

FETAL ANOMALY EXCEPTIONS IN ABORTION LAWS: INCONSISTENT AND POORLY
DEFINED LANGUAGE INCREASES LEGAL UNCERTAINTY AND RESTRICTS ACCESS
TO CARE

Myna Engineer and Jessica Bustamante

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ABSTRACT

Introduction

Following *Dobbs v. Jackson Women's Health Organization* (2022), abortion access in the U.S. is determined at the state level. Many states include vague or narrow exceptions for fetal anomalies. This study examines how all 50 states define fetal condition exemptions in abortion laws and how that language affects clinical practice and access to care.

Purpose

We hypothesized that inconsistent definitions of fetal anomalies contribute to legal ambiguity, ethical uncertainty, and barriers to abortion access. This study investigates how states define fetal health and viability conditions and the authority granted to healthcare professionals in such cases.

Methods

Abortion statutes effective as of February 10, 2025, were reviewed for references to fetal condition exceptions. Statutory language was compiled into a database, coded for definitions, exclusions, and decision-making authority, and analyzed thematically by two independent reviewers.

Results

Seventeen states included fetal condition exceptions, but terminology varied widely—terms like “lethal fetal anomaly,” “fatal abnormality,” and “incompatible with life” were used inconsistently, often without definitions. Definitions of viability differed or were absent entirely. Five states explicitly excluded conditions like Down syndrome or spina bifida from exceptions,

despite potential lethality. Decision-making authority ranged from requiring physician certification to offering no guidance, leading to confusion and legal risk.

Conclusions

The lack of standardized, medically informed language across state laws creates uncertainty and delays in care. Ambiguous definitions and inconsistent exclusions compromise both patient access and provider safety, highlighting the urgent need for clearer legislative standards.

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INTRODUCTION

It is an unspoken truth that abortions have always been a part of American history, but the question of who has the power to decide where, when, and for whom abortion should be permissible has changed over time. Before the 1840s, abortion was largely a private matter between women and midwives. However, the formation of the American Medical Association led to an organized push to criminalize abortion except in the context of medical necessity, shifting decision-making power to physicians (Thaxton et al. 2023). Over time, abortion care and access became increasingly entangled in legal debates. In 1959, the American Law Institute proposed that abortion should be legalized in four circumstances: cases of rape, incest, fetal abnormality, and threats to the physical or mental health of the pregnant individual (Thaxton et al. 2023). This framework, which some states used when legalizing abortion before *Roe v. Wade*, reaffirmed the authority of physicians while also involving legal authorities in cases of sexual assault.

The 1973 decision in *Roe v. Wade* was an important step in returning the right to access abortion care to the pregnant individual, though the Court famously framed this right as a choice made in consultation with a "responsible physician," thus perpetuating medical authority over abortion decisions. *Roe* established that the constitutional right to privacy included the right to an abortion until the third trimester or the point of viability ("*Roe v. Wade* (1973)," n.d.). The Court divided pregnancy into three stages, allowing unrestricted abortion rights in the first trimester while permitting states to regulate but not ban abortion in the second trimester.

Importantly, *Roe* also clarified that the state's interest in protecting potential life becomes compelling at the point of fetal viability—generally understood at the time to occur near the

beginning of the third trimester. From that stage onward, the Court acknowledged that states had the constitutional authority to prohibit abortion, provided they made exceptions when the life or health of the pregnant person was at risk. This framework gave states considerable discretion to restrict abortion access in the final trimester, effectively establishing viability as the legal boundary for broad abortion rights. While this compromise aimed to balance individual autonomy with state interests, it also reinforced a medicalized approach to abortion law by tying permissible access to clinical determinations about viability and maternal health.

