tion is an unusual single issue, one which eats away perhaps—at least in my belief—does eat away at the foundation of the theory which sustains this country. I believe that the opinions and prospective rulings of a Supreme Court Justice in this matter are pertinent to anyone's concern about the general welfare, and that is why I undertook such a long exploration into the subject.

Thank you, Mr. Chairman.

The CHAIRMAN. Senator, what did you decide about that article? Do you want it to go in now or be placed with the records in the committee? How would you prefer to handle it.

Senator DENTON. We would like to put it in now, and we are not going to use it in any other way.

The CHAIRMAN. Without objection, so ordered.

[Material supplied follows:]

[From the Philadelphia Inquirer, Aug 2, 1981]

ABORTION

(By Liz Jeffries and Rick Edmonds)

A woman's scream broke the late-night quiet and brought two young obstetrical nurses rushing to Room 4456 of the University of Nebraska Medical Center. The patient, admitted for an abortion, had been injected 30 hours earlier with a salt solution, which normally kills the fetus and causes the patient to deliver a mass of lifeless tissue, in a process similar to a miscarriage.

This time, though, something had gone wrong. When nurse Marilyn Wilson flicked on the lights and pulled back the covers, she found, instead of the still born fetus she'd expected, a live 2½-pound baby boy, crying and moving his arms and legs there on the bed.

Dismayed, the second nurse, Joanie Fuchs, gathered the squirming infant in loose bedcovers, dashed down the corridor and called to the other nurses for help. She did not take the baby to an intensive care nursery, but deposited it instead on the stainless steel drainboard of a sink in the maternity unit's Dirty Utility Room—a large closet where bedpans are emptied and dirty linens stored. Other nurses and a resident doctor gathered and gaped.

Finally, a head nurse telephoned the patient's physician, Dr. C. J. LaBenz, at home, apparently waking him.

"He told me to leave it where it was," the head nurse testified later, "just to watch it for a few minutes, that it would probably die in a few minutes."

This was in Omaha, in September 1979. It was nothing new. Hundreds of times a year in the United States, an aborted fetus emerges from the womb kicking and alive. Some survive. A baby girl in Florida, rescued by nurses who found her lying in a bedpan, is 5 years old now and doing well. Most die. The Omaha baby lasted barely 2½ hours after he was put in the closet with the dirty linen.

Always, their arrival is met with shock, dismay and confusion.

When such a baby is allowed to die and the incident becomes known, the authorities often try to prosecute the doctor. This has happened several dozen times in the past eight years, most recently in the case of Dr. LaBenz, who is to go on trial in Omaha this fall on two counts of criminal abortion. But interviews with nurses, some of them visibly anguished, uncovered dozens of similar cases that never reached public attention.

In fact, for every case that does become known, a hundred probably go unreported. Dr. Willard Cates, an expert on medical statistics who is chief of abortion surveillance for the Center for Disease Control in Atlanta, estimates that 400 to 500 abortion live births occur every year in the United States. That is only a tiny fraction of the nation's 1.5 million annual abortions. Still, it means that these unintended live births are literally an everyday occurrence.

They are little known because organized medicine, from fear of public clamor and legal action, treats them more as an embrassment to be hushed up than a problem to be solved. "It's like turning yourself in to the IRS for an audit," Cates said. "What is there to gain? The tendency is not to report because there are only negative incentives."

One result of the medical community's failure to openly acknowledge the problem is that many hospitals and clinics give their staffs no guidelines for dealing with

abortion live births. Even where guidelines exist, they may not be followed. The doctor is seldom present when a live birth occurs, because most late abortions—those done later than the midpoint of pregnancy—are performed by the injection of a solution (the method used in the Omaha case) that slowly induces delivery of the fetus many hours later. Crucial decisions therefore fall to nurses and physician residents with secondary authority over the case.

Signs of life in the baby may or may not be recognized. At some hospitals a liveborn abortion baby is presumed dead unless it conspicuously demonstrates otherwise, by crying or waving its arms and legs. Even then, the medical personnel on the scene may let the baby die rather than try to save it.

Because they are premature, these infants need immediate care, including machine support, in order to live. Given such care, many can survive in good health, as did a pair of abortion babies born in separate incidents in Wilmington, Del., in the spring of 1979 and since adopted. Others are too premature to be saved even with the best care.

