DOCTORED RIGHTS: MENSTRUAL EXTRACTION, SELF-HELP GYNECOLOGICAL CARE, AND THE LAW

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INTRODUCTION

> The right of privacy [under the United States Constitution] is broad enough to encompass a woman's decision to terminate her pregnancy.[1]
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> [T]he abortion decision and its effectuation must be left to the medical judgment of the woman's attending physician. . . . This holding . . . vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.[2]
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> In the 1970's, as a necessary and political act women learned how to perform abortions without the help of a physician. *You can too.*[3]

So whose right is it, anyway? On its face, the Supreme Court's decision in *Roe v. Wade* appears at the very least ambiguous. Does the right announced—the right to terminate a pregnancy in the first trimester—vest in the pregnant woman or in her physician?[4] While the Supreme Court in subsequent major abortion decisions,[5] as well as most Americans, has assumed that the abortion right is the *woman's*, the decision most closely touching on this issue implies a different conclusion. Only two years after *Roe*, in *Connecticut v. Menillo*,[6] the Supreme Court held that the abortion right did not encompass abortions performed by nonphysicians. Thus, the constitutional right to pri-

1. Roe v. Wade, 410 U.S. 113, 153 (1973).

2. *Id.* at 164, 165-66.

3. ANONYMOUS QUEERS, WOMENPOWER! DO IT YOURSELF ABORTION (1992) (pamphlet handed out at the March for Women's Lives in Washington, D.C., on April 5, 1992) (on file with author).

4. The assumption that individuals, male or female, have their "own" physician is less reflective today than it once was of the reality of most Americans' lives. A recent New York Times/CBS News poll indicated that at least 24 percent of those polled have no particular physician they consider their own. Robin Toner, *Poll on Changes in Health Care Finds Support Amid Skepticism*, N.Y. TIMES, Sept. 22, 1993, at A1, A25 (It was unclear from this article whether respondents had been asked the question directly or whether the result had been inferred from other answers). Only 10 percent of physicians in the United States are general practitioners (GPs), and the proportion of GPs to the population has decreased dramatically in the last 50 years. Milton Terris, *Failing Health: A Wasteful System that Doesn't Work*, PROGRESSIVE, Oct. 1990, at 15. This lower number of general practitioners per capita is one factor contributing to the decrease in the number of women who maintain an ongoing relationship with a single physician.

5. *See, e.g.*, Planned Parenthood v. Casey, 112 S. Ct. 2791, 2803 (1992) ("19 years after our holding that the Constitution protects a woman's right to terminate her pregnancy in its early stages"); Hodgson v. Minnesota, 497 U.S. 417, 435 (1990) (O'Connor, J., concurring) (referring to abortion as "an individual decision that a woman has a right to make for herself"); Webster v. Reproductive Health Services, 492 U.S. 490, 492 (1989) ("a woman's right to choose an abortion").

6. 423 U.S. 9 (1975) (per curiam).

vacy protects a woman's right to an abortion *only* if a physician performs the procedure.[7]

For many, whether the right is the physician's or the woman's is of no practical consequence. The campaign for legal abortion has always been premised on the still largely unquestioned assumption that only legal abortions are safe abortions because they are performed by physicians, who are licensed (and therefore presumably skilled), rather than by the notorious "back-alley abortionists" (who are presumably untrained and unskilled). For many people, to imagine abortions performed by nonphysicians is to conjure nightmares of bloody coat hangers, turpentine or lye ingestion, and other "home remedies" leading to injury and even death.[8] Thus, while pro-choice advocates have repeatedly challenged almost every other restriction that state and federal governments have attempted to place on the performance of abortions,[9] physician requirements have never provoked the same aggressive litigation and advocacy.[10] In fact, in cases like *Menillo*, where a state prosecuted a nonphysician for performing an unauthorized abortion, pro-choice legal organizations have shown an uncharacteristic silence on the issue.[11]

For at least the last twenty years, however, a determined minority of women's health advocates has been exploring the possibilities offered by menstrual extraction, an uncomplicated suction abortion procedure whereby the contents of a woman's uterus can be aspirated slowly using a hand-operated vacuum device. The procedure is performed at home, almost always by nonphysicians.[12]

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7. *Id.* at 11 ("[P]rosecutions for abortions conducted by nonphysicians infringe upon no realm of personal privacy secured by the Constitution against state interference.").

8. Such "home remedies," including the more dangerous versions, are unfortunately not a relic of pre-*Roe* days. Even today, in areas where abortion is restricted, heavily regulated, or heavily stigmatized, such practices continue. *See* Alissa J. Rubin, *Throwing Babies*, NEW REPUBLIC, Oct. 26, 1992, at 19.

9. *See, e.g., Casey*, 112 S. Ct. at 2830 (mandatory waiting period, parental and spousal consent, mandatory directive counseling, and reporting requirements); *Webster*, 492 U.S. at 492-93 (viability tests requirement); Thornburg v. American College of Obstetricians and Gynecologists, 476 U.S. 747, 748 (1986) (requirement specifying standard of care for post-viability abortions and presence of second doctor); City of Akron v. Akron Ctr. for Reprod. Health, 462 U.S. 416, 424 (1983) (requirements for hospitalization, parental notification, waiting period, and disposal of post-abortion fetal remains).

10. This trend may be changing. Recently, pro-choice advocates filed a suit challenging the physician-only requirement in Montana's abortion law, representing the director of a clinic who allows physician's assistants to perform abortions. Complaint, Armstrong v. Esch, No. 93-060-GF-PGH (D. Mont. filed May 17, 1993). The defendants conceded the unenforceability of the restriction. Brief in Support of Defendant's Motion for Summary Judgment at 16, *Armstrong*, No. 93-060-GF-PGH. The challenge, however, was prompted by a threat of prosecutorial harassment of the clinic director, a physician. Declaration of James H. Armstrong, M.D., *Armstrong*, No. 93-060-GF-PGH.

11. *But see* State v. Hultgren, 204 N.W.2d 197 (Minn. 1973) (where lawyers from the Minnesota Civil Liberties Union submitted an amicus brief in the appeal of a layperson's conviction for performing abortion); Complaint, *Armstrong*, No. 93-060-GF-PGH, (filed by, inter alia, Center for Reproductive Law & Policy).

12. Menstrual extraction or menstrual regulation can be performed by physicians or other health care professionals and is often promoted in the developing world as a cheaper and more

Proponents of menstrual extraction tend to be advocates of self-help gynecological care generally, practicing and promoting a variety of home remedies to treat common gynecological problems.[13] They laud the inherent empowerment of women and the attendant freedom from the medical establishment provided by menstrual extraction and self-help gynecological care.[14] Many women have had negative experiences seeking abortions at women's health clinics, facing long delays in crowded waiting rooms, and alienation due to what they perceive to be an overmedicalized procedure.[15] Anecdotal evidence indicates that many women who have undergone both pregnant menstrual extractions and clinical abortions have preferred the former.[16] Moreover, self-helpers claim that menstrual extraction is as safe as, if not safer than, clinical abortions.[17]

Many self-helpers also cite political reasons for learning and practicing menstrual extraction: given the instability of federal constitutional protection for abortion, they foresee a potential need for the ability to perform clandestine procedures without the intervention of the official medical establishment.[18] Indeed, increased restrictions proposed or adopted in many states since the Supreme Court's *Planned Parenthood v. Casey*[19] decision in 1992

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accessible abortion procedure. REBECCA CHALKER & CAROL DOWNER, A WOMAN'S BOOK OF CHOICES: ABORTION, MENSTRUAL EXTRACTION, RU-486, at 123-27 (1992). For purposes of this Article, however, I am concerned solely with the practice of menstrual extraction in the context of self-help gynecological groups. For a fuller description of the menstrual extraction process, see *infra* text accompanying notes 69-82.

13. CHALKER & DOWNER, *supra* note 12, at 113-29; FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., HOW TO STAY OUT OF THE GYNECOLOGIST'S OFFICE 3 (Carol Downer, Rebecca Chalker & Lorraine Rothman eds., 1981); Herbally Aroused Gynecological Squad, *So, What Is "Self-Help," Anyhow?*, URBAN HERBALIST (WHAM!, New York, N.Y.), Apr. 1992, at 2 (on file with author and the *New York University Review of Law and Social Change*) [hereinafter HAGS I]. This description of self-help is further supported by interviews I conducted with self-helpers who have requested anonymity due to fear of both legal consequences and anti-abortion harassment. All such interviews took place during March, April, or September, 1993, in New York City. When, in the course of this Article, I refer to "anecdotal evidence," I am referring to those interviews.