Planned Parenthood v. Casey (1992) reaffirmed the “essential holding” of *Roe* by maintaining that states could not ban abortions prior to viability but initiated a shift in judicial approach by introducing the undue burden standard, granting legislatures and courts broader authority to determine which abortion restrictions were constitutionally permissible. Different standards of review are used by the courts to determine how much deference is given to legislation that is challenged on Constitutional grounds. The standard under *Roe* was strict scrutiny, which makes it very difficult for laws to withstand judicial review. The undue burden standard—which operates more as a balancing test—which resulted in courts upholding restrictions that might have been struck down under strict scrutiny. As a result, decision-making power began shifting away from pregnant individuals and their doctors and toward lawmakers and the judiciary. This realignment became even more apparent between 2013 and 2021, when multiple states enacted “reason bans” that prohibited abortions based on specific motivations, such as a diagnosis of fetal anomaly (Suter, 2023) . These laws further limited reproductive autonomy and, in many cases, invited law enforcement into the process of evaluating abortion decisions—effectively positioning the state as a gatekeeper of which abortions were legally justified. While it’s fair to say that these changes indirectly gave legislatures more power—since

their laws were more likely to survive judicial scrutiny—it's more precise to view this as a shift in the legal framework that subtly, but significantly, rebalanced authority over reproductive decision-making.

The 2022 Supreme Court decision, *Dobbs v. Jackson Women's Health Organization* removed constitutional protection for abortion altogether, shifting decision-making power from pregnant individuals to state legislatures. In many states, access to abortion now depends on narrow legal exemptions, which place physicians in the precarious position of interpreting vague laws while facing the threat of civil or criminal penalties (Thaxton, Gonzaga, & Tristan, 2023) . The uncertainty surrounding when abortion is legally permissible has already harmed pregnant individuals, as seen in lawsuits challenging restrictive laws in Texas and other states.

One notable example is *Zurawski v. State of Texas*, where a total of 22 plaintiffs, including lead plaintiff Amanda Zurwaski, testified that they faced severe health risks due to lack of clarity in the state's restrictive abortion laws. Among the 22 plaintiffs were two doctors who joined the lawsuit due to its impact on their ability to provide care to their patients. At 18 weeks pregnant, Zurawski was diagnosed with a condition that made her pregnancy nonviable. However, fearing Texas' stringent abortion restrictions, her healthcare providers told her they were unable to intervene. The delay in care led to severe infection and permanent reproductive damage. In August 2023, a state district court judge ruled that Texas' abortion laws were too vague, and as a result, granted a preliminary injunction to allow abortions in cases of serious pregnancy complications. However, the Texas Supreme Court ultimately upheld the state's abortion bans, rejecting the conclusion that the laws were unconstitutionally vague (*Zurawski v. State of Texas*, 2023) (Sobol, 2023).

The Zurawski case highlights the danger associated with language that feels vague to doctors and underscores the critical need for clarity in abortion legislation. Ambiguities in the law not only jeopardize the health and lives of pregnant individuals but also place unnecessary burdens on physicians, hindering their ability to practice medicine according to best practices to ensure patient safety. The way a statute defines exemptions and/or fetal anomalies can dictate how physicians, genetic counselors, hospital legal teams, and law enforcement navigate the question of what constitutes a legal abortion and what kind of care they can provide for patients. This study examines how different states frame exceptions to abortion regulations related to the health or viability of the fetus, with the goal of shedding light on the power dynamics embedded in legislative language and its impact on access to care.

METHODS

We examined all the statutes pertaining to abortion care in all 50 states to document language related to fetal exceptions and viability. Official state government websites were used to identify the most up-to-date legislation. Data analysis included all current statutes. Statutes that were proposed but not enacted were not considered eligible. During the data analysis period, laws continued to change. Our analysis represents, to the best of our knowledge, all changes through February 10, 2025. Each state law was analyzed for any specific language used to describe or explain exemptions or restrictions related to fetal condition as well as who was empowered to decide whether termination was legally permissible. Analysis also included a review of the terms and definitions used to describe the basis for any exemption or restrictions, including fetal anomaly, lethal or non-lethal anomaly, and any specific conditions cited.

An Excel spreadsheet was utilized to systematically organize data from all 50 states. States with exceptions related to fetal anomaly were color-coded to facilitate identification and analysis

of relevant terms and concepts. The dataset underwent an independent review by both principal investigators, who initially coded the data to identify key patterns. A comprehensive, collaborative analysis of these codes was then conducted to synthesize overarching themes through thematic analysis. Once themes were identified and mutually validated, a separate Excel file was created to categorize the finalized themes, corresponding codes, and their respective state origins. Peer debriefing and review was conducted to enhance the reliability and validity of the coding and analysis process.