Whether they live or die, these abortion live births—and even successful, routine abortions of late terms, highly developed fetuses—are taking a heavy emotional toll on medical staffs across the country. Some physicians say they have "burned out" and have stopped doing abortions altogether. Nursing staffs at hospitals in Cleveland, Grand Rapids, Fort Lauderdale and elsewhere have rebelled at late abortions and have stopped their hospitals from performing any abortions later than the midpoint of pregnancy. Some staff members who regularly perform late abortions report having nightmares about fetuses, including recurring dreams in which they frantically seek to hide fetuses from others.

In legalizing abortion in 1973, the Supreme Court said it was reserving the right to protect the life of a viable fetus—that is, one with the potential to survive outside the womb. But the court never directly acknowledged the chance of an aborted fetus' being born alive, and it therefore never gave a clear guideline for dealing with what Dr. Thomas Kerenyi, a leading New York expert on abortions, has called "the dreaded complication."

Twenty states (including Pennsylvania, New Jersey and Delaware) have no laws limiting late abortions or mandating care for live-born abortion babies. Even where such state laws exist,
unconstitutional.

"Everyone—doctors, attorneys, state legislators—is looking for some clear guidelines concerning disposition of these infants," said Newman Flanagan, district attorney for the City of Boston. "If a baby has rejected an abortion and lives, then it is a person under the Constitution. As such, it has a basic right to life. Unfortunately, it is difficult to protect that right, because there are no guidelines addressed to this specific issue."

Medical trends indicate that abortion live births will continue. They may even become more frequent. For one thing, demand for late-term abortions is undiminished, and with the growing popularity of genetic testing to screen for fetal defects midway through pregnancy, educated and affluent women are now joining the young, the poor and the uninformed who have been, until now, the main groups seeking late abortions.

Furthermore, estimating the gestational age of a fetus in the womb—a crucial aspect of a successful abortion—remains an inexact art. In March, doctors at the Valley Abortion Clinic in Phoenix estimated that one woman was 19 to 20 weeks pregnant; days later she delivered not an aborted fetus but a 2½-pound, 32-week baby. It survived after two months of intensive care at a Phoenix hospital.

Finally, medical science in the past 10 years has greatly improved its ability to care for premature babies. Infants are becoming viable earlier and earlier. Those with a gestational age of 24 weeks and weighing as little as 1½ pounds can now survive if given the best of care.

So long as doctors perform abortions up to the 24th week of pregnancy (as is legal everywhere in the United States under the 1973 Supreme Court ruling), it is statistically certain that some of these borderline cases will turn out to be viable babies, born alive. It happened again last May in Chicago—a 19-to-20-week estimate, a live-born 2-pound baby boy.

By ignoring the problem of abortion live births, the courts and the medical establishment are choosing to overlook a long, well-documented history of cases: *January 1969,* Stobhill Hospital, Glasgow, Scotland: A custodian heard a cry from a paper bag in the snow beside an incinerator. He found a live baby. It was taken inside and cared for in the hospital's operating theater but died nine hours later. The infant's gestational age had been estimated at 26 weeks by the physician performing the abortion. It was actually closer to 32 weeks. No efforts were made to check for signs of life before the aborted baby was discarded. No charges were filed.

Because the case had been written about in British medical journals, it was a matter of record—before abortion was legalized in this country—that such things could happen.

April 1973, Greater Bakersfield Hospital, Bakersfield, Calif.: A 4½-pound infant was born live following a saline abortion (induced by an injection of salt solution) performed by Dr. Xavier Hall Ramirez. Informed by phone, Dr. Ramirez ordered two nurses to discontinue administering oxygen to the baby. His instructions were countermandated by another doctor; the baby survived and later was placed for adoption. Ramirez was indicted for solicitation to commit murder. His attorney argued that a medical order based on medical opinion, no matter how mistaken, is privileged. Dr. Irvin M. Cushner of the University of California at Los Angeles, later to become a top health policy official in the Carter administration, testified that it was normal for Ramirez to expect the delivery of a dead or certain-to-die infant as the result of a saline abortion.

July 1974. West Penn Hospital, Pittsburgh: Dr. Leonard Laufe performed an abortion on a woman who contended she had been raped—though that and her account of when she became pregnant were later disputed. She had been turned down for an abortion at another hospital, where the term of her pregnancy was estimated at 26 to 31 weeks. Laufe put it at 20 to 22. The abortion, induced by an injection of prostaglandin, a substance that stimulates muscle contraction and delivery of the fetus, was filmed for use as an instructional film. The film showed the three-pound infant moving and gasping. Also, a nurse and a medical student testified that they had noticed signs of life. No charges were filed, however, after a coroner's inquest at which Laufe testified that the infant sustained fatal damage during delivery.

