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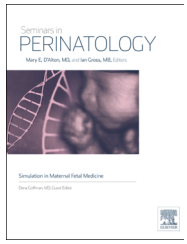

Peri-viable birth: Legal considerations

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ABSTRACT

Peri-viable birth raises an array of complex moral and legal concerns. This article discusses the problem with defining viability, touches on its relationship to abortion jurisprudence, and analyzes a few interesting normative implications of current medical practice at the time of peri-viable birth.

1. Definitional concerns

Viability is a clinical term of art that, for better or worse, casts a much wider normative net. In its simplest rendition, viability connotes the possibility that a fetus may survive after birth for an extended period of time with or without the assistance of healthcare providers. Its broader significance in public discourse, however, is suggested in the following U.S. Supreme Court opinion:

> ..viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions. The soundness or unsoundness of that constitutional judgment in no sense turns on whether viability occurs at approximately 28 weeks, as was usual at the time of *Roe*, at 23 to 24 weeks, as it sometimes does today, or at some moment even slightly earlier in pregnancy, as it may if fetal respiratory capacity can somehow be enhanced in the future.[1]

By relying on words such as "point" and "moment," this portion of the opinion written by Justices O'Connor, Souter, and Kennedy arguably leaves an impression that certitude exists in a clinical space where honest obstetricians and pediatricians recognize none can be found. What we know from publically reported data is that once a fetus has passed into at least 22 weeks of normal gestation, it is statistically possible to survive after birth beyond the neonatal period with the assistance of intensive medical care.[2] Is this enough information to establish a working definition of viability? The answer depends on what the definition is *working* to establish. If it merely means, as perhaps the Supreme Court intends, a threshold above which a fetus has been reported to survive after birth beyond the immediate neonatal period, the answer is yes.

However, such a definition is deceptive. For example, we do not actually know if a fetus born a few days before entering the 22nd gestational week could survive because we are not in the professional habit of attempting resuscitations after earlier births. We also know that dating of pregnancies is an imprecise affair with a margin of error of 3–5 days even with good estimation techniques.[3] Based on the limited data we have on actual births and our understanding of fetal developmental biology, we are confident that the chance of survival approaches nil for those born earlier than 22 weeks, but it would be dishonest to assert that there is zero chance of survival for any specific fetus near this margin. We simply do not know.

The definition is also simplistic. Convenient though it may be to treat viability as a threshold "point" or "moment" in a developing human life, it is better characterized as a dynamic interaction between the individual newly born and intensive medical care which requires assessment over time. Viability

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not only depends on the initial upfront maturity of a fetus at the moment of birth, but also on how well multiple fetal organ systems adapt to a series of targeted therapies directed at sustaining them over days, weeks, and months after birth.

Difficulty with pinpointing a robust, generalizable moment in time for viability does not (and should not) prevent us from declaring that at some point before 22 weeks' gestation there is no chance of survival after extremely premature birth. In specific individual cases, we just lack the ability to make a precise forecast. The problem of imprecision runs in the other direction too. Based on the same publically reported data, we know that a majority of fetuses delivered even into their 23rd week of gestation do not survive despite rescue attempts.[2] And, while the chances of survival dramatically increase with each passing week of gestation, even after 26 weeks, it is a certainty that a small percentage of neonates will suffer too many physiological derangements after birth during the transition phase to extra-uterine life to survive.[2] As such, the promise of viability for any particular fetus is really nothing more than the promise of a place on a range of statistical possibilities, as opposed to a guarantee, of survival. This is one reason clinicians practicing in this field are inclined to characterize several precarious weeks within a pregnancy as the "peri-viable" period—which accurately reflects the probabilistic uncertainty surrounding the situation.

2. Normative implications

Statistical data on survival probabilities, non-controversially, provide a rational starting point for a discussion about viability. However, in considering what *ought* to follow as a matter of social convention from the limited data we have available, it is clear that we move from the fairly firm footing of discoverable fact to the murkier swamp of subjective human value. In the fields of obstetrics and pediatrics, it is stereotypically presumed that such kind of data can only reasonably be clinically interpreted in one manner. Indeed, we have devised operational guidelines that dictate practice norms based on this presumption. For example, after entering 25 weeks of gestation, where survival after birth can exceed 90% in skilled hands, we remove the option of refusal of resuscitation by parents after birth barring exceptional circumstances.[4] And, as previously described, before entering 22 or 23 weeks of gestation, where the data suggests an improbable chance of survival, we may refuse to even offer a trial of resuscitation.[4] In between these extremes, with some wiggle room for reasonable differences of opinion, we generally grant parents the option of choosing or refusing a trial of therapy.[4] As such, consensus of professional medical reflection on the range of survival probabilities at the time of peri-viable birth sets up a social framework, which determines when and what interventions are justifiable. Anyone who seeks to challenge this normative orthodoxy is tasked with offering a compelling reason to evaluate the data differently.

It is worth emphasizing that legally resolving the impermissibility of abortion in the peri-viable period has had minimal impact on how the medical profession has chosen to resolve the question about what to do when a woman cannot avoid delivery of a neonate during this time frame. The Supreme Court has only confirmed that the State can assert a constitutionally derived, compelling interest in the life of a fetus once a generic viability threshold has been crossed.[1] It has not insisted that any particular State actually do so. Furthermore, it has not prescribed how the State's interest might manifest in practice. Most state legislatures have chosen to restrict women's access to abortion services after some gestational age approximating a plausible definition of viability.[5] However, most state legislatures have steered clear of commenting on what providers and parents can or cannot do with respect to care options after the unanticipated, accidental birth of a peri-viable newborn.

Why might this be so? The constitutional basis for restricting the right to abortion after viability has been criticized as arbitrary by Supreme Court scholars ever since *Roe v. Wade* was decided.[6] Nevertheless, many in our society intuitively countenance a claim that fetal life gains in moral recognition throughout pregnancy and, after viability, is so valuable that the State might justifiably restrict a fundamental liberty. Carried to its logical conclusion, this suggests that after birth a state that so desires to protect post-viable fetal life could also seek to protect post-birth neonatal life. If so, it would be consistent to legally require that we do all in our clinical power to rescue peri-viable neonates, rather than leave it to the discretion of physicians and parents to decide if they should receive a trial of therapy based on their assessment of statistical odds. Indeed, we could imagine an alternate societal framework that compelled providers to attempt to rescue any live-born neonate during the peri-viable period.[7]

One plausible rationale for why states have not chosen to compel rescue attempts after peri-viable birth despite severely limiting access to abortion stems from a difference in the moral expression perceived to radiate from these two distinct clinical situations. When a woman has an abortion, many in society perceive an expression of willful intention to end human life typically not otherwise at immediate risk of sudden death. When a woman enters into labor and threatens delivery during the peri-viable period, she rarely (if ever) expresses an intention to precipitate the death of her soon-to-be-born child. As sociological phenomenon, a woman who cannot avoid a peri-viable birth is more likely to be regarded as an "innocent" victim and worthy of moral sympathy rather than scorn.

A second rationale more relevant to this discussion involves a complex societal value judgment longstanding in the United States about the relative scope of parental rights and the ultimate interests of children. Parents generally are presumed to be the best situated decision-makers for their children while they remain incompetent to make decisions for themselves. This moral sentiment is captured in the following Supreme Court opinion:

> The law's concept of the family rests on a presumption that parents possess what a child lacks in maturity, experience, and capacity for judgment required for making life's difficult decisions. More importantly, historically, it has recognized that the natural bonds of affection lead parents to act in the best interests of the their child. As with so many legal presumptions, experience and reality may rebut what the law accepts as a starting point.[8]