RESULTS

1. Language used to describe a fetal condition¹ and their definitions

Of the statutes in each of the 50 states that we examined, 17 contained language used to describe a fetal condition. Figure 1 categorizes the most frequently used terms for fetal conditions in state abortion laws, highlighting their prevalence, the states that use them, and whether they are explicitly defined in the statute.

¹ For the purposes of this study, a fetal condition refers to any issue that affects or has the potential to affect fetal health during pregnancy, either prior to or during the fetal period, while a fetal anomaly is defined more specifically as a structural or functional defect that arises during fetal development and may impact the health and development of the baby.

Term	Occurrences	States Using It	Definition Status
“Lethal fetal anomaly” / “Lethal anomaly”	5	AL, IN, MA, WV, WY	Defined
“Fetal abnormality/anomaly”	4	DE, IA, UT, NH	Ambiguous / Not Defined
“Medically futile”	2	GA, LA	Defined
“Fatal fetal abnormality/anomaly”	2	FL, SC	Defined
“Lethal fetal condition”	1	AZ	Defined
“Life-limiting anomaly”	1	NC	Defined
“Nonviable”	1	KS	Ambiguous
“Genetic defect, deformity, or abnormality”	1	MD	Not Defined

Figure 1| Terminology Used to Describe Fetal Conditions in State Abortion Laws. This figure presents the most frequently used terms to describe fetal conditions in abortion statutes across 17 U.S. states. Terms are categorized by their frequency of occurrence, the specific states in which they appear, and whether they are explicitly defined in the respective statutes.

Clearly Defined Terms

The most commonly used and clearly defined terms were “*lethal fetal anomaly*,” “*fatal fetal abnormality/anomaly*” and “*medically futile*.” These terms were labeled as defined because the legislation provided specific medical and time-based criteria to determine when a fetal condition qualifies under the law. Examples of the way these terms are specifically defined in the state legislature can be found below.

Alabama: “*Lethal anomaly. A condition from which an unborn child would die after birth or shortly thereafter or be stillborn.*”

Indiana: “*Lethal fetal anomaly means a fetal condition diagnosed before birth that, if the pregnancy results in a live birth, will with reasonable certainty result in the death of the child not more than three (3) months after the child’s birth.*”

South Carolina: “*Fatal fetal anomaly means that, in reasonable medical judgment, the unborn child has a profound and irremediable congenital or chromosomal anomaly that, with or without the provision of life-preserving treatment, would be incompatible with sustaining life after birth.*”

Georgia: “*Medically futile means that, in reasonable medical judgement, an unborn child has a profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth.*”

Louisiana: “‘Medically futile’ means that, in reasonable medical judgement as certified by two physicians, the unborn child has profound and irremediable congenital or chromosomal anomaly that is incompatible with sustaining life after birth. The Department of Health establishes the following exclusive list of anomalies, diseases, disorders, and other conditions that shall deem an unborn child ‘medically futile’

1. achondrogenesis;

2. acrania;

3. anencephaly;

4. arcadia;

5. body stalk anomaly;

6. campomelic dysplasia;

7. craniorachischisis;

8. dysencephalia splanchnocystica (Meckel-Gruber syndrome);

9. ectopia cordis;

10. exencephaly;

11. gestational trophoblastic neoplasia;

12. holoprosencephaly;

13. hydrops fetalis;

14. iniencephaly;

15. perinatal hypophosphatasia;

16. *osteogenesis imperfecta (type 2);*

17. *renal agenesis (bilateral);*

18. *short rib polydactyly syndrome;*

19. *sirenomelia;*

20. *thanatophoric dysplasia;*

21. *triploidy;*

22. *trisomy 13;*

23. *trisomy 16 (full);*

24. *trisomy 18;*

25. *trisomy 22; and*

26. *a profound and irremediable congenital or chromosomal anomaly existing in the unborn child that is incompatible with sustaining life after birth in reasonable medical judgment as certified by two physicians that are licensed to practice in the state of Louisiana.”*

Ambiguously Defined Terms

The most ambiguously defined terms include “*fetal abnormality/anomaly*” and “*nonviable.*” These definitions were labeled as ambiguous due to the lack of specific criteria regarding timing, medical certainty, or the necessity for medical intervention. These terms were described using non-specific language such as “*without extraordinary measures,*” “*a reasonable likelihood,*” and “*incompatible with life,*” as shown in the following statutes:

Delaware: “...or in the event of a fetal anomaly for which there is not a reasonable likelihood of the fetus’s sustained survival outside the uterus without extraordinary medical measures.”