February 1975, Boston: Dr. Kenneth Edelin was convicted of manslaughter for neglecting to give care to a 24-week infant after a 1973 abortion at Boston City Hospital. Witnesses said Edelin held the infant down, constricting the flow of oxygen through the umbilical cord and smothering it. He was the first and only American doctor ever convicted on charges of failing to care for an infant born during an abortion. The conviction was overturned by the Massachusetts Supreme Court on the ground that improper instructions had been given to the jury. Edelin and his lawyer argued that he had taken no steps to care for the infant because it was never alive outside the womb.

March 1977, Westminster Community Hospital, Westminster, Calif.: A seven-month baby girl was born live after a saline abortion performed by Dr. William Waddill. A nurse testified that Waddill, when he got to the hospital, interrupted her efforts to help the baby's breathing. A fellow physician testified that he had seen Waddill choke the infant. "I saw him put his hand on this baby's neck and push down," said Dr. Ronald Cornelson. "He said, 'I can't find the goddamn trachea,' and 'This baby won't stop breathing.' " Two juries, finding Cornelson an emotional and unconvincing witness, deadlocked in two separate trials. Charges against Waddill were then dismissed. He had contended the infant was dying of natural causes by the time he got to the hospital.

July 1979, Cedars-Sinai Medical Center, Los Angeles: Dr. Boyd Cooper delivered an apparently stillborn infant, after having ended a problem pregnancy of 23 weeks. Half an hour later the baby made gasping attempts to breathe, but no efforts were made to resuscitate it because of its size (1 pound 2 ounces) and the wishes of the parents. The baby was taken to a small utility room that was used, among other things, as an infant morgue. Told of the continued gasping, Cooper instructed a nurse, "Leave the baby there—it will die." Twelve hours later, according to testimony of the nurse, Laura VanArsdale, she returned to work and found the infant still in the closet, still gasping.

Cooper then agreed to have the baby boy transferred to an intensive care unit, where he died four days later. A coroner's jury ruled the death "accidental" rather than natural but found nothing in Cooper's conduct to warrant criminal action.

A common thread in all these incidents is that life was recognized and the episode brought to light by someone other than the doctor. Indeed, there is evidence that doctors tend to ignore all but the most obvious signs of life in an abortion baby.

In the November 1974 newsletter of the International Correspondence Society of Obstetricians and Gynecologists, several doctors addressed a question from a practitioner who had written in an earlier issue that he was troubled by what to do when an aborted infant showed signs of life.

One was Dr. Ronald Bolognese, an obstetrician at Pennsylvania Hospital in Philadelphia, who replied:

"At the time of delivery, it has been our policy to wrap the fetus in a towel. The fetus is then moved to another room while our attention is turned to the care of [the woman]. She is examined to determine whether complete placental expulsion has

occurred and the extent of vaginal bleeding. Once we are sure that her condition is stable, the fetus is evaluated. Almost invariably all signs of life have ceased."

(Bolognese recanted that statement in a 1979 interview. "That's not what we do now," he said. "We would transport it to the intensive care nursery.")

In addition, Dr. William Brenner of the University of North Carolina Medical School suggested that if breathing and movement persist for several minutes, "the patient's physician, if he is not in attendance, should probably be contacted and informed of the situation. The pediatrician on call should probably be apprised of the situation if signs of life continue."

Dr. Warren Pearse, executive director of the American College of Obstetrics and Gynecology, was asked in a 1979 interview what doctors do, as standard practice, to check whether an aborted fetus is alive.

"What you would do next [after expulsion] is nothing," Pearse said. "You assume the infant is dead unless it shows signs of life. You're dealing with a dead fetus unless there is sustained cardiac action or sustained respiration—it's not enough if there's a single heartbeat or an occasional gasp."

These seemingly callous policies are based on the assumption that abortion babies are too small or too damaged by the abortion process to survive and live meaningful lives. That is not necessarily the case, though, even for babies set aside and neglected in the minutes after delivery.

A nursing supervisor who asked not to be identified told of an abortion live birth in the mid-'70s in a Florida hospital. The infant was dumped in a bedpan without examination, as was standard practice. "It did not die," the nurse said. "It was left in the bedpan for an hour before signs of life were noticed. It weighted slightly over a pound."

The baby remained in critical condition for several months, but excellent care in a unit for premature infants enabled it to survive. The child, now 5 years old, was put up for adoption. The nursing supervisor, who has followed its progress, said she has pictures of the youngster "riding a bicycle and playing a little piano."