14. *See* FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 5; HAGS I, *supra* note 13, at 2.

15. *See generally* FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 64-67; WOMEN'S HEALTH EDUC. PROJECT, ABORTION: A NEW YORK CITY RESOURCE GUIDE (1992).

16. Andrea Peyser, *She Prefers It to a Clinic*, N.Y. POST, Jan. 27, 1992, at 7, 16; anonymous anecdotal reports from self-helpers. "Pregnant" menstrual extractions, are distinguishable from nonpregnant menstrual extractions, which are performed to eliminate the annoyance, inconvenience, and cramping of menstruation. CHALKER & DOWNER, *supra* note 12, at 121-23; FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 43; THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, THE NEW OUR BODIES, OURSELVES 358 (1992).

17. *See* Ann Japenga, *The New Abortionists*, IN HEALTH, Nov. 1991, at 51, 57.

18. *See, e.g.*, ANONYMOUS QUEERS, *supra* note 3; CHALKER & DOWNER, *supra* note 12, at 1-3; HERBALLY AROUSED GYNECOLOGICAL SQUAD, IT'S THE END OF THE CENTURY—DO YOU KNOW WHERE YOUR CERVIX IS? (1993) (unpublished pamphlet, on file with author and the *New York University Review of Law and Social Change*) [hereinafter HAGS II].

19. 112 S. Ct. 2791 (1992).

have already decreased access to abortion.[20] Moreover, the escalating harassment and violence by anti-abortion protestors outside abortion clinics[21] are at least partially responsible for a marked decrease in available providers[22] and have led many women to consider other options.

Still other women appeal to economic justifications for considering self-help: the cost of physician-performed clinical abortions, especially for poor women, can be prohibitive.[23] Women as a group are disproportionately affected by the health insurance crisis; only 50 percent of working women have any health insurance.[24] Even for those women with health insurance, coverage for abortion procedures is sometimes not provided.[25]

Whatever their reasons, more women are turning to self-help gynecological care generally and to menstrual extraction in particular.[26] Almost all of

20. For example, the only three abortion providers in Mississippi reported a sharp decline in the number of abortions they performed after the state's restrictive waiting period and "informed consent" restrictions went into effect. *Supreme Court Urged to Take Mississippi Case*, REPROD. FREEDOM NEWS (Center for Reprod. Law & Policy, New York, N.Y.), Nov. 25, 1992, at 2.

21. The incidence of violence at abortion clinics, including arson, vandalism, and burglary, doubled between 1991 and 1992 alone. NATIONAL ABORTION FED'N, INCIDENTS OF VIOLENCE & DISRUPTION AGAINST ABORTION PROVIDERS (1992). The number of clinic blockades also doubled in the same time period. *Id.* In 1993, two abortion providers were shot in anti-abortion attacks, one of them fatally. Ronald Smothers, *U.S. Seeking Curbs on Clinic Attacks*, N.Y. TIMES, Sept. 12, 1993, § 1, at 31.

22. Smothers, *supra* note 21. In addition, fewer physicians today are being trained to perform abortions. Most obstetrics/gynecology residency programs do not provide this training. NATIONAL ABORTION FED'N, WHO WILL PROVIDE ABORTIONS? ENSURING THE AVAILABILITY OF QUALIFIED PROVIDERS 8 (1991). Finally, there is already a shortage of abortion providers. Fifty-one percent of urban counties and 93 percent of rural counties have no abortion provider. Stanley K. Henshaw & Jennifer Van Vort, *Abortion Services in the United States, 1987 and 1988*, 22 FAM. PLAN. PERSP. 102 (1990).

23. Susan Brenna, *Women Turn to Self-Help Groups for Abortions, Despite the Risks*, N.Y. TIMES, Sept. 9, 1992, at C13. Currently, the cost of a first trimester abortion in New York City ranges from $275 to $350. WOMEN'S HEALTH EDUC. PROJECT, *supra* note 15, at 25. Nationwide, the average cost of a first trimester, nonhospital, physician-provided abortion is $251. Stanley K. Henshaw, *The Accessibility of Abortion Services in the United States*, 23 FAM. PLAN. PERSP. 246 (1991).

24. CITIZEN ACTION, HEALTH CARE SECURITY FOR ALL: THE SINGLE PAYER ANSWER at III-9 (1992) (unpublished pamphlet, on file with author and the *New York University Review of Law and Social Change*).

25. Since 1978, the Hyde Amendment has prohibited federal Medicaid reimbursement for abortion except in limited circumstances. Departments of Labor and Health, Education, and Welfare Appropriations Act of 1977, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976) (authorizing Medicaid reimbursement only where abortion is necessary to save the life of the mother); *see also* Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act of 1994, Pub. L. No. 103-112, § 509, 107 Stat. 1082, 1113 (1993) (expanding Medicaid reimbursement to include abortions subsequent to rape or incest). Furthermore, some states require that private insurance coverage for abortion be offered only in a separate, optional rider to the main policy, at an additional premium. *See, e.g.*, IDAHO CODE § 41-3439 (1991); KY. REV. STAT. ANN. § 304.5-160 (Baldwin 1988); MO. REV. STAT. § 376.805 (1986); N.D. CENT. CODE § 14-02.3-03 (1991); R.I. GEN. LAWS § 27-18-28 (1989) (found unconstitional, National Educ. Ass'n of R.I. v. Garahy, 598 F. Supp. 1374 (D. R.I. 1984), *aff'd*, 779 F.2d 790 (1st Cir. 1986)).

26. It is unclear exactly how many women currently practice self-help gynecological care

the women involved, however, worry about the latter's legal status. These concerns are fostered in part by a legal climate perceived to be hostile to even traditional abortion, as well as by a quasi-official disapproval of the use of alternative therapies or home remedies. Abortion has been constitutionally protected for only the last twenty years, and even that protection has proven uncertain. State legislators have made continued efforts to restrict and limit the provision of abortion.[27] Consequently, those who practice menstrual extraction are understandably fearful that their activities will be targeted next.

To allay these fears, and as a defensive strategy, many self-help groups have at least preliminarily researched some of the relevant legal issues in their home states.[28] To date, however, the only published discussion of the legality of menstrual extraction is a general overview in Chalker and Downer's *A Woman's Book of Choices.*[29]

This Article represents an attempt to fill that void and to present a careful evaluation of legal arguments in support of menstrual extraction. While, to my knowledge, no indictments of self-helpers have been brought or even threatened since 1976,[30] menstrual extraction arguably violates both physician-only abortion requirements and state medical practice acts. It is not hard to imagine an anti-abortion prosecutor invoking these laws to harass pro-choice advocates. In addition, a small but vocal minority within the self-help movement has begun calling for the open performance of menstrual extractions as a form of civil disobedience, in part to challenge its presumed illegality.[31] Moreover, an increasing number of physician's assistants, nurse practitioners, and other nonphysicians perform clinic-based abortions. In many states, the legal status of their activities is as uncertain as that of self-

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or menstrual extraction; according to self-helpers themselves, the numbers are growing. Still, relative to women seeking gynecological care generally, the number of self-helpers is thought to be quite small, likely numbering in the hundreds. Jane Pendergrast, *Women Learn How to Do Own Abortion*, CINCINNATI ENQUIRER, Feb. 6, 1992, at B1 (quoting Carol Downer and Rebecca Chalker).

27. New abortion restrictions were proposed in every state legislature that was in session during 1992-93, Interview with Janet Crepps, Staff Attorney, Center for Reproductive Law & Policy, in Brooklyn, N.Y. (Sept. 21, 1993), and four states enacted restrictions. MICH. COMP. LAWS ANN. § 722.903 (West 1992) (mandating parental consent for abortion); 1993 Neb. Laws L.B. 110 (establishing civil liability for failure to provide scripted counseling information prior to performance of abortion); S.D. CODIFIED LAWS ANN. §§ 34-23A-10.1 to 34-23A-10.3 (1993) (informed consent requirement), § 34-23A-7 (1993) (mandatory waiting period for minors); UTAH CODE ANN. § 76-7-305 (1993) (informed consent and waiting period).

