceptions to effectuate this interest.⁷¹ *Casey* increased the ways in which government may interfere with reproductive choice, requiring only that such regulations not be “unduly burdensome,” and interpreted *Roe* as not granting a constitutional right to “abortion on demand.”⁷²

III. CURRENT REPRODUCTIVE RIGHTS

Although precedent for certain restrictions on reproductive choice were previously established, the *Casey* holding “opened the floodgates to a relentless, purposeful effort to erode and burden the right” to reproductive choice primarily through state legislation.⁷³ In the wake of a lesser constitutional standard applicable to regulation of abortion, numerous state statutes placed specific restrictions and additional burdens not only upon access to abortion, but also upon classes of women who seek abortions, as well as limiting and banning certain abortion procedures.⁷⁴ Enactment of such restrictions are often based upon questionable claims of legitimate state interests, with the regulations failing to meet permissible state interests protecting the health of the woman and unborn fetus as outlined in *Roe*.⁷⁵

69. *See id.* *See also* Bellotti v. Baird, 443 U.S. 622 (1979) (endorsing parental notice and consent statutes which do not present an undue burden upon seeking an abortion right).

70. *Casey*, 505 U.S. at 899. *See also* 18 Pa.C.S. §§ 3203, 3205, 3206, 3209, as amended in 1988 and 1989 (1990).

71. *See generally* *Roe*, 410 U.S. 313.

72. *Casey*, 505 U.S. at 887.

73. *Who Decides?: A State-by-State Review of Abortion and Reproductive Rights*, EXECUTIVE SUMMARY 2003, at 3 (NARAL Pro-Choice America and NARAL Pro-Choice America Foundation, Washington, D.C. 12th ed. 2003) [hereinafter *Who Decides?*].

74. *See id.* *See also* Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105 (2003) (prohibiting “partial birth abortion” procedures as defined within the federal statute). *See generally* *Casey*, 505 U.S. 833.

75. *See Unconstitutional Assault on the Right to Choose: “Partial-Birth Abortion Ban” is an Affront to Women and the the U.S. Supreme Court*. Center for Reproductive Rights, (Feb. 2003) at http://www.reproductiverights.org/pub_bp_pba.html (last visited Apr.

Minors were perhaps the most significantly affected group, with forty-three states enacting some form of mandatory parental consent requirement before a minor may obtain an abortion.⁷⁶ The creation and judicial support for such legislation is more often based upon the “moral nature of the issues” of abortion, teenage sexual activity, and unplanned pregnancies, rather than ensuring minors’ receipt of appropriate medical treatment.⁷⁷ The purported intention of such laws is to pose “serious obstacles” for teenagers who decide to seek an abortion.⁷⁸ Parental consent laws also aim to serve as a “deterrent” to teenage sexual activity, illogically reasoning that minors will not engage in sex if they know they must obtain parental permission should they seek an abortion in the event of an unwanted pregnancy.⁷⁹ The Supreme Court has recognized the discouragement of “promiscuous sexual activity of minors” as a legitimate state interest, but has simultaneously recognized that regulation of contraceptives to minors does not legitimately serve a deterrent purpose.⁸⁰ Given this concession by the Court, it is difficult to view parental consent laws as having any level of deterrence upon teenage sexual activity.⁸¹

Even broader restrictions were placed upon reproductive choice with the passage of the first federal abortion regulation in 2003, which directly undermines the principles the government must follow when enacting abortion regulation as established in *Roe*.⁸² The federal Partial Birth Abortion Ban Act is almost identical to a state statute struck down by the Supreme Court in 2000.⁸³ A main point of contention is the failure of the Act to include a health exception, which “actually disserves the state’s interest in maternal health.”⁸⁴ By “infringing upon a woman’s liberty interest” in a right to privacy “without serving either of the state’s legitimate interests,” the act is “a per se undue burden,” prevented by *Casey*.⁸⁵

19, 2004) [hereinafter *Unconstitutional Assault*].

76. See *Who Decides?*, *supra* note 73, at 34-35.

77. PETCHESKY, *supra* note 3, at 311.

78. *Id.*

79. *Id.*

80. *Id.*

81. See *id.* See also *Mandatory Parental Consent and Notice Laws Burden Freedom to Choose*. NARAL Pro-Choice America, (Jan. 20, 2003) at <http://www.naral.org>. (last visited Apr. 19, 2004) [hereinafter *Mandatory Parental Consent*].

82. See *Unconstitutional Assault*, *supra* note 75.

83. See *id.*

84. Brief for Petitioners at 35, *Stenberg v. Carhart*, 530 U.S. 914 (8th Cir. 2000) (No. 99-830).

85. *Id.* See also *Casey*, 505 U.S. 833.

A. Informed Consent for Minors

B. United States Law

Although abortion is legal in the United States, it is not readily available to all women of childbearing age.⁸⁶ Such “hindering laws” of the United States limits individual choice on abortion and provides for few reasonably accessible services.⁸⁷ Teenagers were one of the first groups of women whose reproductive rights were limited by state regulation.⁸⁸ Parental consent laws have been enacted in forty-three states and thirty-three of these states presently enforce these statutes.⁸⁹ These laws minimally require women under the age of eighteen to notify or obtain the consent of a parent or designated adult prior to receiving an abortion, and all but one state allows for minors to obtain an abortion in the absence of parental consent through a complicated and intimidating judicial bypass system.⁹⁰

The Supreme Court first addressed the reproductive rights of minors in the 1979 case of *Bellotti v. Baird*.⁹¹ Although the *Bellotti II* Court rendered the Massachusetts statute under review unconstitutional, the Court held that state statutes requiring notification and/or parental consent prior to a minor’s receipt of abortion procedures were permissible on the basis that the “constitutional rights of children cannot be equated with those of adults.”⁹² The Court reasoned that due to the “potentially serious consequences” of abortion, states may regulate constitutional freedoms of minors to choose

86. See generally M. Berer, *Making Abortions Safe: A matter of good public health and policy practice*, Bulletin of the World Health Organization (2000).

87. *Id.* at 583.

88. See *Supreme Court Guide*, *supra* note 2.

89. See *Who Decides?*, *supra* note 73, at 23 (listing states maintaining and enforcing parental notification and consent laws as AL, AR, DE, GA, ID, IN, IA, KS, KY, LA, ME, MD, MA, MI, MN, MS, MO, NE, NC, ND, OH, PA, RI, SC, SD, TN, TX, UT, VA, WV, WI, WY).

90. See *Supreme Court Guide*, *supra* note 2. See generally *Bellotti*, 443 U.S. 622 (setting out procedure for judicial bypass of parental consent requirements by minors).

91. *Bellotti v. Baird*, 443 U.S. 622 (1979).

92. *Bellotti II*, 443 U.S. at 634-35. This case was known as *Bellotti II* as inquiry on the issue began in *Bellotti v. Baird*, 428 U.S. 132 (1976). The statute at issue in *Bellotti II* was deemed unconstitutional as it failed to provide minors with “an alternative procedure to obtain consent” in absence of parental consent. The Court determined that requiring “parental notification of judicial proceedings brought by a minor to obtain an abortion imposed an undue burden upon the minor’s right to seek an abortion.” The statutory provision allowing a judge to “withhold consent from a minor deemed capable of making an informed and reasonable decision to have an abortion was unconstitutional” and such an “absolute third-party veto over minor’s right to an abortion was “inappropriate” and unconstitutional.” *Id.*

this option and exercise control of minors' reproductive health.⁹³ Such limitation was justified by the *Bellotti II* Court due to the "guiding role of parents in the upbringing of their children" and parental responsibility for children's "full growth and maturity" and "eventual [meaningful and rewarding] participation in society."⁹⁴

The Court's emphasis on the parental role of encouraging "morality" for minors in their reproductive choices bears little on the issue that certain minors are able to give their informed consent to receive medical treatment, inclusive of abortion, without the assistance of their parents.⁹⁵ Sensitive issues frequently faced by minors, often requiring medical treatment, such as "testing for sexually transmitted diseases, assistance with substance abuse problems, eating disorders, [and] mental health issues" are often better dealt with as confidential between the minor and the health care professional.⁹⁶ In certain instances, parental involvement may be "counterproductive" to the minor's health and impede prompt and accurate treatment by the physician.⁹⁷ Parental consent and notification requirements may "deter teens from seeking treatment, thereby threatening their health."⁹⁸ Situations where a physician must weigh the health of the minor patient against the benefits of involving the patient's parents are "legal barriers and deference to parental involvement should not stand in the way of [necessary] health care."⁹⁹ Parental consent laws pose a substantial barrier to necessary medical services to minors, as "[i]t is nearly impossible to establish a professional, therapeutic relationship without a promise of confidentiality" from the health care professional to the minor.¹⁰⁰ Consent laws by their very nature discourage such a physician-patient relationship, and thereby render complete and adequate consultation and treatment unattain-

93. *Id.* at 635.