In the spring of 1979 two babies were born alive, five weeks apart, after saline abortions at the Wilmington Medical Center. They were given vigorous care, survived and were later adopted. One had been discovered by a nurse, struggling for breath and with a faint heartbeat, after having been placed in a plastic specimen jar. The second was judged to be a live delivery and was given immediate help breathing.

A baby girl, weighing 1 pound 11 ounces, was born in February 1979 after a saline abortion at Inglewood (Calif.) Hospital. Harbor General Hospital, which is associated with UCLA and is fully equipped to care for premature babies, was called for help, but the neonatal rescue team did not respond. The infant died after three hours.

The Los Angeles Department of Health Services investigated and was told that there had been confusion over the baby's weight and that it reportedly showed poor vital signs. It was "very unusual for them not to pick up [an infant] of this size," Dr. Rosemary Leake of Harbor General told investigators.

The administrator of a New York abortion unit, asked what would be done for a live-born abortion baby, said, "The nurses have been trained in how to handle this. I'd like to think we would do everything to save it. But honestly I'm not sure."

These incidents together suggest that life in an aborted infant may or may not be recognized. If it is, supportive treatment may or may not be ordered.

Such incidents, when discovered, often provoke prosecutions. A few may seem something like murder at first blush. But on closer inspection the doctors' actions have been judged, time and again, not quite to fit the definition of a crime.

Nowhere was this more vividly shown than in the case of Dr. Jesse J. Floyd, who was indicted on charges of murder and criminal abortion by a grand jury in Columbia, S.C., in August 1975. The charges were the result of an abortion a year earlier of a baby that appeared to have a gestational age of 27 to 28 weeks. It weighed 2 pounds 5 ounces and lived for 20 days.

In October 1979 the state dropped its case against Floyd. County prosecutor James C. Anders later conceded in an interview that South Carolina's abortion law was of dubious constitutionality. "In the second place," he said, "I had a reluctant witness [the infant's mother]. That and the passage of time worked against me."

A detailed record was developed in the case, as part of a federal suit that Floyd brought against Anders in which he sought to block the state prosecution. The 20-year-old mother, Louise A., lived in the small town of Hopkins, worked at a military-base commissary and had plans to enroll in a technical college. Those plans made her unwilling to have the baby she was carrying, so she presented herself for an abortion at Floyd's office in July 1974. Court records indicate that she had been told erroneously by her hometown doctor's nurse that she was not pregnant, and that she only slowly realized that she was.

Floyd found her to be past the first trimester of pregnancy, and under South Carolina law that meant an in-hospital abortion would be required. There were delays in her raising $450 for the abortion and more delays in admitting her to Richland Memorial Hospital. She was injected with prostaglandin on Sept. 4 and expelled the live baby early on the morning of Sept. 6.

"I started having real bad labor pains again," Louise recalled in her deposition, "and finally my baby was born. I called the nurse. Then about four or five of them came in the room at the time. The head nurse came in the same time the other nurses came in and she told me did I know that the baby was a seven-month baby. I told her no.

"One of the nurses said that the baby was alive. They took the baby out of the room. He never did cry, he just made some kind of a noise."

The first doctor on the scene, paged from the cafeteria, was a young resident. She did not hesitate. On detecting a heartbeat of 100, she clamped and severed the umbilical cord and had the baby sent to the hospital's intensive care unit.

"It was a shock, a totally unique emergency situation, very upsetting to all of us," the doctor, who now practices in California, said in an interview. "Some people have disagreed with me [about ordering intensive care for an abortion live birth] but that seems to me the only way you can go.

"It's like watching a drowning. You act. You don't have the luxury of calling around and consulting. You institute life preserving measures first and decide about viability later on."

Ten days after birth, the baby had improved markedly and was given a 50-50 chance of survival. Then he developed a tear in the small intestine and died of that and other complications on Sept. 26.

Louise A. never saw the child. She checked out of the hospital two days after the abortion and did not return. But she did show a passing interest in the baby's progress.

"I kept calling this nurse," Louise said in her deposition. "I would call . . . and get information from them about the baby, and they told me he was doing fine. They told me he had picked up two or three pounds. I started going to school, and one afternoon I called home and they told me the baby had died, but no one told me the cause of his death."

Floyd never saw the infant either. On the day of the abortion, his hospital privileges at Richland were withdrawn, and they have never been restored.

These circumstances presented prosecutor Anders with a difficult case. Floyd had had no physical contact with the live-born infant, nor was he issuing orders concerning its care. Nonetheless, Anders thought the doctor could be held responsible for the infant's death.