28. CHALKER & DOWNER, *supra* note 12, at 167.

29. *Id.* at 167-82.

30. In 1972, Carol Downer was investigated and indicted in California for practicing medicine without a license. She was accused of inserting yogurt into a woman's vagina to treat a yeast infection. After trial, a jury acquitted her. *Id.* at 180-81. In 1976, Downer was again investigated, but no charges were brought and the investigation was dropped. *Id.* at 182-83. In 1991, Dale Breaden of the Federation of State Medical Boards stated that he was unaware of any complaints filed involving menstrual extraction. Japenga, *supra* note 17, at 56.

31. ANONYMOUS QUEERS, *supra* note 3; *see also* Lynn M. Paltrow, *Women, Abortion and Civil Disobedience*, 13 NOVA L. REV. 471, 474 (1989).

helpers.[32]

This Article focuses primarily on state rather than federal constitutional arguments. Federal consideration of the right to abortion is probably at its most volatile point since *Roe v. Wade*.[33] In *Planned Parenthood v. Casey*,[34] the Court announced a new constitutional standard of review for abortion restrictions that has already produced confusion, if not yet conflicting opinions, in lower courts.[35] Pro-choice advocates are increasingly turning to state constitutions in the hopes of finding more rights-protective climates.[36] This Article adopts the same strategy for several reasons: the apparent futility of seeking any cogent, consistent or enduring doctrine in federal constitutional abortion law; the Supreme Court's refusal in *Connecticut v. Menillo*[37] to find a federal right to abortion when performed by nonphysicians; and the relatively clean theoretical and legal slates offered by state constitutional litigation in this area.[38]

The legal questions raised by menstrual extraction fall into three general overlapping areas: (1) the text, enforcement history, and common law interpretation of each state's medical practice act; (2) similar questions in relation to the state's abortion restrictions; and (3) the state's constitutional jurisprudence, particularly in the areas of privacy and equal protection. To explore these issues in each state would, of course, require a booklength study and

32. Patricia Donovan, *Vermont Physician Assistants Perform Abortions, Train Residents*, 24 FAM. PLAN. PERSP. 225 (1992); Frank H. Olmstead, *Abortion Choice and the Law in Vermont: A Recent Study*, 7 VT. L. REV. 281, 299-300 (1982); Complaint, Armstrong v. Esch, No. 93-060-GF-PGH (D. Mont. filed May 17, 1993). In many states, the licensing statutes for physician's assistants and nurse practitioners authorize a general delegation of medical duties to these providers, under the supervision of a doctor. *See, e.g.*, VT. STAT. ANN. tit. 26, § 1735(b) (1989) ("The physician's assistant's scope of practice shall be limited to that delegated to the physician's assistant by the supervising physician . . . ."); FLA. STAT. ch. 458.347 (1989).

33. 410 U.S. 113 (1973).

34. 112 S. Ct. 2791 (1992).

35. Casey v. Planned Parenthood, Parenthood, 14 F.3d 848, 860, (3d Cir. 1994) (holding that "undue burden" standard can be assessed based on record developed in prior facial challenge brought under old "strict scrutiny" standard); Fargo Women's Health Organization v. Schafer, No. 93-1579, 1994 WL 34980, 34983 (8th Cir. Feb. 10, 1994) (finding it an open question whether to apply *Salerno* test, United States v. Salerno, 481 U.S. 739, 745 (1987), for facial challenge or new, broader, "undue burden" standard); Planned Parenthood v. Casey, 114 S. Ct. 909 (1994) (application for stay) (per Souter, J., Circuit Justice) (indicating that holding in original *Casey* decision may not control facial challenges to similar restrictions in other states); Fargo Women's Health Org. v. Schafer, 113 S. Ct. 1668 (1993) (application for stay) (O'Connor, J., concurring) (maintaining that "undue burden" standard mandates new standard for facial challenges to abortion statutes and rejecting *Salerno* test). These contradictions are likely to multiply over the next several years.

36. *See, e.g.*, Amended Complaint, Women of Minn. v. Haas-Steffen, No. MC93003995 (Dist. Ct. Hennepin Co., Minn. filed Apr. 5, 1993); Amended Complaint, Aware Woman Medical Ctr. v. William, No. 93-2017AF (15th Jud. Cir. Fla. filed Mar. 12, 1993); Low Income Women v. Raiford, No. 93-0283 (Dist. Ct. Travis Co., Tex. filed Mar. 10, 1993).

37. 423 U.S. 9 (1975).

38. As noted *infra* text accompanying note 246, local advocates will be in the best position to ascertain the viability of state constitutional arguments, in light of not only the case law but also the political views of the judges on the state's highest court.

would probably be obsolete by the time it was finished. Instead, I have chosen two states—Vermont and Florida—with very different combinations of constitutional jurisprudence, medical practice law interpretation and enforcement, and abortion law interpretation and enforcement.[39] By exploring the legal and policy issues raised by menstrual extraction in these concrete settings, I hope to provide a model, or at least a starting point, for similar arguments in other states with different jurisprudential constellations.

Menstrual extraction and self-help gynecological care stand at a crowded intersection of medical and moral history. Their practice implicates many issues, including the development and continued legitimacy of medical practice acts; the professional monopoly of health care delivery; the feminist health movement; the historical role of women in health care delivery; the economic, medical, political, and ethical issues raised by home health care; and, of course, the inescapable abortion controversy. Volumes have been written about each of these subjects.[40] Consequently, this Article can only scratch the surface of some of the issues raised by menstrual extraction. Part I discusses the nature and history of menstrual extraction, self-help, and related methods of woman-directed fertility control. Part II provides a brief overview of the history of medical practice laws, abortion restrictions, and their interconnections. Part III presents statutory arguments supporting menstrual extraction's legality in Vermont and Florida. Part IV outlines potential state constitutional challenges to abortion restrictions and medical practice statutes in Vermont and Florida.

39. The choice of these two states was initially spurred by interesting, albeit somewhat anomalous, features of each state's abortion law. In Vermont, physician's assistants regularly perform abortions without any clear statutory authorization. Florida's constitution boasts an explicit right to privacy, which has been expressly construed by the state's highest court as encompassing a woman's right to terminate her pregnancy. *See infra* part IV.A.1. As I further explored these states' abortion and medical practice laws, I discovered a fortuitous combination of provisions, which provide the basis for a discussion of most of the legal issues likely to be raised by the practice of menstrual extraction. See discussion *infra* part III for more on the degree to which Florida's and Vermont's regulatory schemes are representative of others states' schemes.

40. *See, e.g.*, BARBARA EHRENREICH & DEIRDRE ENGLISH, FOR HER OWN GOOD: 150 YEARS OF THE EXPERTS' ADVICE TO WOMEN (1978) (analyzing the history of the disempowerment and expulsion of women from health care delivery); FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 113-82 (discussing women's health movement); JAMES C. MOHR, DOCTORS AND THE LAW: MEDICAL JURISPRUDENCE IN NINETEENTH-CENTURY AMERICA (1993) (discussing history of medicine in America); GUENTER B. RISSE, MEDICINE WITHOUT DOCTORS: HOME HEALTH CARE IN AMERICAN HISTORY 31-95 (Guenter B. Risse, Ronald L. Numbers & Judith Leavitt eds., 1977) (analyzing home health care); SHERYL B. RUZEK, THE WOMEN'S HEALTH MOVEMENT: FEMINIST ALTERNATIVES TO MEDICAL CONTROL (1978) (discussing the women's health movement); PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (discussing history of medicine in America).