94. *Id.* at 638-39.

95. PETCHESKY, *supra* note 3, at 302-03.

96. *Congress Should Not Give Parents A Right to Access Their Teenagers' Medical Records*, NARAL Pro-Choice America at <http://www.prochoiceamerica.org/facts/medical-records.cfm>. (last visited Apr. 19, 2004) (stating that the possibility of their parents having access to their medical information could deter minors from seeking medical treatment for serious conditions) [hereinafter *Teenager's Medical Records*].

97. *Id.* at 2 (quoting the statement by the American Medical Association that "[w]hen an immature minor requests . . . pregnancy-related care . . . physicians must recognize that requiring parental involvement may be counterproductive to the health of the patient.").

98. *Id.* at 1.

99. *Id.* at 2 (quoting Janet E. Gans, et al., *Adolescent Health Care: Use, Costs and Problems of Access*, at 65-66 in AMERICAN MEDICAL ASSOCIATION PROFILES OF ADOLESCENT HEALTH SERVICES, Vol. 2 (Chicago: AMA 1991)).

100. *Id.* at 1 (quoting *Planned Parenthood Affiliates of California v. Van De Kamp*, 181 Cal.App. 3d. 245, 268-269 (Ct. App. 1986)).

able for minors.¹⁰¹

In *Bellotti II*, the Court deemed abortion decisions as “unique” and separate from other medical decisions a minor may be required to make relating to her own health care.¹⁰² Parental consent and notification statutes seem to have a purpose in regulating the minor’s “moral interests,” rather than objective medical concerns, and it is such “moral judgments that [minors] are deemed incompetent to make” for themselves.¹⁰³

Parental consent laws also disregard the ability and right of physicians to administer abortions, which was the foundation of the *Roe* holding.¹⁰⁴ The *Bellotti II* Court reiterates the importance of a minor’s consultation with the abortion providing physician, but deems parental consent and notification necessary nonetheless, finding physicians are “relatively uninvolved in the counseling process” prior to receipt of an abortion.¹⁰⁵ This statement renders little confidence in the ability and duty of physicians to provide adequate information and obtain the informed consent of their patient prior to performing a medical service. In his dissent from the majority opinion in *H. L. v. Matheson*, Justice Marshall concluded that “by law the physician already is obligated to obtain all information necessary to form his best medical judgment [as to the capacity of a minor to consent to an abortion] and nothing bars consultation with the parents should the physician find it necessary.”¹⁰⁶

The *Bellotti II* Court, perhaps in an attempt to constitutionally justify the placement of such blanketing limitations on minor’s reproductive rights, called for legislation making such parental consent mandates include a judicial bypass.¹⁰⁷ This alternative established in *Bellotti II* provided a judicial procedure in which a minor, in the absence of parental consent, could demonstrate she was “mature . . . and well enough informed to make her abortion decision, in consultation with her physician, independently of her parents’ wishes” or, alternatively show that if she is not able to make such a decision independently, the abortion would be in “her best interests.”¹⁰⁸ The Massachusetts statute overturned in *Bellotti II* lacked such a provision, hence the parental consent requirement placed a “minor’s decision to se-

101. See generally *Teenager’s Medical Records*, *supra* note 96.

102. PETCHESKY, *supra* note 3, at 307.

103. *Id.*

104. See *id.* at 309.

105. *Id.* See also *Bellotti II*, 443 U.S. 622.

106. *H.L. v. Matheson*, 450 U.S. 398, 441 (1981) (Marshall, J., dissenting) (stating that the majority opinion posed an argument supporting parental consent laws based upon factually mistaken medical principles in claiming abortion to be more dangerous to a young woman’s health than childbearing).

107. See *Bellotti II*, at 643-44.

108. *Id.*

cure an abortion . . . subject to an absolute third-party veto,” regardless of the minor’s maturity and capacity to consent.¹⁰⁹

Although this case-by-case review of the maturity and ability to consent to an abortion appears fair and unburdensome in theory, judicial by-pass procedures subject minors to “significant burdens” on obtaining an abortion that are not typically faced by adults.¹¹⁰ The judicial bypass requirement, coupled with parental consent laws, often leave young women seeking abortions with few legitimate and feasible choices.¹¹¹ Many young women, from both dysfunctional and healthy family environments, have “real and confirmed fears” of obtaining consent from their parents, but are similarly “traumatized by the thought of going before a judge to discuss such an intimate matter.”¹¹² Minors who do chose to prove their maturity and obtain judicial consent to receive an abortion face significant logistical obstacles in obtaining information regarding the process and physically getting to courts (which are commonly only open during school hours), to then have “what may be the most important decision of their lives . . . [decided] by a stranger.”¹¹³

Parental consent statutes and judicial by-pass procedures often create greater harm to the minors they “purport to protect.”¹¹⁴ Such regulations lead to an increase in “illegal and self-induced abortion, family violence, suicide, later abortions [than would have been completed earlier at a lesser health risk] and unwanted childbirth.”¹¹⁵ A main health risk posed to minors as a result of parental consent and judicial by-pass requirements is the forced delay in the receipt of “appropriate medical care.”¹¹⁶ By usurping these medical decisions from the minor and her physician, parental consent and judicial by-pass laws place an additional burden and risk upon the rights of female minors in violation of the principles established in *Roe* and *Casey*.¹¹⁷

109. *Id.* at 653-54 (Rehnquist, J., concurring).

110. Center for Reproductive Rights, *Tell It to the Judge: Teens Face Hard Times*, REPROD. FREEDOM NEWS, Sept. 1999 Vol. VIII, No. 8, available at <http://www.reproductiverights.org> (last visited Apr. 19, 2004).

111. *See id.*

112. *Id.*

113. *Id.*

114. *Mandatory Parental Consent*, *supra* note 81.

115. *Id.* (citing J. Shoshanna Ehrich, *Journey Through the Courts: Minors, Abortion and the Quest for Reproductive Fairness*, 10 YALE J. L. & FEMINISM 1 (1998)).

116. *Id.* (quoting American Academy of Pediatrics, Committee on Adolescence, *The Adolescence's Right to Confidential Care When Considering Abortion*, 97 PEDIATRICS 746 (1996)).

117. *See generally* *Roe v. Wade*, 410 U.S. 113 (1973); *Planned Parenthood v. Casey*, 505 U.S. 833 (1992).

Specifically, the judicial by-pass system creates an “overwhelming and . . . [usually] impossible” situation for minors seeking abortions.¹¹⁸ Even if the minor is able to overcome logistical and physical complications, the process is often tainted by anti-choice judges who frequently disregard valid showings of maturity and best interest by the minor.¹¹⁹ When such decisions are based upon unwavering beliefs of judges, rather than the standards established by the Supreme Court, minors’ rights are violated.¹²⁰ Decisions in judicial by-pass proceedings are increasingly motivated by the personal morals and beliefs of the presiding judges and less about the rights of minors and the duties and decisions of physicians to ensure appropriate and timely medical treatment.¹²¹

Parental consent statutes undermine the right to choose abortion and reproductive services in that it “disqualifies” the capacity to choose, an essential element to exercising the right.¹²² If states are permitted to eliminate this capacity by age and maturity level, such disqualification could also be statutorily based upon “emotional stability,” previous life history, and other such immeasurable and ambiguous qualities.¹²³ Such limitations and burdens, once allowed to be placed on one group of women can easily

118. See *Mandatory Parental Consent*, *supra* note 114, at 4.

119. *Id.* (quoting *T.L.J v. Webster*, 792 F.2d 734, 738-39, n.4 (1986). A Missouri judge stated in the court’s decision to deny the petition of a minor in a judicial by-pass proceeding stating: “Depending upon what ruling I make I hold in my hands the power to kill an unborn child . . . I don’t believe that this particular juvenile has sufficient intellectual capacity to make a determination that she is willing to kill her own child.”). See also *Mandatory Parental Consent*, *supra* note 114, at 4 (quoting *Ex Parte Anonymous*, 812 So.2d 1234 (Ala. 2001); Bill Poovey, *Divided Court Upholds Denial of Abortion for Unemotional Teen*, ASSOCIATED PRESS, Aug. 17, 2001) A decision by the Alabama Supreme Court to deny a seventeen-year-old’s petition for a judicial by-pass on the basis that her “testimony appeared ‘rehearsed,’” and she did not show emotion, rather than on her showing of maturity, best interest, and that her decision was based upon accurate information. In addition, the court refused to consider additional relevant information demonstrating petitioner’s maturity and decision-making ability, including the fact that she had discussed her options with trained professionals, family members and friends, was informed as to the abortion procedure and its associated risks, and demonstrated valid reasons for her unwillingness to obtain parental consent for the procedure. *Id.*

120. See *Mandatory Parental Consent*, *supra* note 114, at 4 (citing *Hodgson v. Minnesota*, 497 U.S. 417 (1990); *Ohio v. Akron Center for Reproductive Health*, 497 U.S. 502 (1990)) Both *Hodgson* and *Akron Center for Reproductive Health* establish by-pass procedures in absence of compliance with parental consent or notification statutes and the standard the petitioning minor must meet. If the petitioner establishes her maturity and that the abortion would be in her best interest, the by-pass must be granted as a matter of law. See *id.* See also *Hodgson*, 497 U.S. 417.