Anders pressed his murder charge using an old English common-law theory. Under this theory, willfully doing damage to a "vital" infant in the womb could be considered a crime against the fetus as a person. The abortion itself, Anders alleged, was an assault.

The line of argument is not entirely farfetched. For instance, a Camden, N.J., man was convicted of murder in 1975 after he shot a woman in the abdomen late in her pregnancy, causing the dealth of the twins she was carrying. But application of the theory to abortion had never been tested—in South Carolina or anywhere else.

South Carolina law in the mid-1970s prohibited third-trimester abortion unless two other doctors certified that the abortion was essential to protect the life or health of the mother. No such certifications were made for Louise. However, various Supreme Court rulings suggested that both the requirement of consultation with other doctors and the explicit definition of viability (as beginning in the third trimester) would make that law unconstitutional.

Floyd's lawyers, George Kosko of Columbia, S.C., and Roy Lucas of Washington, also filed voluminous expert affidavits on the difficult of estimating gestational age accurately. At worst, they argued, Floyd had made a mistaken diagnosis. What proof was there that he had intentionally aborted a viable baby?

District Court Judge Robert Chapman and the Fourth Circuit Court of Appeals agreed that the prosecution was based on flimsy evidence and should be blocked. However, the Supreme Court disagreed, in a ruling in March 1979, and suggested that judgment should be withheld on constitutional matters until the state prosecution had run its course. The way was thus cleared for Anders to proceed, but with witnesses dispersed, memories fading and the legal basis for prosecution still doubtful, Anders chose to drop the case.

Floyd, 49, continues performing first-trimester abortions at his Ladies Clinic, but the loss of hospital privileges and the damage to his reputation caused his surgical practice to collapse, he said.

The long legal proceeding also seems to have had a chilling effect on abortion practice throughout South Carolina, which Anders concedes was one of his intentions.

"The main thing is the dilemma it puts the other physicians in," Floyd said in an interivew. "It's just about dried up second-trimester abortions in this state. I have to send mine to Atlanta, Washington or New York."

Asked about late abortions and the risk of live births, Floyd said he thought abortions performed through the sixth month of pregnancy create "a problem to which there isn't an answer. We probably need to move back to 20 weeks. I would be reluctant to do one now after 20 weeks."

A similar case occurred about the same time in South Carolina, when Anders obtained a criminal indictment charging Dr. Herbert Schreiber of Camden, S.C., with first-degree murder and illegal abortion.

On July 18, 1976, a month after the charges had been filed, the 60-year-old doctor was found dead in a motel room in Asheville, N.C. A motel maid discovered the body slumped in a chair. Several bottles of prescription drugs were recovered from the room. Two days later the Buncombe County medical examiner ruled the death a suicide from a drug overdose.

Schreiber, who left no not, had pleaded not guilty to the charge of having kilied a live baby girl after an abortion by choking or smothering her to death.

Comparing the Floyd and Schreiber cases, Anders found an irony: Schreiber "just reached in and strangled the baby," the prosecutor said his evidence showed. "I charged him with murder, and he committed suicide. If he had been willing to wait, he probably would have been OK too"

Not every doctor who performs a late abortion has to confront an aggressive prosecutor like Anders. But even those abortion live births that escape public notice raise deeply troubling emotions for the medical personnel involved. "Our training disciplines you to follow the doctor's orders," explained a California maternity nurse. "If you do something on your own for the baby that the doctor has not ordered and that may not meet with his commitment to his patient, the mother can sue you. A nurse runs a grave risk if she acts on her own. Not only her immediate job but her license may be threatened."

Nonetheless, nursing staffs have led a number of quite revolts against late abortions. Two major hospitals in the Fort Lauderdale areas, for instance, stopped offering abortions in the late 1970s after protests from nurses who felt uncomfortable handling the lifelike fetuses.

A Grand Rapids, Mich., hospital stopped late-term abortions in 1977 after nurses made good on their threat not to handle the fetuses. One night they left a stillborn fetus lying in its mother's bed for an hour and a half, despite angry calls from the attending physician, who finally went in and removed it himself.

In addition, a number of hospital administrators have reported problems in mixing maternity and abortion patients—the latter must listen to the cries of newborn infants while waiting for the abortion to work. And it has proved difficult in general hospitals to provide round-the-clock staffing of obstetrical nurses willing to assist withg the procedure.