Iowa and Utah: “...the fetus has a fetal abnormality that in the physician’s reasonable medical judgement is incompatible with life.”

New Hampshire: “Except in the case of fetal abnormalities incompatible with life, or a medical emergency as specifically defined in paragraph III, no health care provider shall knowingly perform, induce, or attempt to perform an abortion....”

Kansas: “If the physician...determines that the unborn child is not viable....”

Terms Not Clearly Defined

States such as Maryland have been labeled as not defined because their statutes offer no clarification or definition.

Maryland: “...the State may not interfere with the decision of a woman to terminate a pregnancy... at any time during the woman's pregnancy, if: (ii) the fetus is affected by genetic defect or serious deformity or abnormality.”

2. How Viability Is Defined

In examining the 17 state laws with fetal anomaly exceptions to laws restricting abortion, we distinguished five distinct categories for which states defined viability: ‘not defined’; ‘cannot

survive with or without extraordinary measures’; ‘cannot survive without extraordinary measures’; ‘cannot survive outside the womb’; and ‘vague language.’ Of these, ‘not defined’ was the most common, followed by ‘cannot survive with or without extraordinary measures.’

Category	Occurrence	States
Not defined	8	GA, MA, NH, NC, SC, UT, WV, WY
With or without extraordinary measures	4	AL, FL, IA, KS
Without extraordinary measures	2	AZ, DE
Survive outside the womb	2	IN, MD
Vague language	1	LA

Figure 2| Definitions of Viability in State Laws with Fetal Anomaly Exceptions. This figure categorizes how viability is defined in 17 state abortion statutes that include exceptions for fetal anomalies. States were grouped into five categories based on the language used in their statutes: (1) “Not defined,”; (2) “Cannot survive with or without extraordinary measures”; (3) “Cannot survive without extraordinary measures”; (4) “Cannot survive outside the womb”; and (5) “Vague language.”

Of the eight states with a fetal anomaly exception that do not provide a definition of viability, some have abortion laws that may suggest an intended standard. The Massachusetts and New Hampshire statutes, for example, list 24 weeks as the limit for a legal abortion (except for legal exceptions) and while they do not define this as the point of viability, it aligns with the

viability standard suggested by *Roe* and affirmed in *Casey*. Other states with laws restricting abortion that are tied to gestational age do not mention viability, and there is no reason to assume that a viability standard was involved in the selection of these gestational age limits: 18 weeks (Utah); 12 weeks (North Carolina); and 6 weeks (Georgia, South Carolina). Both West Virginia and Wyoming have a total ban on abortions, with certain exceptions such as fetal anomalies. However, these statutes provide no legal definition of viability. For example, while Wyoming laws reference 'pre-viability' in one category of abortion exceptions, they do not define what that term means.

Alabama, Florida, Iowa, and Kansas define viability as an unborn child's ability to survive with or without the use of extraordinary medical measures. Florida specifically uses the term "standard medical measures" and, within the same statute, defines "standard medical measures" as including or not including artificial support. Arizona and Delaware define viability as the ability of an unborn child to survive without the use of extraordinary medical measures, with no statutory language that defines the term "extraordinary medical measures." Indiana's and Maryland's statutes define viability as the point at which an unborn child can survive outside the womb, without specifying whether survival depends on medical intervention. Of all 17 states, only Louisiana's statute falls into the "vague language" category. Louisiana's legal definition of viability specifies that a physician must determine whether the unborn child is viable. While a separate part of the statute outlines procedures for making this determination, the legal definition of viability does not establish specific thresholds that must be met.