121. See *Mandatory Parental Consent*, *supra* note 114.

122. PETCHESKY, *supra*, note 3, at 308.

123. *Id.*

be expanded, leading to further attrition of already limited reproductive freedoms.¹²⁴ Such a subjective test left to the discretion of the courts indeed presents a “sharp political edge to the issue of ‘choice’ once particular categories of women” are deemed incompetent to exercise control of whether to have a child.¹²⁵

2. European Law

Although minors in nations abroad are similarly subjected to particular limitations under what are otherwise relatively liberal abortion laws, these restrictions are far less stringent than those imposed by United States laws and policies.¹²⁶ European laws regarding the reproductive rights of minors, particularly those in France, Belgium, and The Netherlands, embrace a greater respect and concern for the health and well-being of minors, as well as their legal autonomy in personal decision-making.¹²⁷ The effect of these liberalized social and legal attitudes is a far lower abortion rate among French, Belgian and Dutch teenagers than their American counterparts.¹²⁸

France provides an interesting example of a nation where minors’ legal access to abortion was recently liberalized following almost thirty years of restriction via a national parental consent law.¹²⁹ Abortion was legalized in France in 1975 with the passing of the Veil Act and the uncomplicated recognition of “the right to abortion as a fundamental woman’s right.”¹³⁰ The

124. *See id.* at 308-09. The author questions: “If the ‘*capacity* to choose’ may be disqualified by age . . . may it not also be conditioned upon ‘emotional stability,’ previous history, or other indicators of ‘competence?’” *Id.* (emphasis added).

125. *Id.*

126. *See generally* Nicoletta Confalone, *Abortion Legislation in Europe*, CHOICES, Vol. 28, No. 2 (2000), available at <http://www.ippf.org/regions/europe/choices/v28n2/legislation.htm> (last visited Apr. 19, 2004).

127. *See generally* Linda Berne & Barbara Huberman, *European Approaches to Adolescent Sexual Behavior and Responsibility*, ADVOCATES FOR YOUTH (1999). *See also generally* Dirk Pyck, *Abortion in Belgium Ten Years On*, CHOICES, Vol. 28, No. 2 (2000), available at <http://www.ippf.org/regions/europe/choices/v28n2/belgium.htm> (last visited Mar. 1, 2004).

128. *See* Jany Rademakers, *Abortion in The Netherlands 1993-2000: Annual Report of the National Abortion Registry*, at 36, available at <http://en.stisan.nl/documents/general/aar.pdf> (last visited Apr. 19, 2004) (discussing the low incidence of teenage pregnancy, birthrate and abortion rates in The Netherlands and France, as compared to the United States). *See also* Susan Cohen, *A Message to the President: Abortion Can Be Safe, Legal and Still Rare*, THE GUTTMACHER REPORT ON PUBLIC POLICY (The Alan Guttmacher Institute, New York, Feb. 2001). *See generally* Berne & Huberman, *supra* note 127.

129. *See* Françoise Laurant, *Sexual and Reproductive Health and Rights and the MFPF*, at <http://www.planning-familial.org/english/indexEnglish.html> (last visited Apr. 19, 2004) [hereinafter *Reproductive Health*].

130. *Id.* France’s Veil Act was named for the then Minister of Health, Simone Veil,

legislation was passed in response to the changing social climate in France and the “public health problem” posed by illegal abortions.¹³¹ It is important to note that abortion in France was legalized by the intentional creation and passage of legislation by a popularly elected parliament, reflecting the view of the societal majority of abortion as a right.¹³² The legislation was brought by its opponents to the French Constitutional Council for review, “on the grounds that it violated constitutional guarantees of human rights and protection of the health of children.”¹³³ The French judicial body upheld the vote of the “parliamentary majority,” delivering a short opinion declaring the law constitutionally permissible.¹³⁴ This mutuality between national legislative and judicial bodies served as an asset in the development of abortion deregulation and lent a heightened degree of legitimacy to the legislation.¹³⁵

Perhaps the most significant aspect of the Veil Act was its unmistakable recognition that “the woman, alone, decided [whether to obtain an abortion] without the need of medical authorization.”¹³⁶ It is this strong support and recognition of women’s reproductive rights in the foundation of French abortion legalization which has led to laws improving, rather than deconstructing, such rights.¹³⁷

The Veil Act covered the “voluntary termination of pregnancy” and included four significant restrictions, including a specific time period during which abortions were legally permitted and a parental authorization requirement for minors.¹³⁸ The 1975 law had a “sunset provision” of five

who voted the abortion legislation into law. *See id.*

131. Françoise Laurant, *Is Abortion a Right? France Reforms the Veil Act*, CHOICES, Vol. 28, No. 2 (2000), available at <http://www.ippf.org/regions/europe/choices/v28n2/legislation.html> [hereinafter *Is AbortionRight?*]. *See also Reproductive Health, supra* note 129.

132. *See* MARY ANN GLENDON, ABORTION AND DIVORCE IN WESTERN LAW 16-17 (1987).

133. *Id.* at 17, 162 n.34. “The constitutional texts appealed to were the Preamble to the 1958 Constitution, which states that “every human being . . . possess sacred and inalienable rights,” and the Preamble to the 1946 Constitution, which states that the nation “guarantees protection of health to all, notably to children, and mothers.” *Id.* at 162 n.34.

134. *Id.* at 17-18. The French Constitutional Council is the French counterpart to the United States Supreme Court. Unlike the Supreme Court, however, the Council rarely rejects a “parliamentary majority on a highly controversial question.” *Id.*

135. *See generally id.* at 18.

136. *Reproductive Health, supra* note 129.

137. *See id.*

138. *See id.* (stating that “[v]oluntary” abortions permitted by law only during the first ten weeks of pregnancy) The additional provisions posed in the Veil Act included prior consultation requirements and “restrictive conditions for foreigners.” *Id.* *See also* GLENDON, *supra* note 132, at 155.

years, but was renewed with minor alterations in 1979.¹³⁹ Article L. 162-7 of the final law permitting abortion requires “unmarried minors” to obtain the “consent of one of the persons exercising parental authority.”¹⁴⁰ It is significant to note, however, that the legislation also specifically requires the “consent of the unmarried minor” herself, in addition to the parental consent, to be given “outside the presence of her parents.”¹⁴¹ Inclusion of this provision demonstrates the respect and consideration granted to minors’ decision-making ability, bodily integrity, and legal autonomy.¹⁴² In general, French legislation regulating abortion is “clearly” aimed at assisting women, rather than posing “threatening, anxiety-provoking” regulations, particularly concerning minors.¹⁴³ However, in recent years, reproductive freedom in France has become increasingly liberal in its application and public sentiment, particularly in regards to the rights of minors.¹⁴⁴ In 1999, public protest and progressive government action succeeded in initiating liberalization of restrictions imposed by the Veil Act.¹⁴⁵ In 1999, the publication of a report commissioned by the French government proposed suggestions to improving equal access to abortion under existing laws.¹⁴⁶ The Nisand Report established the importance of recognizing abortion as a “fundamental right,” in legislation, practice, and public perception.¹⁴⁷ The Report specifically stipulated that changes were necessary “concerning access to abortion for minors.”¹⁴⁸ One of the factors indicating the “neces-

139. GLENDON, *supra* note 132, at 18.

140. Law No. 79-1204 of Dec. 31, 1979, J.O., Jan. 1, 1980, p.3, available at <http://cyber.law.harvard.edu/population/abortion/France.abo.htm>.

141. *Id.*

142. See *Reproductive Health*, *supra* note 129.

143. GLENDON, *supra* note 132, at 19-20. The author contrasts the consent regulations at issue in the American cases of *City of Akron v. Akron Center for Reproductive Health, Inc.*, 462 U.S. 416 (1983) and *Thornburgh v. American College of Obstetrics and Gynecologists*, 54 U.S.L.W. 4618 (1986) to French abortion regulations, and finds that French legislation “stresses assistance to, and alternatives for, the pregnant woman,” while American legislation often “emphasiz[es] only the risks of the procedure.” *Id.*

144. See generally Heather Boonstra, *Promoting Contraceptive Use and Choice: France’s Approach to Teen Pregnancy and Abortion*, THE GUTTMACHER REPORT ON PUBLIC POLICY, Vol. 3, No. 3 (June 2000), available at <http://www.guttmacher.org/pubs/journals/gr030303.html> (last visited Apr. 19, 2004).