I
MENSTRUAL EXTRACTION AND SELF-HELP GYNECOLOGICAL CARE

An oft-repeated slogan of feminist and pro-choice advocacy groups claims that "women have always had abortions and always will, regardless of abortion's legal status." Unlike many political slogans, this one is entirely true. In ancient Rome, for example, abortion was common and completely legal.[41] In the United States, "bringing it down" and "removing a menstrual obstruction" have been common practices since the colonies were first established.[42] Similarly, home-administered herbal remedies for a variety of uses, including gynecological care and "menstrual regulation," have a longstanding history, especially among women.[43]

For most of this history—until the last 150 years—doctors have not played a significant role.[44] In fact, traditionally women, especially mothers, have been the primary purveyors of health care. Reproductive health care, including fertility control, abortion, and childbirth, fell entirely into this woman-controlled realm. Only with the rapid medicalization and commodification of health care delivery in the nineteenth century did women and their families begin to look outside of the home to meet their health needs.[45]

Self-help gynecological care, and home health care in general, is thus properly viewed in the context of a long tradition of private, family-based care only relatively recently institutionalized in the "public" sphere. Menstrual extraction itself (as well as herbal remedies for bringing on a woman's period) is neither new nor "radical" as some have claimed,[46] but rather falls squarely within this tradition.

Since the late 1960s and the early 1970s, however, providers and teachers of nonphysician abortions have both described themselves and have been designated by the media as a radical wing of the women's movement.[47] This appellation arose primarily out of abortion's illegality. Prior to 1973, most

41. A HISTORY OF PRIVATE LIFE: FROM PAGAN ROME TO BYZANTIUM 9 (Phillipe Ariès, Georges Duby & Paul Veyne eds., Arthur Goldhammer trans., Belknap Press 1987) (1985); *see also* Roe v. Wade, 410 U.S. 113, 130-41 (1973) (discussing history of abortion practices).

42. Brief of 250 American Historians as Amici Curiae for Planned Parenthood of Southeastern Pennsylvania at 6-11, Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992) (Nos. 91-744, 91-902); KRISTEN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 18-19 (1984); JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY, 1800-1900, at 4-7, 106-07 (1978).

43. CHALKER & DOWNER, *supra* note 12, at 183-89.

44. LUKER, *supra* note 42, at 19-26; MOHR, *supra* note 42, at 3-19.

45. EHRENREICH & ENGLISH, *supra* note 40, at 44-48; STARR, *supra* note 40, at 32-37 (describing domestic medicine in America before rapid medicalization).

46. *See, e.g.*, Japenga, *supra* note 17, at 51-57 (discussing the practice of menstrual extraction and the menstrual extraction movement in the United States).

47. Andrea Peyser, *Do Your Own Abortion*, N.Y. POST, Jan. 27, 1992, at 1, 7; Delia Rios, *The Secret Sisterhood*, OTTAWA CITIZEN, Sept. 8, 1991, at B6; ANONYMOUS QUEERS, *supra* note 3.

states prohibited abortions except to save the life of the mother.[48] As has been well-documented, many doctors, medical students, and untrained personnel provided illicit abortions to women despite the laws.[49] In many instances, these clandestine abortions were performed under unsanitary conditions or by "providers" who did not actually know how to perform the procedure. The consequences are well-known: thousands of women suffered injury or death each year as a result of infections, uterine perforations, or other sequelae of botched abortions.[50] Those illegal abortions that were relatively safe were prohibitively expensive for many women, forcing most to risk the cheaper, less professional alternatives.[51] Not surprisingly, this two-tiered system of illegal abortions had a disproportionate effect on women of color.[52]

In response, groups of women in many cities began seeking out safer and more reliable abortion providers in order to set up referral networks. The most well-known of these groups was "Jane," which formed in Chicago in 1969 to provide counseling and referrals to women seeking abortions.[53] Jane relied primarily on one provider whom its members trusted and who performed effective abortions under sanitary conditions. When the women of Jane discovered that this provider was not in fact a physician—and, therefore, that elaborate medical training was not necessary to perform abortions—they decided to learn how to perform the procedure on their own. This decision was both financial and political: by learning the procedure, Jane could increase the number of reliable providers and reduce costs for women seeking abortions; by placing control of the procedures squarely in women's hands, Jane could empower women to control their own health care. From the summer of 1971 until the spring of 1973 (when Jane dissolved in response to *Roe* and the opening of the first legal abortion clinic in Chicago), the women of Jane performed over eleven thousand abortion procedures.[54]

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48. *See* Roe v. Wade, 410 U.S. 113, 118 (1973).

49. CHALKER & DOWNER, *supra* note 12, at 97-109; LUKER, *supra* note 42, at 73-76.

50. *See, e.g.*, Margaret Cerullo, *Hidden History: An Illegal Abortion in 1968*, *in* FROM ABORTION TO REPRODUCTIVE FREEDOM: TRANSFORMING A MOVEMENT 87, 87-90 (Marlene G. Fried ed., 1990).

51. CHALKER & DOWNER, *supra* note 12, at 107; SUZANN GAGE, WHEN BIRTH CONTROL FAILS: HOW TO ABORT OURSELVES SAFELY at iii (1979).

52. *See* Dazon Dixon, Loretta Ross, Byllye Avery & Sabrae Jenkins, *The Reproductive Health of Black Women and Other Women of Color*, *in* FROM ABORTION TO REPRODUCTIVE FREEDOM: TRANSFORMING A MOVEMENT, *supra* note 50, at 157, 157-59 (noting that in 1969, 75 percent of women who died from illegal abortions were women of color); *see also* Brief Amicus Curiae of the City of New York, et al., Planned Parenthood v. Casey, 112 S. Ct. 2791 (1992) (Nos. 91-744, 91-902), *reprinted in* 19 N.Y.U. REV. L. & SOC. CHANGE 135, 143-44 (1991).

53. "Jane," *Just Call "Jane," in* FROM ABORTION TO REPRODUCTIVE FREEDOM: TRANSFORMING A MOVEMENT, *supra* note 50, at 93, 93-100. Anecdotal evidence indicates that there were other such groups around the country, but Jane is the most well-known and well-documented.

54. *Id.* at 93. In four years of operation as both a referral network and as providers, only seven members of Jane were arrested, and all charges were dropped in 1973. *See* ROSALIND P. PETCHESKY, ABORTION AND WOMAN'S CHOICE 129 (1984) (speculating that this low arrest

The women learned the simple dilation and curettage (D & C) procedure, which is still sometimes used by abortion providers today.[55] As with most gynecological exams and procedures, the walls of the vagina are first gently opened and held in place with a speculum. The woman's cervix is then dilated by inserting a plastic or metal rod (the dilator) into the os (the cervical opening) and gently opening the cervix.[56] Then, a long metal scraper (the curette) is introduced into the uterus and the contents are literally scraped out.[57] Jane usually performed this procedure in someone's home, always under sterile conditions.[58] At the time of the abortion, Jane would also perform pap smears and show women how to look at their own cervixes with a mirror.[59]

Finally, Jane would give the women antibiotics to take in case of infection and would follow up with phone calls over the subsequent two weeks.[60] The rate of complications resulting from Jane procedures (including infections and excess bleeding) was approximately 3 percent, roughly the same rate as for physician-performed D & C procedures.[61] There are no reports of serious injury or death as a result of Jane abortions.[62]

At the same time that Jane was developing, Carol Downer, a housewife active in the Los Angeles chapter of the National Organization for Women, also discovered the simplicity of early abortions.[63] In April 1971, Downer organized an event entitled the "Self Help Clinic" where women discussed the possibility of performing abortions without the assistance of a physician.[64] Downer and others began to learn abortion procedures from sympathetic doctors.[65] Some of the abortions they observed were performed with a new suction device developed in Europe.[66]

Finding the D & C procedure needlessly painful, one of the women, Lorraine Rothman, began worked with the suction device and improved it. The result was the "Del-Em," a simple hand-operated suction device used for menstrual extractions. The Del-Em can be constructed from materials readily available in hardware stores.[67] Only the cannula, the flexible, plastic, straw-like tube that is actually inserted into the cervix, cannot be obtained outside

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rate was attributable to police sympathy toward providers of safe abortions, whose existence often saved their own wives from injury or death).

55. "Jane," *supra* note 53, at 96.

56. CHALKER & DOWNER, *supra* note 12, at 82-83.

57. *Id.*

58. "Jane," *supra* note 53, at 96.

59. *Id.* at 97.

60. *Id.*

61. Barbara Brotman, *Secret Abortion Group of '60s Prepares for Return*, CHI. TRIB., Aug. 28, 1989, at C1.

62. *Id.*

63. CHALKER & DOWNER, *supra* note 12, at 114.

64. *Id.* at 115-17.