State Definitions of Fetal Viability in Abortion Statutes

“‘Viability’ refers to the stage of fetal development when... there is a reasonable likelihood that the unborn child could sustain life outside the mother’s womb, **with or without artificial support.**” AL

“‘Viability’ is that stage of fetal development when the life of the unborn child may be continued indefinitely outside the womb **by natural or artificial life support systems.**” IA

“‘Viable’ means that stage of fetal development when...there is a reasonable probability that the life of the child can be continued indefinitely outside the mother's womb **with natural or artificial life-supportive measures.**” KS

“‘fetal viability’ is ‘the point in pregnancy when ... significant likelihood of the fetus’s sustained survival outside the uterus **without the application of extraordinary medical measures.**’” AZ

“‘Viability’ means the point in a pregnancy when, in a physician's good faith medical judgment based on the factors of a patient's case, there is a reasonable likelihood of the fetus's sustained survival outside the uterus **without the application of extraordinary medical measures.**” DE

“‘Viability,’ for purposes of IC 16-34, means the ability of a fetus to **live outside the mother's womb.**” IN

“In this section, ‘viable’ means that stage when... there is a reasonable likelihood of the **fetus’s sustained survival outside the womb.**” MA

“Except in the case of a medical emergency... the physician, by use of his good faith medical judgment, **shall first determine if the unborn child is viable.**” LA

3. Healthcare Provider Determinations

Most of the 17 states that include language describing a fetal condition also specify who is responsible for making this medical determination. The chart below summarizes the key findings:

States that explicitly require <u>2 physicians</u>	AL, FL, LA, WV, UT
States that require a <u>physician</u>	DE, GA, IA, KS, MA, NC, WY
States that rely on determination by a <u>licensed medical professional</u>	AZ, IN, MD, WV
States that <u>do not define</u> who makes the determination	NH, SC

Figure 3| Designated Decision-Makers for Diagnosing Fetal Conditions in State Abortion Statutes. This figure

summarizes how 17 state abortion statutes with fetal anomaly exceptions specify who is authorized to determine the

presence of a qualifying fetal condition. States were grouped into four categories based on the level of specificity in their legal requirements.

States such as Alabama and Louisiana provide clear guidelines by requiring certification from multiple physicians, using language such as “*medical judgment as certified by two physicians*” and “*the physician’s determination shall be confirmed in writing by a second physician.*” In contrast, South Carolina lacks the same level of specificity, relying solely on “*reasonable medical judgment,*” without specifying how many physicians must be involved.

Other states group determinations under broader terms like “*healthcare professional,*” “*pregnant woman’s physician,*” or “*licensed medical professional.*” These states do not establish the number of medical professionals needed to assess the presence of a fetal condition, leaving room for interpretation in medical and legal contexts.

4. What is Not a Fetal Anomaly Exception

Of the 17 states with fetal anomaly exceptions, five states list specific conditions or categories that explicitly do not fall under the legal definition of fetal anomaly: AZ, IN, LA, NC, and UT. The most common descriptor used to exclude conditions from the anomaly exception is “genetic abnormality.” Others are “any other disability” and “malformation, defect, or condition that does not cause an individual to live in a mentally vegetative state.” Both Arizona and Louisiana specifically define “genetic abnormality” as an unlawful reason to pursue an abortion. The statutes in these states specify that any defect, disease, or disorder that is genetically inherited (LA) or due to abnormal gene expression (AZ) does not fall under the fetal anomaly

exception. Indiana's statutes use the term "any other disability" to exclude conditions from the fetal anomaly exception, defining any genetically inherited disease, defect, or disorder as not grounds for a legal abortion exception. Utah's statutes state that malformations or defects that do not cause one to live in a mentally vegetative state are not grounds for a legal abortion.

"Genetic abnormality": (a) Means the presence or presumed presence of an abnormal gene expression in an unborn child, including a chromosomal disorder or morphological malformation occurring as the result of abnormal gene expression." AZ

"[A]ny other disability" means any disease, defect, or disorder that is genetically inherited." IN

"[I]t shall be unlawful for any person to intentionally perform or attempt to perform an abortion of an unborn child of twenty or more weeks post fertilization age...with knowledge that the pregnant woman is seeking the abortion solely because the unborn child has been diagnosed with either a genetic abnormality or a potential for a genetic abnormality." LA

Indiana's, Louisiana's, and Utah's statutes include a list of medical conditions that are not included in the fetal anomaly exception. Indiana and Louisiana specifically mention physical disability, mental/intellectual disability, scoliosis, dwarfism, Down syndrome, albinism, and amelia. Utah's statute excludes from its fetal anomaly exception Down syndrome, spina bifida, and cerebral palsy as well as any other malformation, condition, or defect that does not cause an individual to live in a mentally vegetative state. North Carolina's statute excludes only Down

syndrome from the fetal anomaly exception list. Arizona's statutes do not specify any particular medical conditions within their legal definition of fetal anomaly.