145. See generally *Is Abortion Right?*, *supra* note 131.

146. See generally *id.* The report by Professor Nisand was entitled “Abortion in France: Proposals for Relieving Women’s Difficulties” and was commonly known as the Nisand Report. The Report aimed to first to assess the issues of access to abortion practices and second, to provide suggestions to the government as to possible improvements to existing law. *Id.*

147. *Id.*

148. *Id.*

sary evolution of the Veil law” was the large number of “young minors who could not obtain the [consent] of their parents,” and were left without any realistic options, often in dire “physical and financial” conditions.¹⁴⁹

The French government issued a positive response to the Nisand Report and proposed an “action plan” for implementing active policies whereby access to abortion would be improved and changes to the Veil Act would be drafted.¹⁵⁰ The Nisand Report and corresponding government response prompted a proposed amendment to the Veil Act, developed largely by the *Mouvement Français pour le Planning Familial* (MFPF).¹⁵¹ The amendment called for the “elimination of parental consent for abortion for minors” on the basis that “an adolescent’s right to decide for herself, whether with or without consulting her parents,” made considerable progress in the national debate regarding mandatory parental consent laws.¹⁵²

The fact that such an amendment to national law was actively advocated, proposed, and carries the weight of French public support signifies the superior consideration of minors’ rights to “anonymous” reproductive decision-making to those recognized in the United States, both by laws and society.¹⁵³ The publication of the Nisand Report encouraged a national campaign aimed at primarily addressing the specific needs of teenagers regarding sexuality and reproductive health.¹⁵⁴ Recognition of the need for policy “revitalization” reflects the prioritization by French society of teenagers’ education on these matters, indicating a general cultural “openness and comfort . . . in dealing with teenage sexuality.”¹⁵⁵ It is partially such cultural sentiments which encouraged and supported government efforts to expand “adolescents[’]. . . access to information and services.”¹⁵⁶

In 2001, the amendment to the Veil Act as proposed by the Nisand Re-

149. *Reproductive Health*, *supra* note 129. See also *Sharing Responsibility: Women, Society, and Abortion Worldwide*, at 17-18, The Alan Guttmacher Institute, available at <http://www.agi-usa.org/pubs/sharing.pdf> (last visited Apr. 19, 2004) [hereinafter *Sharing Responsibility*]. The author lists some reasons minors may have for wishing to terminate a pregnancy: not wanting to raise a child alone, being too young to be a good mother, not wanting parents to know about the pregnancy, socioeconomic reasons such as completion of education and inadequate finances, health reasons, etc. See *id.*

150. *Is Abortion Right?*, *supra* note 131. The “three-point action plan” developed by the French Ministry for Employment and Solidarity also suggests governmental policies regarding contraception, emergency contraception, and improving existing abortion rights. *Id.*

151. *See id.*

152. *Id.*

153. *See generally id.*

154. *See* Boonstra, *supra* note 144.

155. *Id.*

156. *Id.*

port was passed into law.¹⁵⁷ Although the amendment brought several changes and improvements to French abortion policies, minors may be the most benefited group.¹⁵⁸ Minors over the age of fifteen are no longer required to obtain parental consent prior to receiving an abortion, but may choose to be accompanied by an adult of their choosing during the procedure.¹⁵⁹ Minors may choose to have an adult present during the procedure so as not to be alone during what can be considered a physically and emotionally distressing time.¹⁶⁰ The amendment provides extended rights to minors; not only does it protect their anonymity, but it also provides the procedure free of charge, thereby alleviating financial burdens often faced by teenagers.¹⁶¹ These resolutions combine to make abortion a feasible option for minors confronted with an unwanted pregnancy.¹⁶²

Since the passage of the Veil amendment, French minors are not faced with the additional burden of confusing parental consent laws and are able to exercise their own discretion regarding their health and circumstances.¹⁶³ Prior to these recent developments, however, France maintained a bypass system comparable to the American judicial bypass procedure in which minors may obtain an abortion without the consent or notification of their parents.¹⁶⁴ In practice, physicians generally tended to “ignore” the parental consent and alternative procedures when they found it to be in the “best interest of the [minor].”¹⁶⁵

The French by-pass process, however, was far less burdensome than its United States counterpart and reflects French legal emphasis upon abortion as a medical service.¹⁶⁶ The French system avoided the logistical, physical, and emotional burdens placed upon minors subjected to the American system by not requiring the minor to navigate the judicial system herself and testify before a judge to demonstrate her maturity and interest in having an abortion.¹⁶⁷ The system was structured within the context of informed consent between the minor and her physician by enabling the physician or hos-

157. See *Reproductive Health*, *supra* note 129.

158. See *id.*

159. See *id.*

160. See *id.*

161. See *id.*

162. See generally *id.*

163. See generally *id.*

164. See Confalone, *supra* note 126. See also generally Berne, *supra* note 127.

165. Berne, *supra* note 127, at 33.

166. See generally *Sharing Responsibility*, *supra* note 149, at 21.

167. See generally *id.* See also *The “Child Custody Protection Act” and the Inadequacy of Judicial Bypass Procedures*, NARAL Pro-Choice America, (Jan. 1, 2004) at http://www.prochoiceamerica.org/facts/ccpa_inadequate.cfm (last visited Apr. 24, 2004) [hereinafter *Inadequacy of Judicial Bypass*].

pital to petition the court on the minor's behalf.¹⁶⁸ This significant distinction in a seemingly similar process, while not granting minors absolute autonomy in their reproductive choices, placed greater importance upon the health and well-being of the minor, by essentially allowing the decision to be made in the course of confidential consultation between a minor and her physician.¹⁶⁹ In allowing the physician or hospital to testify as to the maturity and knowledge of the minor, as well as her medical, social, economic, and emotional interests, these qualifications were inherently granted greater legitimacy and were more likely to be approved by the court in granting the minor permission to obtain an abortion.¹⁷⁰

The French judicial by-pass system was far less arduous upon the access to abortion by minors.¹⁷¹ Most significantly, it avoided the various problems associated with forcing minors to appear before a judicial body and testify as to extremely personal decisions.¹⁷² Although the by-pass system is no longer necessary in light of the 2001 amendment nullifying parental consent requirements, it provides a unique and vastly simplified counterpart to the confusing and impractical American system.¹⁷³

Other European nations allow minors even broader freedoms with respect to obtaining abortions and similarly do not involve complicated court proceedings.¹⁷⁴ Several nations require parental consent for minors but do not impose eighteen as the legal age requirement, as in the United States.¹⁷⁵ The most liberal nations in respect to age limitations for parental consent range from age fourteen in Austria, to age sixteen in Greece, the Czech Republic, and Norway.¹⁷⁶ Younger age requirements avoid the often unfair results present in the United States blanket system which subjects older teenagers to the same supervision and dictated decision-making required of younger adolescents.¹⁷⁷ In Denmark and Italy, where parental consent is mandated until age eighteen, and in Norway where consent is mandated until age sixteen, minors wishing to obtain an abortion without such parental

168. See generally *Sharing Responsibility*, *supra* note 149, at 21.

169. See generally *Is Abortion Right?*, *supra* note 131.

170. See generally *Sharing Responsibility*, *supra* note 149, at 21. See also *Inadequacy of Judicial Bypass*, *supra* note 167.