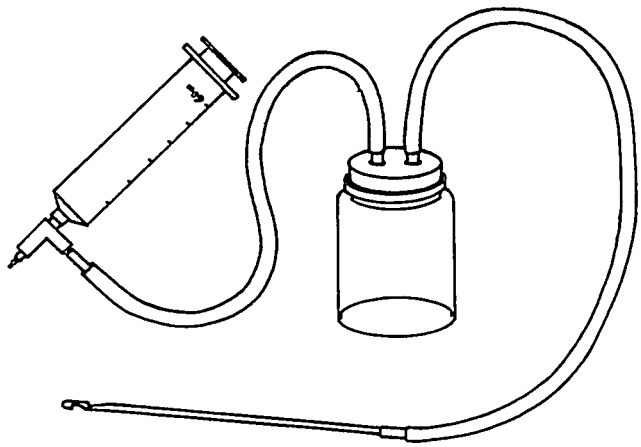
65. *Id.*

66. Letter from Rebecca Chalker to Diane Curtis (Apr. 7, 1994) (on file with author).

67. CHALKER & DOWNE, *supra* note 53, at 116.

medical supply houses.[68]

The menstrual extraction procedure itself is extremely simple.[69] A thin cannula is inserted into the woman's cervix. The cannula is attached to plastic tubing (similar to that used in home aquariums) that is connected to a sealed mason jar. A separate piece of tubing connects the mason jar to a large syringe equipped with a one-way valve (to prevent air from going the wrong way, into the uterus, which could introduce bacteria into the uterus, causing infection or even death). Suction is created by drawing on the syringe, gently evacuating the contents of the woman's uterus into the mason jar.[70]



From *Rebecca Chalker & Carol Downer, A Woman's Book of Choices: Abortion, Menstrual Extraction, RU-486*, at 124 (Four Walls Eights Windows 1992). Used by permision.

Several aspects of the procedure are important to note. First, menstrual extractions can be performed on pregnant women only until the eighth week of pregnancy[71] or on nonpregnant premenstrual or menstruating women. Consequently, the cannulas used to dilate and evacuate the uterus are very thin, usually no more than six millimeters in diameter (as compared to up to

68. *Id.* at 250-51. Self-helpers report that it can also be difficult to obtain, outside medical supply houses, the 50cc syringes needed to create suction and the one-way valve.

69. For a fuller description, see CHALKER & DOWNER, *supra* note 12, at 129-64; GAGE, *supra* note 51, at 21-26. As is routinely repeated in these sources, the purpose of menstrual extraction (i.e., as a woman-controlled, educational procedure sensitive to a particular woman's needs) would be entirely defeated if the process were learned only from a book.

70. The most common abortion procedure used today, vacuum aspiration, is essentially a high-tech version of menstrual extraction. Instead of a hand pump, an electrically powered vacuum is used, and often a stiffer, less flexible cannula is used. THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 16, at 357.

71. Eight weeks is counted from the last menstrual period (LMP). Since conception occurs at ovulation, which is usually in the middle of a four-week cycle, *id.* at 262, eight weeks LMP is usually six weeks since conception.

twelve millimeters for clinical first-trimester abortions).[72] Because of their small size, and because smaller cannulas are more flexible, the woman on whom the menstrual extraction is being performed usually experiences much less pain than in a clinical abortion.[73]

Second, contrary to popular media accounts,[74] menstrual extraction is not and probably cannot be performed by the woman herself. In order to safely insert the cannula into the cervix and to maintain the necessary sanitary conditions, at least one other person is needed. Moreover, in order to ascertain that the uterus has been completely evacuated, the person performing the menstrual extraction should gently rub the sides of the uterus with the cannula.[75] If the woman undergoing the extraction were to perform this maneuver, she would greatly increase the risk of uterine perforation.[76]

Third, menstrual extraction seems to be as safe as clinical abortions. Anecdotal evidence from self-helpers indicates a universal and careful use of sterile technique with few postprocedure infections. There have been no reports of any more serious complications.[77] However, to date there have been no controlled safety studies of menstrual extraction.

Fourth, menstrual extraction serves other purposes besides abortion. The effect of a menstrual extraction is to evacuate the contents of a woman's uterus. For women who are menstruating, this can mean a shortcut through the usual four to seven days of bleeding, cramping, and inconvenience.[78] Athletes can use the procedure before important competitions to avoid menstrual pain and to put themselves in their best physical condition.[79]

Fifth, even where menstrual extraction results in the termination of a pregnancy, this does not necessarily mean that an abortion was intended. Many home remedies, including menstrual extraction, have traditionally been cast not as abortions, but as bringing on a woman's period. This is not merely a semantic distinction. A woman's period may be late for any number of reasons, including stress or illness, as well as pregnancy. Any intervention which

72. THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 16, at 357.

73. This is not to say there is no pain; anecdotal reports indicate that some women experience intense pain regardless of the method used. This variation in reports should not be surprising given the differences among women in their experiences of other gynecological pains, including menstrual cramps and childbirth. It should also be noted that while women undergoing clinical abortions have the option to use local or general anesthesia, they may still experience cramping after the anesthesia wears off. THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 16, at 360.

74. *See, e.g.*, Peyser, *supra* note 47.

75. This is much gentler than the scraping involved in a D & C, since its purpose is not to remove the contents, but to feel the texture of the interior of the uterus. When the uterus is empty, the interior walls become slightly ridged or bumpy. GAGE, *supra* note 51, at 26.

76. *See* CHALKER & DOWNER, *supra* note 12, at 113.

77. Telephone Interview with Rebecca Chalker (Mar. 24, 1993). Most groups make arrangements with professional health care providers to serve as a backup in case of complications. CHALKER & DOWNER, *supra* note 12, at 148-49.

78. FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 43.

79. CHALKER & DOWNER, *supra* note 12, at 121.

has the effect of bringing on a period—whether it be high doses of Vitamin C,[80] an herbal preparation,[81] or a menstrual extraction—is therefore not strictly the equivalent of an abortion.

Finally, proponents of menstrual extraction stress the importance of context. For example, Chalker and Downer advise that menstrual extraction be performed only by ongoing self-help groups, or "friendship groups."[82] The women in such groups see themselves as women's health education collectives, gathered not for the purpose of performing menstrual extraction but for promoting health care. They do not envision women setting up storefront abortion services for strangers. On the contrary, self-helpers highlight the empowerment aspects of both menstrual extraction and other home gynecological care: the point is to make women the controlling center of their own care rather than passive recipients. Self-helpers adamantly reject the segmentation of gynecological care into isolated components;[83] they argue that such isolation serves only the interests of the medical establishment, who must commodify their services in order to maintain a competitive market.[84]

After the development of the Del-Em in the early 1970s, Downer and Rothman focused less attention on menstrual extraction and, with others, founded several nonprofit clinics where women were taught how to take care of their own gynecological needs.[85] In addition to these clinics, many women over the years have formed their own self-help groups, meeting on a regular basis to learn more about their own bodies and to share information and techniques for health maintenance and promotion.[86] Usually women in these

80. GAGE, *supra* note 51, at 40.

81. *Id.* at 41-44.

82. CHALKER & DOWNER, *supra* note 12, at 129.

83. For example, many argue that the separation of gynecology—the health care needs of women—from general practice is artificial. *See, e.g.*, FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 4.

84. *See* THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 16, at 660-62; FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 5-6; HAGS II, *supra* note 18.