One young nurse in the Midwest, who quit to go into teaching, remembers "a happy group of nurses" turning nasty to each other and the physicias because of conflicts over abortion. Ond day, she recalled, a woman physician "walked out of the operating room after doing six abortions. She smeared her hand [which was covered with blood] on mine and said,'Go wash it off. That's the hand that did it.' "

Several studies have documented the distress that late abortion causes many nurses. Dr. Warren M. Hern, chief physician, and Billie Corrigan, head nurse, of the Boulder (Colo.) Abortion Clinic, presented a paper to a 178 Planned Parent-hood convention entitled "Waht About Us? Staff Reactions . . ."

The clinic, one of the largest in the Rocky Mountain states, specializes in the D&E (dilation and evacuation) method of second-trimester abortion, a procedure in which the fetus is cut from the womb in pieces. Hern and Corrigan reported that eight of the 15 staff members surveyed reported emotional problems. Two said they worried about the physician's psychological well-being. Two reported horrifying dreams about fetuses, one of which involved the hiding of fetal parts so that other people would not see them.

"We have produced an unusual dilemma," Hern and Corrigan concluded. "A procedure is rapidly becoming recognized as the procedure of choice in late abortion, but those capable of performing or assisting with the procedure are having strong personal reservations about participating in an operation which they view as destructive and violent."

Dr. Julius Butler, a professor of obstetrics and gynecology at the University of Minnesota Medical School, is concerned about studies suggesting that D&E is the

safest method and should be used more widely. "Remember," he said, "there is a human being at the other end of the table taking that kid apart.

"We've had guys drinking too much, taking drugs, even a suicide or two. There have been no studies I know of of the problem, but the unwritten kind of statistics we see are alarming."

"You are doing a destructive process," said Dr. William Benbow Thompson of the University of California at Irvine. "Arms, legs, chests come out in the forceps. It's not a sight for everybody."

No all doctors think the stressfulness is overwhelming. The procedure "is a little bit unpleasant for the physician," concedes Dr. Mildred Hanson, a petite woman in her early 50s who does eight to 10 abortions a day in a clinic in Minneapolis, just a few miles across town from where Bulter works. "It's easier to . . . leave someone else—namely a nurse—to be with the patient and do the dirty work.

"There is a lot in medicine that is unpleasant" but necessary—like amputating a leg—she argues, and doctors shouldn't let their own squeamishness deprive patients of a procedure that's cheaper and less traumatic.

However, Dr. Nancy Kaltreider, an academic psychiatrist a the University of San Francisco, has found in several studies "an unexpectedly strong reaction" by the assisting staff to late-abortion procedures. For nurses, she hypothesizes, handling tissues that resemble a fully formed baby "runs directly against the medical emphasis on preserving life."

The psychological wear-and-tear from doing late abortions is obvious. Philadelphia's Dr. Bolognese, who seven years ago was recommending wrapping abortion live-borns in a towel, has stopped doing late abortions.

"You get burned out," he said. Noting that his main research interest is in the management of complicated obstetrical cases, he observed: "It seemed kind of schizophrenic, to be doing that on the one hand [helping women with problem pregnancies to have babies] and do abortions."

Dr. John Franklin, medical director of Planned Parenthood of Southeastern Pennsylvania, was the plaintiff in a 1979 Supreme Court case liberalizing the limits on late abortions. He does not do such procedures himself. "I find them pretty heavy weather both for myself and for my patients," he said in an interview.

Dr. Kerenyi, the New York abortion expert, who is at Mt. Sinai Hospital, has similar feelings but reaches a different conclusion. "I first of all take pride in my deliveries. But I've seen a lot of bad outcomes in women who did not want their babies—so I think we should help women who want to get rid of them. I find I can live with this dual role."

The legal jeopardy, the emotional strain, the winking neglect with which "signs of life" must be met—all these things nurture secrecy. Late abortions take place "behind a white curtain," as one prosecutor put it, well sheltered from public view.

Only one large-scale study has been done of live births after abortions—by George Stroh and Dr. Alan Hinman in upstate New York from July 1970 through December 1972 (a period during which abortion was legal in New York alone). It turned up 38 cases of live births in a sample of 150,000 abortions.

Other studies, including one that found signs of life in about 10 percent of the prostaglandin abortions at a Hartford, Conn., hospital, date from the mid-1970s. No one is so naive as to think there is reliable voluntary reporting of live births in the present climate, according to Dr. Cates of the Center for Disease Control.

Evidence gathered during research for this story suggests, without proving definitively, that much of the traffic in later abortions now flows to the New York and Los Angeles metropolitan areas, where loose practice more easily escapes notice.