“No person shall perform or attempt to perform an abortion upon a pregnant woman if the person has knowledge that the pregnant woman is seeking the abortion.... The presence or presumed presence of Down syndrome.” NC

“Severe brain abnormality means a malformation or defect that causes an individual to live in a mentally vegetative state. Does not include:

(i) Down syndrome;

(ii) spina bifida;

(iii) cerebral palsy;

or (iv) any other malformation, defect, or condition that does not cause an individual to live in a mentally vegetative state.” UT

The other 12 states with fetal anomaly exceptions did not have statutes defining what is not considered a lethal fetal anomaly, only statutes defining the term used to describe the fetal anomaly exception.

DISCUSSION

The Emergence of Fetal Condition in Law

Historically, exceptions made for fetal conditions in abortion laws were uncommon. Prior to the 1973 *Roe v. Wade* decision, some states banned abortion without exception, while others allowed it under specific circumstances. These included harm to the pregnant individual's health,

rape, or incest, but rarely fetal anomalies (Liu, 2013). *Roe v. Wade* established the Constitutional right to abortion only until the third trimester or viability, but even with this, exceptions for fetal anomalies in states that banned abortions after viability were still rare (Mellquist et al., 2024). As a result of the Supreme Court's 2022 decision overturning *Roe v. Wade*, the current landscape reflects states' legislative control over abortion policies. Many states have passed laws banning abortion, typically with no exception for fetal anomalies. In states that do have exceptions, they are limited to severe anomalies, and our analysis suggests that many lack clear definitions or specific criteria as to which anomalies qualify (Felix, Sobel, & Salganicoff, n.d.).

The introduction of terms like "lethal fetal anomaly" and "medically futile" in state laws coincided with increasing medical knowledge about congenital and chromosomal anomalies. Over the last several years, states have adopted differing approaches—some providing clear medical definitions and criteria for termination, while others use vague language that leaves significant room for interpretation. This variety of legislative language reflects broader ethical and political debates regarding fetal rights, medical decision-making, and reproductive autonomy.

Disparities in Definitions and Their Implications

One of the key findings of this study is the inconsistent use of terminology across state statutes. While some states clearly define terms such as "lethal fetal anomaly" and "medically futile," others use ambiguous language or omit definitions altogether. The presence or absence of these definitions has substantial legal and medical implications, as it influences how easily healthcare providers determine who may obtain an abortion under the law. For instance, Alabama, Indiana, and South Carolina provide explicit definitions with medical criteria and

time-based parameters, ensuring a more consistent interpretation. In contrast, terms like "fetal abnormality" and "nonviable" are vague in abortion laws in states like Delaware and Kansas, potentially leading to legal uncertainty and inconsistent application of the law.

This study also highlights the critical distinction in how states are defining what does not qualify as a fetal anomaly. Some states list specific conditions that do not fall under fetal anomaly exceptions, "genetic abnormality" being the most common exclusion. The use of genetic abnormality as the exception to the exceptions clause does not take into account that many genetic abnormalities can also be coincident with or be a lethal abnormality. This suggests that some states are searching for a way to further limit abortion access even in cases where there is a serious medical condition. The fact that 12 out of the 17 states found to have fetal anomaly exceptions do not specify conditions that do not qualify is suggestive of a lack of consensus on the issue. In these states, the definition of fetal anomaly is based on general language rather than specific exclusions and could allow for more medical discretion in determining eligibility. This variation among states demonstrates inconsistencies in abortion laws and raises questions on how physicians interpret and apply these restrictions in real medical settings.

The Role of Medical Professionals in Decision-Making

The study also reveals discrepancies in how states determine who is responsible for diagnosing a fetal condition under abortion laws. Some states, such as Alabama, Florida, and Louisiana, mandate that two physicians certify the diagnosis, adding a layer of regulatory control. Other states, such as Maryland and Massachusetts, defer to the judgment of a licensed medical professional without stipulating that the professional must be a physician or requiring multiple opinions. Meanwhile, states like South Carolina fail to specify which medical authority

must make the determination, instead relying solely on "reasonable medical judgment." While stricter requirements as to who must determine whether the exception applies may lead to delays in accessing abortion services, vaguer language may inhibit medical providers from providing abortions in any circumstances, especially in states like South Carolina where the penalty for violating the statute is severe even if the violation is unintentional.