171. See generally *Is Abortion Right?*, *supra* note 131.

172. See *Inadequacy of Judicial Bypass*, *supra* note 167.

173. See *id.* See also *Is Abortion Right?*, *supra* note 131.

174. See generally *Confalone*, *supra* note 126.

175. See *id.*

176. See *id.*

177. See generally *Mandatory Parental Consent*, *supra* note 114 (stating examples of several seventeen-year-old girls subjected to judicial by-pass proceedings despite the fact that they held jobs, were planning to attend college, managed their own expenses, among other qualities and characteristics evidencing maturity).

authorization have the option of petitioning either a judge or a hospital committee for permission.¹⁷⁸

The availability of the hospital committee option for minors is seemingly far less problematic for minors than United States judiciary proceedings and is more attentive to their medical health.¹⁷⁹ The mere fact that such committees are composed of medical professionals is evidence of their primary concern with the physical and mental health of the minor patient. Thus, such committees are more apt to base their decisions on these factors, rather than their own moral dictates, as is frequently a problem in American judicial by-pass proceedings.¹⁸⁰ Nations offering this type of medical committee bypass show a "reduced abortion mortality and morbidity" rate, to the point where such results are a "rarity."¹⁸¹ Further, due to ethical commitments to confidentiality inherent in their professional training, adjudicating medical professionals are seemingly more appropriate to deal with such emotionally and physically sensitive issues than a judge who is trained in strict application of the law.¹⁸²

Belgium is one of the few European nations where abortion legislation does not contain a clause specifically regulating receipt of abortion by minors.¹⁸³ Current laws are relatively liberal on this subject, and the ability of minors to obtain an abortion is not contingent upon parental consent, but rather on the minors' own informed consent to medical treatment.¹⁸⁴ The issue of a minor's ability to consent to this type of "medical intervention" is raised in Belgian law, but only by the threat of criminal prosecution of physicians who perform abortion procedures upon minors who have not in fact given their informed consent.¹⁸⁵ Potential criminal liability serves as a safeguard of a minor's independent decision-making and receipt of treatment, rather than an obstacle to obtaining an abortion.¹⁸⁶ The general "consensus within the medical profession" in Belgium deems "minors of a certain age and maturity" capable of "lawful consent to some medical treatment" and will weigh the "maturity and understanding" of the minor against the level of risk associated with the treatment to determine whether abortion is appropriate without parental consent.¹⁸⁷ Due to the fact that

178. See Confalone, *supra* note 126.

179. See *id.* See also *Inadequacy of Judicial Bypass*, *supra* note 167.

180. See *Mandatory Parental Consent*, *supra* note 114. See also *Inadequacy of Judicial Bypass*, *supra* note 167; Confalone, *supra* note 126.

181. Berer, *supra* note 86.

182. See generally Confalone, *supra* note 126.

183. See Pyck, *supra* note 127.

184. See *id.*

185. See *id.*

186. See generally *id.*

187. *Id.* The Belgian "age of maturity" is commonly recognized in the medical profes-

abortion is considered a “low-risk medical intervention,” abortions will typically be performed once the physician establishes that the minor understands and consents to the procedure.¹⁸⁸ The lack of legal distinguishment between abortion and other medical services provided to minors protects minors’ rights to appropriate medical care and respects informed decisions regarding individual physical and mental health.¹⁸⁹

Although less restrictive abortion laws themselves allow greater availability of the abortion services to European teenagers, access to “reproductive and sexual health services” in general are more accessible, particularly in France and The Netherlands, than in the United States.¹⁹⁰ The American health care system in general is “cumbersome and confusing” and may be particularly so to teenagers.¹⁹¹ This, combined with the rigid judicial bypass system by which many American teenagers must navigate in order to gain access to certain health services perhaps pose the greatest barrier to American teenagers seeking abortions in absence of parental consent.¹⁹² The extreme lack of information and knowledge as to the procedural aspects of the systems often present substantial logistical obstacles of availability for American teenagers.¹⁹³ Without looking at the availability and accessibility to clinics, hospitals, and the services they provide to teenagers, access to the judicial bypass system alone is “burdensome.”¹⁹⁴

France and The Netherlands have recognized the importance of creating reproductive health services that are not only legal, but also highly accessible for minors.¹⁹⁵ These two nations have utilized “innovative strategies” to accommodate teenagers’ unique needs and make reproductive services more available to minors.¹⁹⁶ France, for example, has *Mercredi Libre*, or “Free Wednesday” where clinics provide additional accommodations to teenagers, given that French schools are closed Wednesday afternoons.¹⁹⁷

Similar measures have been implemented by the Dutch government, with the development of Rutgers clinics.¹⁹⁸ In The Netherlands, the na-

sion as fifteen or older but is not a legal mandate. *Id.*

188. *Id.*

189. *See* Pyck, *supra* note 127.

190. *See* Berne, *supra* note 127, at 1.

191. *See id.* at 25.

192. *See generally id.* *See also Inadequacy of Judicial Bypass*, *supra* note 167.

193. *See Inadequacy of Judicial Bypass*, *supra* note 167 (noting that courts are only open during school hours, lack of transportation to the courts, and lack of knowledge as to technicalities of the system poses significant problems for minors).

194. Berer, *supra* note 86, at 583.

195. *See* Berne, *supra* note 127.

196. *Id.* at 33.

197. *See id.*

198. *See id.* at 29.

tional government established and funded the Rutgers Foundation in 1980 for the purpose of making reproductive health care available and accessible to adolescents.¹⁹⁹ The clinics are “easily accessible for adolescents . . . as they are located . . . near schools or railway stations” and remain open during convenient hours.²⁰⁰ Broad accessibility is a prerequisite to ensuring the safety of abortions; the “risks of exposure” and other associated fears must be removed, even where abortion is legal.²⁰¹ These goals are being actualized in France and The Netherlands.

The more liberal laws governing abortions as pertinent to minors provide benefits often prevented by restrictive parental consent and judicial by-pass statutes in the United States.²⁰² The increased availability of reproductive health services, particularly in France and The Netherlands, also promotes the health of minors and the realistic exercise of their reproductive rights.²⁰³ Such liberalized laws and policies protect minors’ “right[s] to physical integrity” and avoid risks associated with parental consent and strict judicial bypass.²⁰⁴ In avoiding such restrictions, certain European nations realistically reduce problems associated with minors obtaining abortions, which United States laws seek, and fail, to avoid.²⁰⁵ “Government[s] cannot mandate healthy family communication” and rather than attempting unsuccessfully to do so, are better suited to protect the health, safety, and rights of minors.²⁰⁶

199. *See id.* at 28.

200. *Id.*

201. Berer, *supra* note 86, at 582. *See also* Berne, *supra* note 127, at 28-29, 33.

202. *See generally* Pyck, *supra* note 127. *See also* Confalone, *supra* note 126. *See generally* *Inadequacy of Judicial Bypass*, *supra* note 167.

203. *See generally* Berne, *supra* note 127. Reproductive health services are not limited to abortion procedures, but include various services such as family planning counseling, contraceptives, birth control, information on and testing for HIV/AIDS and other sexually transmitted diseases. *See id.*

204. *Inadequacy of Judicial Bypass*, *supra* note 167 (stating risks associated with judicial bypass laws as lack of confidentiality, access to courts and information regarding the process, intimidation by anti-choice judges, delays in obtaining the abortion posing medical risk). *See also* *Mandatory Parental Consent*, *supra* note 114. Risks associated with parental consent and notification statutes include “illegal and self-induced abortion, family violence, suicide,” health risks associated with delayed abortions, forced childbearing posing “health and life” threats. *Id.*

205. *See generally* *Mandatory Parental Consent*, *supra* note 114. *See also* Pyck, *supra* note 127.

206. *Mandatory Parental Consent*, *supra* note 114.

B. Partial Birth Abortion and Late-Term Abortion

1. United States Law

In addition to subjecting specific classes of women to increased regulations and procedures by which their reproductive choices are burdened, laws have been enacted to ban certain types of abortion procedures.²⁰⁷ Specifically, procedures deemed as falling under the legislatively defined title “partial birth abortions” have been banned by state statutes and most recently, by federal law.²⁰⁸

The Nebraska statute criminalizing partial birth abortions was successfully challenged in the 2000 Supreme Court case of *Stenberg v. Carhart*.²⁰⁹ This statute, by use of the overly broad and non-medical term “partial birth abortion,” referred to an abortion procedure commonly used during second trimester abortions, known medically as “dilation and evacuation” (D&X) and a variation of the D&X procedure conducted when the woman is past the sixteen-week point of her pregnancy.²¹⁰ These types of procedures can be used to facilitate an abortion both when the fetus is non-viable and viable.²¹¹ The *Stenberg* Court, following precedent established in both *Roe* and *Casey*, deemed this legislation unconstitutional as violating the undue burden standard of governmental interference with abortion by removing the ability of a woman to choose, and the physician to perform, an abortion by the D&X procedure, as well as the statute’s failure to include an exception allowing the performance of this procedure to preserve the health of the woman.²¹²

207. See Neb. Rev. Stat. § 28-328 (Supp. 1999). This Nebraska statute was enacted to criminalize performance of “partial birth abortions” as defined within the statute. *Id.* See also Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105 (2003), for the federal law enacted to prohibit “partial birth abortion” procedures as defined within the statute. *Id.*

208. Neb. Rev. Stat. § 28-328 (Supp. 1999); Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105 (2003).

209. 530 U.S. 914 (2000).

210. *Id.* at 922-930. According to medical literature which served as the basis for the Court’s fact finding, the most common abortion procedure during the second trimester is “dilation and evacuation.” This process “involves dilation of the cervix, removal of at least some fetal tissue using nonvacuum surgical instruments, and [after a certain point in pregnancy,] the potential need for instrumental dismemberment of the fetus or the collapse of fetal parts to facilitate evacuation from the uterus . . . [T]he risk of mortality and complications that accompany [this procedure] are significantly lower than those accompanying induced labor procedures.” Similarly, the “dilation and evacuation” procedure used after sixteen weeks of pregnancy was found to be “superior to, and safer than” the dilation and extraction procedure. *Id.* at 929.