"The word has spread," the Daily Breeze, a small Los Angeles suburban paper, said in July 1980, "that facilities in greater Los Angeles will do late abortions. How late only the woman and the doctor who performs them know."

This kind of thing is disturbing even to some peole with a strong orientation in favor of legal abortion. For instance, the Philadelphia office of CHOICE, which describes itself as "a reproductive health advocacy agency," will recommend only Dr. Kerenyi's service at Mt. Sinai among the half-dozen in New York offering abortion up to 24 weeks. The others have shortcomings in safety, sanitation or professional standards, in the agency's view.

An internal investigation of the abortion unit at Jewish Memorial Hospital in Manhattan, showed that six fetuses aborted there in the summer of 1979 weighed more than 1⅓ pounds. The babies were not alive, but were large enough to be potentially viable. A state health inspector found in June 1979 that the unit had successfully aborted a fetus that was well over a foot long and appeared to be of 32 weeks gestation. Hospital officials confirmed in an interview that later in 1979 a fetus weighing more than four pounds had been aborted.

"It's disconcerting," Iona Siegel, administrator of the Women's Health Center at Kingsbrook Jewish Medical Center in Brooklyn, said of abortions perfomed so late that the infant is viable. When Ms. Siegel hears, as she says she often does, that a patient turned away by Kingsbrook because she was past 24 weeks of pregnancy had an abortion somewhere else, "that makes me angry. Number one, it's against the law. Number two, it's dangerous to the health of the mother."

Though one might expect organized medicine to take a hand in bringing some order to the practice of late abortions, that is not happening.

"We're not really very pro-abortion," said Dr. Ervin Nichols, director of practice activities for the American College of Obstetrics and Gynecology. "As a matter of fact, anything beyond 20 weeks, we're kind of upset about it."

If abortions after 20 weeks are a dubious practice, how does that square with abortion up to 24 weeks being offered openly in Los Angeles and New York and advertised in newspapers and the Yellow Pages there and elsewhere?

"That's not medicine," Nichols replied. "That's hucksterism."

Cates, of the Center for Disease Control, concedes that he has ambivalent feelings about those who do the very late procedures. There is obviously some profiteering and some bending of state laws forbidding abortions in the third trimester. But since late abortions are hard to get legally in many places, Cates puts a low priority on trying to police such practices. Medical authorities leave the late-abortion practitioners to do what they will. And so, too, by necessity, do the legal authorities.

The Supreme Court framed its January 1973 opinion legalizing abortion around the slippery concept of viability. As defined by Justice Harry Blackmun in the landmark *Roe* v. *Wade* case, viability occurs when the fetus is "potentially able to live outside the mother's womb albeit with artificial aid."

The court granted women an unrestricted right to abortions, as an extension to their right of privacy, in the first trimester of pregnancy. From that point to viability, the state can regulate abortions only to make sure they are safe. And only after a fetus reaches viability can state law limit abortion and protect the "rights" of the fetus.

"Viability," Blackmun wrote, after a summer spent researching the matter in the library of the Mayo Clinic, "is usually placed at about seven months (28 weeks) but may occur earlier, even at 24 weeks."

The standard was meant to be elastic, changing in time with medical advances. Blackmun took no particular account, though, of the possibility of abortion live births, or of errors in estimating gestational age.

In subsequent cases, the high court ruled that:

A Missouri law was too specific in forbidding abortion after 24 weeks. "It is not the proper function of the legislature or the court," Blackmun wrote, "to place viability, which essentially is a medical concept, at a specific point in the gestational period."

A Pennsylvania law was too vague. The law banned abortions "if there is sufficient reason to believe that the fetus may be viable." The court said it was wrong to put doctors in jeopardy without giving them clearer notice of what they must do.

State laws could not interfere with a doctor's professional judgment by dictating the choice of procedure for late abortions or by requiring aggressive care of abortion live births.

According to a 1979 survey by Jeanie Rosoff of Planned Parenthood's Alan Guttmacher Institute, 30 states have laws regulating third-trimester abortions. Some of these laws prohibit or strictly limit abortions after the fetus has reached viability. Some require doctors to try to save abortion live-born babies. Only a few states have both types of laws.

In addition, a number of these laws have been found unconstitutional. Others obviously would be, in light of Supreme Court rulings. Virtually all the state laws would be subject to constitutional challenge if used as the basis of prosecution against an individual doctor.

New York and California, ironically, have among the strongest, most detailed laws mandating care for survivors of abortions. But these laws have proved only a negligible check on the abortion of viable babies.