Furthermore, this study shows the varying, and in some cases absent, definitions of fetal viability between states. In many states, viability serves as the cutoff point for when an abortion is permitted without the need of an exception. In states such as Arizona and Delaware, where viability is defined as survival "without extraordinary measures," the term "extraordinary measures" is not legally defined, creating ambiguity for physicians who must interpret its meaning. This vague statutory language can leave physicians uncertain about whether their medical judgment—that a fetal condition qualifies under the exception—will be deemed incorrect by prosecutors or the courts. This uncertainty heightens legal risk and may lead to inconsistent decision-making in clinical practice. While there may be general agreement within the medical community about which conditions meet the definition based on standards of care, significant ambiguity remains about whether those medical assessments will align with how the law interprets the exception. Louisiana specifically defines viability as a determination made by the physician under the law, but provides few criteria and gives physicians even broader discretion to determine viability with no clear medical or legal threshold. This open-ended approach contrasts with other states discussed in this study and it could therefore contribute to greater medical uncertainty and delays in care as physicians navigate its medical and legal implications.

Additionally, in the 33 states where there is no fetal condition exception the lack of clear definitions of viability could raise questions about whether such prohibitions apply when a fetus has a condition that prevents survival. Many of these states define viability using broad or vague terms, such as the categories listed previously. In particular, states that define viability as survival “without extraordinary measures” may still permit abortions for severe fetal anomalies if those conditions fall outside the definition of viability. This adds another layer of legal and medical uncertainty.

Ethical and Legal Considerations

The ways in which the states identified in this study describe or define fetal conditions in abortion regulations and establish the methods of assessment raise significant legal and ethical concerns. The ambiguity in some statutes may result in differing interpretations by physicians, policymakers, courts, and prosecutors, potentially leading to defensive applications of the law that limit the real-world impact of exceptions. Additionally, the requirement for certification by multiple physicians in some states could disproportionately impact individuals in rural or underserved areas, where access to specialized medical care is already limited. These factors contribute to disparities in reproductive healthcare access, further complicating the landscape of abortion rights in the United States. It should be noted that the most restrictive states also have the vaguest language regarding fetal condition exceptions. The consequences of these restrictions are already evident, as seen in Texas, where infant mortality has risen since 2021, with an even starker increase in deaths due to congenital anomalies (Gemmill, Margerison, Stuart, & Bell, 2024). This alarming trend underscores the real-life implications of restrictive abortion policies, particularly in cases involving severe fetal anomalies.

With nearly half of the states with abortion laws that have fetal anomaly exceptions but no legal definition of viability, questions arise about how viability is determined in practice. While some states follow the gestational limits historically established by *Roe* and reaffirmed in *Casey*, others, like North Carolina (12 weeks), impose much earlier restrictions without any connections to a legally or medically defined framework. Other states like Georgia and South Carolina have an even stricter 6 weeks limit due to “heartbeat bans,” creating a standard clearly untethered to fetal viability. These laws establish a six-week gestational age limit based on a “detectable heartbeat,” even though it is well established that the embryo does not have a fully developed heart that early in development (Haining, Keogh, & Savulescu, 2022). These findings suggest that in most cases viability is not the guiding principle for setting gestational limits for abortion laws. The differences indicate a lack of medical knowledge being applied to determine an important legal stage in many pregnancies for both medical providers and patients.

Future Directions and Policy Implications

Given the findings of this study, there is a need for standardization in the language used to define fetal conditions in abortion laws. Clearer, more medically based definitions would allow for consistency and ensure that legal frameworks align with the ways in which a situation may present in the clinical setting. Additionally, policies should consider the accessibility of healthcare professionals and the potential burdens imposed by multiple physician certification requirements. Future research should explore how these legal ambiguities influence real-world decision-making among healthcare providers and pregnant individuals, as well as their broader implications for reproductive justice.

In conclusion, this study highlights the need for legislative clarity and medical alignment in defining fetal anomalies within abortion statutes. Addressing these inconsistencies would improve the predictability and fairness of legal determinations while promoting equitable access to abortion care for those facing complex fetal diagnosis.

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