211. See *id.* at 965.

212. See *id.* at 929-930.

The Court held that the state interest in preserving potential life, as established in *Roe*, was not furthered by limiting specific means by which an abortion could be obtained.²¹³ The *Stenberg* Court also concluded that because the statute made it possible for criminal prosecution of physicians who used the D&X procedures, this common, pre-viability abortion procedure would be inaccessible to women.²¹⁴ This restriction of choice placed an undue burden upon “a woman’s right to make an abortion decision,” in violation of the *Casey* holding.²¹⁵

The Nebraska statute was also struck down as violating remaining principles of *Roe*, as it failed to name an exception to allow performance of the procedure when necessary to preserve the health and life of the woman.²¹⁶ Nebraska argued in defense of its statute that no such exception was necessary, as “safe alternatives [to the banned procedure] remain available” and “a ban [on this specific procedure] would create no risk to the health of women.”²¹⁷ The *Stenberg* Court did not accept this argument, relying on *Roe*’s dictation that states’ interests in potential human life must heed to preserve the life and health of the pregnant woman, when medically determined to be necessary.²¹⁸ The Court concluded that based on “substantial medical authority,” a statute mandating such a blanket ban on a specific procedure in itself “creates a significant health risk” and the “absence of a health exception will place women at an unnecessary risk of tragic health consequences.”²¹⁹

Three years after the Supreme Court’s ruling in *Stenberg*, Congress passed legislation similar to the unconstitutional Nebraska statute and this bill was signed into law by President Bush in October 2003.²²⁰ The federal legislation, known as the Partial Birth Abortion Ban Act, contains the same provisions deemed unconstitutional in the *Stenberg* decision.²²¹ The federal Act bans more than one pre-viability abortion procedure, including “the safest and most commonly used abortion technique in the second trimester,” and fails to include a health exception.²²²

213. *See id.* at 930.

214. *See id.* at 945.

215. *Stenberg*, 530 U.S. at 945-46. *See also Casey*, 505 U.S. 835.

216. *See Stenberg*, 530 U.S. at 931.

217. *Id.* at 931-932. *See also* Brief for Petitioners at 36, *Stenberg*, 530 U.S. 914 (No. 99-830). Petitioners claimed “safe alternatives” to the D&X procedure include “both the D&E abortion procedure and the induction procedure.” *Id.*

218. *See Roe v. Wade*, 410 U.S. 113, 164-64 (1973). *See also Stenberg*, 530 U.S. at 935.

219. *Stenberg*, 530 U.S. at 937.

220. *See* Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105 (2003).

221. *See Unconstitutional Assault*, *supra* note 75.

222. *Id.*

The *Stenberg* Court firmly held that any legislation restricting abortion must comply with two standards: the restriction must not impose an undue burden, and it must allow for a health exception.²²³ The federal ban ignores these constitutional mandates by tailoring its regulations almost identically to those struck down in *Stenberg* in failing to include a health exception and in the use of overly broad language posing potential for “undue burden” upon reproductive rights.²²⁴

The federal ban on commonly used abortion procedures, including pre-viability procedures, has the potential to be expanded into bans on equally common abortion procedures.²²⁵ The broad and ambiguous language of the federal bill leaves open potential for criminalization of abortions not specifically identified and discussed by the bill’s sponsors.²²⁶ The bill “fails to limit the stage of pregnancy to which the . . . provisions apply,” therefore posing the possibility that abortion procedures could be criminalized at all stages of pregnancy.²²⁷ The statutory language also fails to define “key terms” in the bill and any future judicially broad interpretation of the bill could serve “criminalize numerous safe abortion procedures.”²²⁸

Such “unprecedented intrusion into medical practice” upon the right to reproductive choice creates an undue burden in obtaining an abortion.²²⁹ The failure of the federal act to limit its application to specific points during the pregnancy, defined in terms of fetal viability or the trimester formula, leads to the most “severe erosion” of the basic reproductive rights recognized in *Roe* and *Casey*: the right to choose abortion free from government regulations and burden in the first trimester.²³⁰ The imposition of the Partial Birth Abortion Act, limiting women’s access to commonly used abortion procedures during the first trimester is both unconstitutional and in violation of Court precedent.²³¹ This first trimester interference is a period where states are specifically deemed lacking such “compelling interests” and are therefore disallowed from imposing such restrictive regulations as included in the Partial Birth Abortion Act.²³²

The World Health Organization has defined “health” as a “total state of well-being” which seemingly includes a woman’s mental health and socio-

223. *See id.*

224. *Id.*

225. *See id.*

226. *See id.*

227. *Id.*

228. *Id.*

229. *Id.*

230. *Id.*

231. *See id.* *See also* *Planned Parenthood v. Casey*, 505 U.S. 833 (1992). *See also generally* *Roe v. Wade*, 410 U.S. 113 (1973).

232. *See generally* *Unconstitutional Assault*, *supra* note 75.

economic considerations, such as the spacing and number of children, which are excluded from “health” considerations of the legislation.²³³ The inadequacy of the provision not only impinges upon a woman’s physical health and refuses to consider her total state of well-being, but also denies physicians the ability to exercise their medical judgment and choice under the principles of *Roe*.²³⁴

The holdings of *Roe* and *Casey* guarantee protection of both the woman’s life and health, and dictate that even legally prohibited abortions may be conducted if the woman’s life or health is at risk.²³⁵ The health exception has been identified as containing two “essential components” mandated by the Court to be included in all regulation of abortion:

The health exception must allow the physician to exercise reasonable medical judgment, even where medical opinions differ . . . [and a] physician must be able to invoke the health exception not only when pregnancy itself creates a health risk for the woman, but also when the abortion restriction would, without such an exception, force women to use riskier methods of abortion.²³⁶

The relatively broad health exception dictated in *Stenberg* allows great discretion to the providing physician in protecting the well-being of the female patient.²³⁷ The Court specifically differentiates health concerns from life-threatening complications, both of which would allow performance of the otherwise prohibited procedure.²³⁸ The health exception dictates the health risk cannot be limited to “an absolute medical necessity,” as doing so would presumably provide little or no meaningful difference between a threat to a woman’s health and one to her life.²³⁹ The *Stenberg* Court’s definition of the health exception is also inclusive of instances where the woman’s health would be threatened by risks resulting from complications other than those associated with pregnancy.²⁴⁰ This condition is limited, however, by the Court’s specifying that such a non-pregnancy risk only

233. Berer, *supra* note 86, at 582.

234. See Brief for Petitioners at 60 n.48, *Stenberg v. Carhart*, 530 U.S. 914 (8th Cir. 1999) (No. 99-830).

235. See generally *Roe*, 410 U.S. 113; *Casey*, 505 U.S. 833.

236. *Abortion Bans Are Unconstitutional—An Analysis of Stenberg v. Carhart*, Planned Parenthood Federation of America, at <http://www.plannedparenthood.org/library/ABORTION/carhart6-02.html> (citing *Stenberg*, at 931, 937) (last visited Apr. 19, 2004) [hereinafter *Abortion Bans are Unconstitutional*].

237. See *id.*

238. See generally *id.* See also *Stenberg*, 530 U.S. 914.

239. *Abortion Bans are Unconstitutional*, *supra* note 236 (quoting *Stenberg*, 530 U.S. at 937).

240. See *id.* See also *Stenberg*, 530 U.S. at 931.

come from the possibility that the woman would endanger her health by seeking a “riskier method of abortion,” presumably self-induced abortion or illegal abortions outside a regulated medical setting.²⁴¹

Congress rationalized the absence of a similar health exception by stating that “partial birth abortion is never necessary to preserve the health of a woman,” the findings of *Stenberg* were “questionable,” and that their findings since the *Stenberg* decision should take precedent.²⁴² Contrary to this congressional basis for enacting the Act, it is firmly held constitutional precedent that congressional legal conclusions, based on their own fact findings, are unsupportable.²⁴³ “Congress cannot simply ignore a legal ruling it dislikes by adopting conflicting legislative findings.”²⁴⁴ In addition to this precedent, the Supreme Court has no “obligation to defer to congressional findings” and may “independently assess” findings of the lower courts.²⁴⁵

The “earlier in pregnancy that an abortion takes place, the safer it is for the woman’s health and the less complicated for the provider.”²⁴⁶ Therefore, regulations taking the “abortion decision” away from the woman herself pose a health risk and “should be avoided” on such grounds.²⁴⁷ Legal “obstacles and [other] delays in obtaining abortions” after the first trimester play a large role in creating unnecessary complications and a greater need for delayed, later term abortions.²⁴⁸

Despite governmental ability to prevent the need for a large percentage of later term abortions in the United States, various non-legal circumstances continue to necessitate the availability of abortion to women beyond the first term of pregnancy.²⁴⁹ A majority of women desire abortions for the purpose of family planning, as well as socio-economic grounds.²⁵⁰ Current laws in the United States generally only allow late term abortions in instances where the “woman is seen as a victim of circumstances, i.e. in a medical emergency . . . or following rape or incest” and are restrictive

241. *Id.* (quoting *Stenberg*, 530 U.S. at 931).