85. CHALKER & DOWNER, *supra* note 12, at 118-19.

86. FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 1-3; HAGS I, *supra* note 13, at 2. I am aware of gynecological self-help groups throughout the United States, including groups in Utah, Los Angeles, San Francisco, Louisiana, Atlanta, New York—both in New York City and elsewhere in the state—and Boston. Downer estimates the number of groups to be approximately 100. Susan Brenna, *Abortions at Home: The Pros and Cons of Self-Help Procedure*, N.Y. NEWSDAY, Oct. 6, 1992, at 40. While there are no statistics, anecdotal evidence indicates that most of these groups are comprised primarily of white, usually middle class, women. Concurrent with the development of these groups, the National Black Women's Health Project began in the early 1970s to set up a different kind of self-help group that addressed women's emotional and informational isolation from one another, paying particular attention to reproductive health. Byllye Avery, *A Question of Survival/A Conspiracy of Silence: Abortion and Black Women's Health*, *in* FROM ABORTION TO REPRODUCTIVE FREEDOM: TRANSFORMING A MOVEMENT, *supra* note 50, at 75, 78-79. Women in these groups meet regularly to discuss all the issues in their lives that impact on their health, from sex and sexuality to the often contradictory tensions inherent in living as African-American women in the late twentieth century. *Id.* More recently, the largely white gynecological care groups and the largely African-American discussion groups have begun sharing their insights with one another

groups examine their own and each other's cervixes, noting differences between women, as well as in each woman throughout her menstrual cycle.[87] Most groups emphasize communication and trust among the members, creating a supportive environment in which to learn about reproductive health in general and self-care techniques in particular.[88] Common self-help group educational activities include cervical self-exams, uterine size checks, breast exams, and monitoring ordinary gynecological problems such as yeast infections and fibroids. Members also often share information about and experiences with both traditional and alternative remedies for these and other problems. While menstrual extraction is frequently included among these practices, it is usually not the central feature; rather, it is most often seen as one of many facets of woman-controlled home health care.

After *Roe v. Wade*[89] was decided, the interest in menstrual extraction waned as women turned more consistently to the newly legal and available clinical abortion providers, almost always physicians.[90] More recently, however, especially since the Supreme Court's decisions in *Webster v. Reproductive Health Services*[91] and *Planned Parenthood v. Casey*,[92] women have expressed a renewed interest in menstrual extraction and self-help gynecological care.[93] *Webster* signaled for many an increasingly favorable federal judicial attitude towards abortion restrictions; *Casey* formally changed the legal standard under which abortion restrictions would be scrutinized.[94] As a result, menstrual extraction is once again becoming popular and more widely practiced.[95]

The ever-shifting legal climate surrounding abortion is not the only reason for this increased popularity. Since the early 1970s, feminists have battled to enhance women's autonomy in health care generally. Initiated largely in response to what was perceived as a pattern of distant, overly medicalized, alienating, and even hostile interactions between women and their physicians, the women's health movement emphasized increased knowledge about health care and widespread education regarding self-care, especially preventive

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and integrating each other's practices into their own activities. Interview with Susan Shaw, an attendee at the Hampshire College Reproductive Rights Conference of Apr. 1992, in Belchertown, Mass. (Mar. 15, 1993).

87. FEDERATION OF FEMINIST WOMEN'S HEALTH CTRS., *supra* note 13, at 1-3.

88. *Id.*

89. 410 U.S. 113 (1973).

90. CHALKER & DOWNER, *supra* note 12, at 119. For many women, participation in an ongoing self-help gynecological group requires a time commitment they are either unable or unwilling to make for a variety of reasons, including work and childcare responsibilities. Moreover, for the majority of Americans, health care is conceptualized not as an ongoing process but as a service purchased when the need arises. Clinical abortions fit more readily into this latter view.

91. 492 U.S. 490 (1989).

92. 112 S. Ct. 2791 (1992).

93. *See, e.g.*, CHALKER & DOWNER, *supra* note 12, at 173; HAGS II, *supra* note 18; Japenga, *supra* note 17, at 51.

94. 112 S. Ct. at 2820 (abandoning "strict scrutiny" analysis and adopting the "undue burden" standard).

95. Brenna, *supra* note 23, at C13.

care.[96] In the late 1980s, a new generation of feminists discovered that despite this movement's work, not much—or at least, not enough—had changed either in the delivery of care or in the average woman's knowledge about her own body, health, and medical treatment. This realization, accompanied by spiraling health care costs and diminished insurance coverage for routine care, has led to a new influx of activists into the women's health movement.[97] The emphasis on self-taught medical expertise in the AIDS activist movement[98] has provided an additional impetus to this revival.

The women's health movement's central criticism of the health care delivery system is that it disempowers the individual by conceptualizing medical care as something the (expert) doctor provides to the (passive, ignorant) patient.[99] Women's health advocates, including self-helpers, assert that access issues represent only one branch of the problems afflicting the American health care delivery system; equally important are the relationships between physicians and patients and the degree of autonomy and self-determination afforded health care consumers.[100] This critique is an important element of any challenge to the application of medical practice acts to women performing menstrual extractions. In selecting legal arguments, advocates for menstrual extraction must therefore choose between those that will embody this critique, such as challenging the statutory schemes, and those that will meet the immediate needs of self-helpers defending themselves against prosecution.[101]

II

A Brief History of Medical Practice and Abortion Laws

The development of medical practice and licensure laws is linked historically and politically to the criminalization of abortion. A short overview of their overlapping histories will help situate the importance of a defense of menstrual extraction in the context of both bodies of law.

Medical practice acts—statutes that limit the authority to practice medicine to licensed physicians—are of relatively recent origin. Prior to the mid-nineteenth century, physicians were not licensed and did not even receive

96. *See generally* The Boston Women's Health Book Collective, *supra* note 16; Federation of Feminist Women's Health Ctrs., *supra* note 13.

97. For example, several new women's health care-focused activist groups were founded in the late 1980s and early 1990s, most notably WHAM! (Women's Health Action and Mobilization). Founded in New York City in 1989, WHAM! has had independent chapters in Los Angeles, San Francisco, Philadelphia, Chicago, Champaign-Urbana, Ithaca, and Southern New Jersey.

98. *See generally* Michael Callen, Surviving AIDS 195-96 (1990).

99. The Boston Women's Health Book Collective, *supra* note 16, at 652-53; Federation of Feminist Women's Health Ctrs., *supra* note 13, at 1-3.

100. The Boston Women's Health Book Collective, *supra* note 16, at 658-59.

101. *See infra* pp. 468-69. For more detailed explorations of some of the ethical issues implicated in representing clients involved in civil disobedience, see Kathryn Abrams, *Lawyers and Social Change Lawbreaking: Confronting a Plural Bar*, 52 U. Pitt. L. Rev. 753 (1991); Martha L. Minow, *Breaking the Law: Lawyers and Clients in Struggles for Social Change*, 52 U. Pitt. L. Rev. 723 (1991).

any uniform education.[102] Several different types of practitioners existed side by side with no social consensus favoring any particular "school." Most health care was delivered in the home by family members, usually women.[103]

In the mid-1800s, various groups of physicians engaged in concerted efforts to "professionalize" medicine. Since there were no uniform criteria for determining who could be called a doctor, physicians in many areas of the country found themselves in a glut—too many doctors for too few citizens. In order to distinguish one medical sect from another and to reduce the overall number of doctors, nascent physicians' associations began building the cornerstones of their professional prestige: they established medical schools and uniform training, certified those who completed the training, and increased lobbying for legal recognition of the profession.[104]

A necessary concomitant of the designation of some practitioners as true medical professionals was the exclusion of others as not good enough. Women—as patients, doctors, and lay healers—were disproportionately targeted by these exclusionary practices.[105] This systematic elimination of women from leadership roles in the medical profession is well documented;[106] less attention has been paid to the growing profession's explicit goal of disempowering all patients, regardless of gender. In order to establish their privileged role in the provision of health care and to emphasize that they were providing a service no one else, least of all home healers, could deliver, physicians engaged in "heroic" medicine—showy interventions such as "bleeding" that looked impressive but that usually had little positive effect.[107] Often, as with bleeding, the results were in fact negative, if not fatal. In addition, professional manuals expressly advised physicians to dissemble their activities so they appeared that much more mysterious and inaccessible (except for a price) to their patients:

> Especially avoid giving self-sufficient people therapeutic points that they can thereafter resort to . . . . If compelled to give a person remedies under a simple form, study to do so in such a way as not to increase his self-conceit and make him feel that he knows enough to practice self-medication and dispense with your services . . . .[108]

The drive to professionalize medicine took place at the same time as the first concerted movement against abortion. Significantly, this movement did

102. *See generally* STARR, *supra* note 40, at 30-144 (1982); JAY KATZ, THE SILENT WORLD OF DOCTOR AND PATIENT 37-39 (1984).

103. STARR, *supra* note 40, at 32-37.

104. *Id.* at 39-40.

105. *Id.* at 49-50. For example, an early advice manual to physicians developing their practices warned that they be on guard against "jealous midwives, ignorant doctor-women and busy neighbors." *Id.* at 87 (quoting D.W. CATHELL, THE PHYSICIAN HIMSELF 143 (1890)).