"We've had a number of claims come up that a baby was born live and full effort was not given to saving it," said Dr. Michael Baden, former chief medical examiner of New York City. "We've not had cases of alleged strangulation (as with Dr. Waddill in California) and that surely must be rare. All [the doctor] has to do is nothing and the result is the same."

Alan Marrus, a Bronx County assistant district attorney, has investigated several live-birth cases and the applicable New York law. He has yet to find "a case that presented us with facts that warranted prosecution. You need an expert opinion

that in fact there was life and that the fetus would have survived. Often the fetus has been destroyed—so there is nothing for your expert witness to examine."

The incidents only come to light at all, Baden and Marrus noted, if some whistle-blower inside the hospital or clinic brings them to the attention of the legal authorities. The credibility of that sort of witness may be subject to attack. And even if the facts do weigh against a doctor, he has some resources left. Almost always he can claim to have made no more than a good-faith error in medical judgment.

"This is happening all over the place" said a California prosecutor. "Babies that should live are dying because callous physicians let them die." But he despairs of winning any convictions. "Nobody's as dumb as Waddill. They're smarter today. They know how to cover themselves."

Unfortunately, advances in medical technique may only aggravate the overall problem. Fetuses are becoming viable earlier and earlier, while the demand for later abortions shows no sign of abating. Some argue that Justice Blackmun's definition of viability as "usually seven months" was obsolete the day it was published. It clearly is now.

A decade ago, survival of an infant less than 3 pounds or 30 weeks gestation was indeed rare, principally because the lungs of smaller infants, unaided, are too undeveloped and fragile to sustain life. Now infants with birth weights of about 1⅔ pounds routinely survive with the best of care, according to Dr. Richard Behrman, chief of neonatology at Rainbow Babies and Childrens Hospital in Cleveland and chairman of a national commission that studied viability in the mid-1970s

Sometimes even smaller babies make it, and the idea that most of them will be retarded or disabled is out-of-date, Behrman said. "Most . . . survive intact."

Even with the medical advances, though, some live-born infants are simply too small and undeveloped to have a realistic chance to survive. A survey last year of specialists in neonatal care found that 90 percent would not order life-support by machine for babies smaller than 1 pound 2 ounces or less than 24 weeks gestation. And on occasion, a newborn may manifest muscular twitches or gasping movements without ever "being alive" according to the usual legal test of drawing a breath that fills the lungs.

Still, it is no longer a miracle for an infant of 24 weeks development (which can be legally aborted) to be saved if born prematurely.

"It is frightening," said Dr. Roger K. Freeman, medical director of Women's Hospital at the Long Beach Memorial Medical Center in Long Beach, Calif. "Medical advances in the treatment of premature babies enable us to save younger fetuses than ever before. When a fetus survives an abortion, however, there may be a collision of tragic proportions between medicine and maternity. Medicine is now able to give the premature a chance that may be rejected by the mother."

In 1970, Freeman developed the fetal stress test, a widely used technique for monitoring the heart rate of unborn fetuses. Also, he and a colleague at Long Beach, Dr. Houchang D. Mondalou, have developed a drug, betamethzene, that matures premature lungs within days instead of weeks. The hospital claims a 90 percent success rate with infants weighing as little as 1 pound 11 ounces.

At the University of California at Irvine, work is used way on an "artifical placenta" that doctors there say could, within five years, push the threshold of viability back even further.

The life-saving techniques are not exclusive to top academic hospitals, either. Good neonatal care is now broadly available across the United States. In fact, the lively issue in medical circles these days is not whether tiny premature babies can be saved, but whether it is affordable. Bills for the full course of treatment of a two-pound infant typically run between $25,000 and $100,000. To some, that seems a lot to pay, especially in the case of an abortion baby that was not wanted in the first place.

The only way out of the dilemma, it would seem, would be for fewer women to seek late abortions. Though some optiomists argue that this is happening, there is evidence that it is not.

Studies show that women seeking abortions late in the second trimester are often young, poor and sexually ignorant. Many either fail to realize they are pregnant or delay telling their families out of fear at the reaction. The patients also include those who have had a change of circumstance or a change of heart after deciding initially to carry through a pregnancy; some of these women are disturbed.

As first-trimester abortion and sex education become more widely available, the optimists' argument goes, nearly all women who choose abortion will get an early abortion. But in fact a new class of older, well-educated, affluent women has now joined the hardship cases in seeking late abortions.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

How Things Sometimes Go Wrong

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

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