242. Partial Birth Abortion Ban Act of 2003, Pub. L. No. 108-105 (2003).

243. *See Unconstitutional Assault*, *supra* note 75.

244. *Id.*

245. *Id.*

246. Berer, *supra* note 86, at 583.

247. *Id.*

248. *Id.* at 584.

249. *See id.* “Women who need abortions after the first trimester of pregnancy include the following: those who are not aware that they are pregnant or who deny the pregnancy until it begins to show; those who think they are too old to get pregnant; those whose personal circumstances change dramatically during the pregnancy; those who develop medical reasons for abortions; and those who find out that the fetus is seriously damaged.” *Id.*

250. *See id.* at 583.

upon the right to, and need for, an abortion.²⁵¹ The curtailment of already limited exceptions signifies a backward movement in American jurisprudence regarding acceptance and respect for women's rights to control reproduction, as well as posing substantial health risks.²⁵²

2. European Law

In general, women governed by more liberal abortion laws and enjoying greater access to abortion services demonstrate a lesser need for late term abortions.²⁵³ Nations which impose fewer restrictions upon abortion often rationalize such laws upon government interest in protection of women's health, in addition to respecting reproductive rights.²⁵⁴ This is also a premise of American abortion regulation, as established in the *Roe* decision.²⁵⁵ However, "legal requirements" even in nations where "abortion is permitted under [relatively] broad conditions," such as the United States, often "create barriers causing women to delay" in accessing and receiving an abortion.²⁵⁶ These restrictions "are likely to [result] in abortions performed later in gestation than they otherwise would be."²⁵⁷ Such delays pose a serious health consequence as the risk and "probability of complications and death" dramatically increases with gestation for women obtaining legal abortions.²⁵⁸

There is little need for legal regulation or restriction of late term abortions in nations such as France, Belgium, and The Netherlands, as few legal or logistical barriers restrict or hinder women obtaining abortions early in pregnancy.²⁵⁹ The Netherlands provides an excellent example of a nation where "abortion is legal," "abortion levels are . . . low," "high-quality services are within the reach of most women . . . of childbearing age," and the

251. *Id.*

252. *See id.* at 582.

253. *See* Cecile Wijen & Jany Rademakers, *Abortus in Nederland 2001-2002*, Rutgers Nisso Groep at <http://www.rng.nl/publicaties/abortusregistratie20012002.pdf> (last visited Mar. 8, 2004).

254. *See id.* *See also* *Is Abortion Right?*, *supra* note 131.

255. *See generally* *Roe v. Wade*, 410 U.S. 113 (1973).

256. *Sharing Responsibility*, *supra* note 149, at 33-36 (noting that "permission . . . from a parent, counseling requirements, mandatory waiting periods, approval procedures and the need to locate and travel to an authorized provider," and costs as complications resulting in late-term abortions).

257. *Id.* at 33.

258. *See Sharing Responsibility*, *supra* note 149, at 33. "In the United States, abortions at 16-20 weeks have a fatality rate of 6.9 deaths per 100,000 procedures, whereas those performed at gestations of eight weeks or less have a fatality rate of only 0.4 per 100,000." *Id.*

259. *See* Wijen & Rademakers, *supra* note 253, at 43.

vast majority of abortions are performed very early in pregnancy.²⁶⁰ Abortion was formally legalized by the Dutch Parliament in 1981 and came into effect in 1984 under the Pregnancy Termination Act (PTA).²⁶¹ Prior to the development of the PTA, abortion clinics existed in The Netherlands since 1969 and were “tolerated by the government” despite their illegality.²⁶² The early clinics were accessible, highly “specialized,” “not unnecessarily medicalized” and most abortions were performed “relatively early in pregnancy.”²⁶³ The PTA implemented several regulations on abortion, such as a permit system for abortion clinics and providers, which can be seen as more of a protective measure for health and safety than a burdensome law.²⁶⁴ Otherwise, the language of the PTA is structured as to allow the abortion decision to be made in a medical, informed-consent context between the woman and her providing physician.²⁶⁵ The relevant provision of the PTA states:

[T]he woman must be in an emergency situation. Whether an emergency situation exists must be determined by the woman and the physician together [T]he physician must perform the treatment only when he or she is convinced that the woman has carefully considered her decision and has made the choice voluntarily.²⁶⁶

Although the PTA requires a woman to be in an “emergency situation,” the law does not define what is considered such a situation, essentially leaving the choice to obtain an abortion unburdened.²⁶⁷

Due largely to the unrestrictive nature of the PTA, the majority of abortions in The Netherlands are performed at a “very early stage” during the pregnancy, “indicating that [due to few restrictions and wide availability] Dutch residents can easily find their way to an abortion-clinic.”²⁶⁸ The Netherlands asserts a few late term abortions, with seventy percent of abortions performed at nine weeks or less.²⁶⁹ Correspondingly, The Nether-

260. *Sharing Responsibility*, *supra* note 149, at 44.

261. See ANNUAL REPORT OF THE NATIONAL ABORTION REGISTRY, *Abortion in The Netherlands 1993-2000*, available at <http://en.stisan.nl/documents/general/aar.pdf> (last visited Apr. 19, 2004) [hereinafter *Abortion in The Netherlands*].

262. See *id.* at 7.

263. *Id.* (The term “medicalized” refers to the fact that abortions performed in early Dutch clinics were generally not performed by gynecologists, but still involved the use of general anesthesia).

264. See *id.*

265. See *id.*

266. *Id.*

267. *Abortion in The Netherlands*, *supra* note 261.

268. Wijen & Rademakers, *supra* note 253, at 43.

269. See *Sharing Responsibility*, *supra* note 149, at 33.

lands also reports a low incidence of “medical complications” associated with abortion.²⁷⁰

Although there is little necessity for regulation of late-term abortions due to the lack of demand, the PTA imposed a viability limitation, past which abortions may not be legally performed.²⁷¹ Unlike the ambiguous viability standard presented in *Roe v. Wade*, viability is explicitly defined within the PTA in medical terms, stating: “Abortions may be performed until the moment that the foetus [sic] can survive outside the body of the woman. Current medical science sets this point at 24 weeks.”²⁷² Such specificity avoids potential governmental intrusion upon earlier term abortions, unlike the lax *Roe* definition that allows for such potential intrusion in the United States.²⁷³ In practice, however, abortions are generally not performed past twenty-two weeks, but the legal option to obtain an abortion is guaranteed up to twenty-four weeks.²⁷⁴

Dutch abortion legislation and policy provides an exemplary combination of respect for reproductive rights and autonomous decision-making, as well as adequately providing for health concerns associated with abortion.²⁷⁵ It essentially removes the need for late term abortions thereby decreasing the number of women subjected to risks associated with such procedures, but permits them upon request, respecting a broad interpretation of reproductive rights.²⁷⁶⁻⁷⁶

The European approach of preventing the need for late term abortions by making abortion accessible during the early stages of pregnancy also avoids the need for implementation of controversial abortion techniques.²⁷⁷ The highly contested procedures at issue in *Stenberg v. Carhart* and banned by the federal Partial Birth Abortion Ban Act are typically performed in late term abortions of fifteen to sixteen weeks gestation.²⁷⁸ Such procedures are necessary due to the level of fetal development found in later term pregnancies.²⁷⁹

270. See Wijen & Rademakers, *supra* note 253, at 43.

271. See *Abortion in The Netherlands*, *supra* note 261.

272. *Id.* at 7. See also PETCHESKY, *supra* note 3, at 291.

273. See *Abortion in The Netherlands*, *supra* note 261. See also PETCHESKY, *supra* note 3, at 291.

274. See *Abortion in The Netherlands*, *supra* note 261, at 7.

275. See *Sharing Responsibility*, *supra* note 149, at 44. See generally *Abortion in The Netherlands*, *supra* note 261.