106. *See, e.g.*, EHRENREICH & ENGLISH, *supra* note 40, at 65-66; STARR, *supra* note 40, at 124; MARY R. WALSH, "DOCTORS WANTED: NO WOMEN NEED APPLY" *passim* (1977).

107. For a description of such therapies, see STARR, *supra* note 40, at 42.

108. *Id.* at 87 (quoting CATHELL, *supra* note 105, at 242).

not originate in either popular outcry or religious condemnation; rather, the impetus came from physicians.[109]

Kristin Luker has argued persuasively that physicians used the abortion issue as a "carefully calculated" strategy for enhancing their legal and moral status.[110] By condemning abortion, physicians positioned themselves as defenders of human life. They did not, however, campaign for complete bans on abortion, as a pro-life stance might suggest. Rather, doctors advocated *regulation* of abortion, specifically, regulation that placed physicians in the central decision making positions. These regulations embodied exceptions to general bans on abortion in order to save the life of the mother (a circumstance requiring a medical determination) as well as explicit bans on abortions by nonphysicians.[111] Physicians could thus cast themselves as both moral leaders—defenders of life—and medical leaders—uniquely able to provide abortions in appropriate circumstances. In light of the fact that abortions were actually widespread in the mid-1800s when these regulatory schemes were evolving and were more often than not performed by nonphysicians,[112] the anti-abortion campaign provided a unique opportunity for the emerging profession to establish its moral and legal primacy. It is within this historical context that most current medical practice acts and physician licensing schemes came into being.

III
STATUTORY ARGUMENTS IN SUPPORT OF MENSTRUAL EXTRACTION'S LEGALITY

Almost all self-helpers who perform menstrual extractions fear some sort of legal prosecution for their acts and often take elaborate precautions to protect their identities and to maintain confidentiality within their self-help groups. These precautions include using code names for menstrual extraction when referring to it in public, refraining from speaking about it on the telephone,[113] concealing their identities when speaking with media representatives,[114] and making sure that everyone involved in a given self-help group is well known to all others.

These precautions are not simply the result of activist paranoia: menstrual extraction is arguably illegal under two different types of statutory proscription. First, a prosecutor could assert that menstrual extraction

109. *See* MOHR, *supra* note 42, at 147-70.

110. LUKER, *supra* note 42, at 31-33; *see also* MOHR, *supra* note 42, at 163-66.

111. LUKER, *supra* note 42, at 30-33.

112. *Id.* at 19-20, 27.

113. CHALKER & DOWNER, *supra* note 12, at 150. Telephone harassment of activists is unfortunately not merely a bad memory from the 1960s but continues to this day. *See, e.g.*, BRIAN GLICK, WAR AT HOME: COVERT ACTION AGAINST U.S. ACTIVISTS AND WHAT WE CAN DO ABOUT IT 10 (1989); Esther Kaplan, *ACT UP Under Siege—Phone Harassment, Death Threats, Police Violence: Is the Government Out to Destroy this Group?*, VILLAGE VOICE, July 16, 1991, at 35.

114. *See, e.g.*, Peyser, *supra* note 47, at 1, 7.

constitutes the practice of medicine and therefore cannot be performed by anyone but a licensed physician under the medical practice acts (on the books in every state). Second, since almost all states specifically limit the authority to perform abortions to licensed physicians, a prosecutor could argue that menstrual extraction constitutes a type of unauthorized abortion. Violation of either law, in almost every state, is a felony.

Arguments in support of menstrual extraction's legality fall into two categories: first, statutory arguments that assert that menstrual extraction constitutes neither the practice of medicine nor abortion; and second, constitutional arguments that challenge the validity of applying the statutes to menstrual extraction on privacy and equal protection grounds. In the remainder of this Article, I will explore these arguments under two different statutory and state constitutional settings—those of Florida and Vermont—to provide a more detailed discussion of how these arguments might fare and what types of obstacles advocates for menstrual extraction are likely to encounter.

A. Medical Practice Law

Medical practice acts are usually a combination of two or more statutory provisions. The first defines the practice of medicine; the second delineates those persons authorized to practice medicine, usually licensed physicians.[115] Often there are statutory exceptions for emergency situations and "family remedies."[116] Separate provisions of these statutes detail the approval procedure and qualification requirements for licensure as a physician. In an increasing number of states, there are analogous provisions regulating the practices of physician's assistants, nurse practitioners, and midwives.[117] These additional provisions usually detail exactly what so-called "midlevel" practitioners can and cannot do without direct supervision by a physician.[118]

115. *See, e.g.*, IDAHO CODE §§ 54-1803 (1988 & Supp. 1993) (defining practice of medicine), 54-1804 (Supp. 1993) (restricting practice of medicine to authorized persons); NEV. REV. STAT. §§ 630.020 (1991) (definition); 630.010 (1991) (restriction); N.Y. EDUC. LAW §§ 6521 (McKinney 1985) (definition), 6522 (McKinney 1985) (restriction); OR. REV. STAT. §§ 677.085 (1991) (definition), 677.325 (1991) (restriction). Some states combine these two provisions into one statutory section. *See, e.g.*, ILL. ANN. STAT. ch. III, para. 4400-1 (Smith-Hurd 1986); OKLA. STAT. tit. 59, § 492 (1991); P.R. LAWS ANN. tit. 20, § 39 (1992).

116. *See, e.g.*, FLA. STAT. ANN. § 458-303(f) (West 1991). Some states include more detailed and lengthy exceptions, but these exceptions normally address providers licensed in other states or categories. *See, e.g.*, COLO. REV. STAT. § 12-36-106 (1990) (recognizing exceptions for the practice of Christian Science, physicians licensed in other states, and commissioned medical officers); CONN. GEN. STAT. ANN. § 20-9 (West Supp. 1993); NEB. REV. STAT. § 71-1, 103 (Supp. 1992).

117. *See, e.g.*, FLA. STAT. ANN. § 458.347 (West 1991) (licensure of physician assistants); FLA. STAT. ANN. § 464.012 (West 1991) (certification of nurse practitioners); FLA. STAT. ANN. § 467.006 (West 1991 & Supp. 1994) (requirements for practice of midwifery).

118. *See, e.g.* FLA. STAT. ANN. § 458.347 (West 1991 & Supp. 1993); VT. STAT. ANN. tit. 26, § 1735 (1989 & Supp. 1993). Most states also have detailed provisions defining separate branches of the medical profession, including podiatry, chiropractic, and osteopathy. *See, e.g.*, FLA. STAT. ANN. §§ 459.003 (West 1992 & Supp. 1993) (osteopathy), 461.003 (West 1992) (podiatry), 460.403 (West 1992) (chiropractic).

The most important aspect of these statutory schemes for the purposes of this discussion is the definition of the "practice of medicine." Does menstrual extraction fall within the definition or within one of the exceptions? Specific arguments in support of menstrual extraction's legality will involve examining statutory language, judicial interpretation and application of the statutes, and state attorney general opinions, and will therefore vary from state to state.

In Florida, the practice of medicine is defined as "the diagnosis, treatment, operation, or prescription for any human disease, pain, injury, deformity, or other physical or mental condition"[119] and is prohibited except by those with an active license.[120] Several exceptions are provided, including emergency cases[121] and acts that constitute "the practice of the religious tenets of any church in this state."[122] Most relevant for the current discussion, however, is the exception for "[t]he domestic administration of recognized family remedies."[123]

The medical practice act in Vermont prohibits practice without a license[124] and defines a "practitioner of medicine" as anyone who "shall prescribe, direct, recommend, or advise, give or sell for the use of any person any drug, medicine or other agency or application for the treatment, cure or relief of any bodily injury, infirmity or disease."[125] There are no exceptions for family remedies.