276. See *Sharing Responsibility*, *supra* note 149, at 44. See also *Abortion in The Netherlands*, *supra* note 261.

277. See *Sharing Responsibility*, *supra* note 149, at 33-34.

278. See Brief for Petitioners at 13, *Stenberg v. Carhart*, 530 U.S. 914 (8th Cir. 1999) (No. 99-830).

279. See *Sharing Responsibility*, *supra* note 149, at 33-34.

Although late term abortions are rarely necessary in nations providing liberal laws and access to quality health services, they are typically still allowed in varying degrees and circumstances in these countries.²⁸⁰ In addition, laws of these nations allow medical decisions to remain between the woman and her provider and do not prohibit specific medical procedures used in performing abortions as experienced in the United States.²⁸¹

In the same amendment to its national abortion law, France extended the period in which abortions can be performed from ten weeks to twelve weeks.²⁸² This increase was advocated in the Nisand Report as part of the overall effort to increase access to abortion in France and to “enable all women to exercise the right to abortion.”²⁸³ It was found that approximately 5,000 French women left the country each year to obtain an abortion, as they were barred from receiving services in France due to the ten-week limitation.²⁸⁴ Almost half of these women were between ten and twelve weeks into their pregnancy, prompting the moderate increase to twelve weeks.²⁸⁵ The report only proposed the extension to twelve weeks, despite government disapproval of arguments opposed to longer limits.²⁸⁶ This reasoning was based not upon a desire to limit women’s access to late term abortions, but to structure legislation in accordance with the available techniques utilized by providers past the ten-week point in pregnancy.²⁸⁷ The French law mandates a strong health exception, stating that abortions may be performed at anytime during pregnancy should the pregnancy “pose a grave danger to the woman’s health.”²⁸⁸ Although the law places the ultimate discretion in the hands of the provider, the health exception is broad.²⁸⁹ It does not mandate that the woman’s physical condition or the pregnancy itself be the source of endangerment to her health, thereby leav-

280. See *Abortion in The Netherlands*, *supra* note 261 (discussing Dutch law regarding legal abortion and length of pregnancy); *Reproductive Health*, *supra* note 129 (discussing French law regarding legal abortion and length of pregnancy); Pyck, *supra* note 183 (discussing Belgian law regarding legal abortion and length of pregnancy).

281. See *Reproductive Health*, *supra* note 129; *Abortion in The Netherlands*, *supra* note 261; Pyck, *supra* note 127.

282. See *generally Is Abortion Right?*, *supra* note 131.

283. *Id.*

284. See *id.*

285. See *id.*

286. See *id.*

287. See *id.*

288. U.N. POPULATION DIVISION, ABORTION POLICIES: A GLOBAL REVIEW, at 50-52, U.N. Sales No. E.01.XIII.18. (2002), available at <http://www.un.org/esa/population/publications/abortion/profiles.htm> (last visited Apr. 19, 2004).

289. See *id.*

ing open the possibility for mental conditions or contemplation of suicide to constitute such a "grave danger."²⁹⁰

French and Belgian abortion legislation permit fetal impairment exceptions, which allow an abortion to be performed at any point during a pregnancy, provided that the "expected child will suffer from a particularly severe illness recognized as incurable."²⁹¹ The Belgian law allows the fetal impairment exception if "the fetus is judged to have 'an extremely serious and incurable disease.'"²⁹² In both nations, the concurring opinion of two doctors is necessary.²⁹³

Generally, certain European nations have recognized the increased health risks associated with later term abortions.²⁹⁴ In response, these nations have designed their laws and public policies to avoid the need for strict regulations upon late term abortions.²⁹⁵ Although Belgium and France only permit abortions during the first twelve weeks of a pregnancy, such regulations were formed in accordance with the general demand from their respective populations.²⁹⁶ Belgium, France and The Netherlands all maintain unambiguous health exceptions, in addition to a fetal impairment exception, allowing abortion at any stage of pregnancy under such circumstances.²⁹⁷

In contrast to current legislation development in the United States, efforts internationally are focused upon increasing the availability and safety of abortions, rather than constructing legal and logistical barriers to such services.²⁹⁸ France, Belgium, and The Netherlands tend to place greater importance and legal consideration upon abortion as a medical service which all women have a fundamental right to receive, rather than viewing it as an immoral act that must be restricted.²⁹⁹ This perspective encourages the increased liberalization of abortion regulations as required by society and medical practice, rather than placing additional restrictions upon women and abortion providers.³⁰⁰

290. *Id.*

291. *Id.* See also Pyke, *supra* note 127.

292. Pyke, *supra* note 127.

293. See *id.* See also U.N. POPULATION DIVISION, *supra* note 288.

294. See *Sharing Responsibility*, *supra* note 149.

295. See *id.*

296. See Pyke, *supra* note 127. See also *Is Abortion Right?*, *supra* note 131.

297. See generally *Sharing Responsibility*, *supra* note 149.

298. See *id.*

299. See generally *id.*

300. See *Is Abortion Right?*, *supra* note 131. See generally *id.*

IV. CONCLUSION

When viewed in a global context, persons in the United States benefit from relatively liberal government policies regarding reproductive health and abortion.³⁰¹ However, when these rights, and the various limitations upon such rights, are selectively compared to certain European nations, reproductive “privileges” allowed in the United States are deemed improvable.³⁰² No one European nation embodies absolute reproductive freedom, but by examining various aspects of law, policy, and societal views from several other nations, it is possible to recognize the practical liberalization of American perceptions of reproductive health issues, particularly in a legal sense.³⁰³

An underlying reason behind the more liberal abortion laws in certain European nations involves different societal views regarding sexuality than held in the United States.³⁰⁴ Sexual issues, particularly teenage sexuality, are viewed in the United States as private issues not appropriate to be liberally and openly discussed in politics and society, as is common in France and The Netherlands.³⁰⁵ These nations adopt a realistic and straightforward approach to issues associated with teenage sexual relations mainly by teaching responsibility and improving access to reproductive health services.³⁰⁶ Contrary to such practices, American law and policy “addresses high abortion rates by making abortion” more difficult to access and by promoting abstinence-only education.³⁰⁷ It becomes extremely challenging to ignore the significant correlation between the open laws and societal attitudes and the low teenage pregnancy and abortion rates in nations such as France and The Netherlands.³⁰⁸

American societal views of teenage sexuality and corresponding legal “solutions” create a cycle of ignorance and discrimination which should not be tolerated or worsened by increasingly restrictive laws and court decisions.³⁰⁹ The United States may not be structured to accept certain European liberal attitudes applied to teenage sexuality and reproductive health, but may not continue to repress the problems associated with unwanted teenage pregnancies.³¹⁰ The greater value generally placed upon absti-

301. See generally *Sharing Responsibility*, *supra* note 149.

302. See *id.*

303. See *id.* See also GLENDON, *supra* note 132.

304. See James Wagoner, *Introduction to Berne*, *supra* note 127, at xi.

305. See *Berne*, *supra* note 127. See also Boonstra, *supra* note 144.

306. See Boonstra, *supra* note 144.

307. *Id.*

308. See *id.*

309. See generally *id.*

310. See Wagoner, *supra* note 304.

nence in America than in other Western nations must not supercede access to services that could protect the health and well-being of American youth.³¹¹

In persisting to limit women's access to abortion, restrictive abortion laws effective in the United States have essentially created an increased demand for a number of late term abortions.³¹² Laws criminalizing certain abortion techniques associated with later term abortions, and the absence of a health exception in the most recent federal regulation, are detrimental to women voluntarily seeking a later term abortion, or those requiring such due to circumstances beyond their control.³¹³ Women are effectively left with few realistic "choices" by such conflicting laws: they are often impeded from obtaining an early abortion, but laws governing later abortions pose substantial health risks by failing to allow physicians to exercise appropriate medical discretion.³¹⁴

A common goal shared by the United States, France, Belgium, and The Netherlands is the maintenance of a low instance of abortion.³¹⁵ Among these developed nations, the United States stands alone in failing to achieve this objective.³¹⁶ By persisting in efforts to restrict abortion services, the United States will not only continue to infringe upon women's rights and place their health and lives at risk, but its aim of making abortions rare will continue to be elusive.³¹⁷

The United States presents itself as a nation embodying respect for Constitutional values, women's rights, and the utmost concern for public health.³¹⁸ Such important principles are not reflected, however, by the post-*Roe* torrent of restrictive, and often unconstitutional, laws infringing upon the established right to obtain an abortion and the ability for it to be provided under the safest conditions.³¹⁹ It is now necessary for the United States to look internationally in order to visualize actual implementation of these "American" values.³²⁰

Fay Sliger

311. *See id.*

312. *See generally* Berer, *supra* note 86, at 583.

313. *See id.*

314. *See generally id.*

315. *See generally* Cohen, *supra* note 128.

316. *See generally id.* *See also* Boonstra, *supra* note 144.

317. *See generally* Cohen, *supra* note 128.

318. *See generally* Berer, *supra* note 86, at 582.

319. *See id.* at 588.

320. *See generally* Cohen, *supra* note 128.