To find menstrual extraction legal under either of these statutes entails exploring and exploiting the cracks in the definitions: what does it mean to "diagnose," "treat," "operate," or "relieve"? Is the woman on whom a menstrual extraction is performed suffering from an "infirmity," "disease," or "condition"? Does the answer to this question depend on whether she is pregnant at the time of the procedure? If not, does menstruation constitute a sufficient "condition" for which relief or treatment is provided? If so, wouldn't tampon insertion also constitute "treatment" or "relief"?[126] If, on the other

119. FLA. STAT. ANN. § 458.305(3) (West 1992).
120. *Id.* § 458.327(1)(a) (West 1992 & Supp. 1993).
121. *Id.* § 458.303(e) (West 1992).
122. *Id.* § 458.303(g) (West 1992).
123. *Id.* § 458.303(f) (West 1992).
124. VT. STAT. ANN. tit. 26, § 1314 (1989).
125. *Id.* § 1311(1) (1989). Most state statutory definitions of medical practice adhere to this same basic pattern consisting of a lengthy list of verbs, such as "diagnose," "treat," or "relieve," followed by an equally lengthy list of nouns, such as "condition," "injury," or "deformity." *See, e.g.*, ALA. CODE § 34-24-50 (1991) ("diagnose, treat, correct, advise or prescribe" for any "human disease, ailment, injury, infirmity, deformity, pain or other condition, physical or mental, real or imaginary"); KAN. STAT. ANN. § 65-2869 (1992) ("prescribe, recommend or furnish medicine or drugs, or perform any surgical operation of whatever nature by the use of any surgical instrument, procedure, equipment or mechanical device for the diagnosis, cure or relief of any wounds, fractures, bodily injury, infirmity, disease, physical or mental illness or psychological disorder"); S.C. CODE ANN. § 40-47-40 (Law. Co-op. 1976 & Supp. 1993) ("diagnose, cure, relieve" any "human disease, ailment, defect, abnormality, complaint" by "attendance or advice, by prescribing, using or furnishing any drug, appliance, manipulation, adjustment or method").
126. The most frequent objection to this analogy is the observation that women typically

hand, the woman must be pregnant to meet the "condition" requirement of the statute, does it matter whether either she or those performing the menstrual extraction knew she was pregnant? Is the result from a home pregnancy test a sufficient diagnosis to constitute knowledge of a pregnancy?[127] If it is sufficient, why wouldn't the use of a home pregnancy kit constitute the unauthorized practice of medicine (as "diagnosing" a "condition")?[128] Absent a definitive diagnosis of a condition, can any care be considered "treatment"?

The above list of questions gives some indication of the imprecision of medical practice statutes. Indeed, the only limit to the types of interpretive arguments in support of or against the applicability of medical practice acts to a specific situation is the existing case law in a given state. Additional competing definitions of key terms to support either side can be found in several sources, including insurance and medical malpractice treatises and practice manuals, medical textbooks, and legal and medical dictionaries. Enterprising attorneys will presumably bring to bear as many of these arguments as they can find support for. For purposes of this Article, however, I examine only those interpretive opinions offered by state judges, legislators, and attorneys general.

1. Vermont Medical Practice Law

Vermont has relatively little jurisprudence in this area. The only reported case construing the relevant portion of the state medical practice statute[129] is *State v. Cantrell*,[130] in which the Vermont Supreme Court rejected both facial and as-applied vagueness challenges to the statute under the United States Constitution.[131] The court, without discussion, concluded that surgi-

insert their own tampons, while menstrual extraction is performed by another person. However, it is crucial to the self-help model of gynecological care that the woman be a full participant in her own extraction, even if she is not the one actually inserting the cannula or creating the suction.

127. Even a blood test performed by a physician is not considered a *definitive* diagnosis of pregnancy; the diagnosis is definitive only when there is physical evidence of the presence of the fetus through either a sonogram or a pelvic examination. *See infra* note 200 and accompanying text.

128. The answer to this somewhat rhetorical question is that the Food and Drug Administration's approval of home pregnancy kits as an over-the-counter medical device preempts state law in this area. 21 U.S.C. § 360k (1988). The Del-Em kit used for menstrual extraction has never been similarly approved, although Loraine Rothman, the inventor of the device, received patent protection for it in 1974. CHALKER & DOWNER, *supra* note 12, at 241. Since FDA approval of any medical treatment for over-the-counter use is arguably contrary to physicians' financial interests, it would be interesting to study the position of the American Medical Association and other professional groups on various drugs and devices granted over-the-counter status.

129. Two cases from the early twentieth century involved prosecutions under a separate clause of Vermont's medical practice statute, which prohibits "hold[ing one]self out to the public as a physician or surgeon." VT. STAT. ANN. tit. 26 § 1311 (1989). *See* State v. Kaatz, 104 A. 873 (Vt. 1918); State v. Lindsay, 84 A. 612 (Vt. 1912).

130. 558 A.2d 639 (Vt. 1989).

131. For discussion of vagueness challenges, see *infra* notes 159-160 and accompanying text.

cally removing a wart, applying sutures to a wound, and administering a local anesthetic "clearly" fell within the statutory definition of medical practice.[132] The absence in *Cantrell* of any discussion—or even recognition—of the possible difficulties in determining whether a given act constitutes the practice of medicine provides no guidance beyond this particular set of facts and circumstances.

A 1960 Attorney General's Opinion, responding to the question of whether the administration of anesthesia constitutes the practice of medicine, explicitly acknowledges the statutory imprecision.[133] In an opinion requested before anesthesiology was widely recognized as a medical specialty, the Attorney General responded that the question "cannot be answered by a simple 'yes' or 'no',"[134] stating that "it may become a hard question to determine whether a particular act requires licensing under our statute. Our statute was passed in 1904. Such question [sic] could only be determined after hearing both sides of a particular set of facts."[135] The absence of any substantive interpretive guidance in Vermont provides the perfect scenario in which to assert the more imaginative arguments suggested by the unanswered questions above.

2. *Florida Medical Practice Law*

Florida courts have developed a more extensive medical practice jurisprudence than Vermont, but a careful reading of these cases reveals that they are generally distinguishable from the practice of menstrual extraction. The cases are marked by an underlying fear of fraud: all of the acts found to be within the definition of the practice of medicine were performed for a fee by persons who pretended to an expert knowledge they did not actually possess. Thus, for example, the court held that a masseur who claimed he could readjust the skeletal structures of paying clients was guilty of the unauthorized practice of chiropractic;[136] a physician's assistant who contracted to aid in the delivery of a child was considered to have "exceeded his duties as an assistant";[137] a man who worked on someone's feet with a surgical knife and on whose office door was stenciled "podiatrist" in Spanish was found to have practiced unauthorized podiatry;[138] and a man who examined clients, offered diagnoses of their ills, and prescribed treatment consisting of a stay at his farm, adhering to a specific dietary regimen, and taking vitamin supplements was found to have practiced medicine.[139] On the other hand, in reversing the medical practice

132. 558 A.2d at 641.
133. 60-62 Op. Att'y Gen. 44 (Vt. 1960).
134. *Id.* at 44.
135. *Id.* at 45.
136. LaCour v. State, 522 So. 2d 33 (Fla. Dist. Ct. App. 1987).
137. Baxter v. State, 47 So. 2d 764 (Fla. 1950). His acts were found, however, to meet the emergency exception in the Florida statute.
138. State v. Ramos, 232 So. 2d 381 (Fla. 1970).
139. Reams v. State, 279 So. 2d 839 (Fla. 1973). This holding, including a careful reading

conviction of a person who had administered blood pressure tests and relayed the results, the Florida Supreme Court found determinative the fact that the defendant did not hold himself out as competent to treat or diagnose anything.[140]

These cases reflect the classic justification for medical practice acts: the need to protect the public from "quacks" who might take a person's money while either providing no service at all or threatening injury through incompetence.[141] It is not surprising then that almost all the reported cases upholding convictions involved either persons pretending to be doctors or religiously motivated faith healers. The court's primary concern in these cases is best articulated in *State v. Ramos*,[142] the podiatry case: "A common sense interpretation of this type of statutory language limits its applicability to those situations which pose a threat to the public. . . . The public interest demands that unlicensed persons be stopped, if possible, before they have the opportunity to do injury to others."[143]

This reasoning, however, is not applicable to menstrual extraction *as practiced by self-help groups* since it poses no such threat of fraud or injury to the public. First, menstrual extraction is not performed for fees or profit, but rather within preexisting friendship groups where there is no pecuniary interest that would motivate fraud. Second, self-helpers do not hold themselves out as offering a service to the public at large; rather, as discussed above,[144] menstrual extraction is most often performed as a component of a broader program of self-education regarding one's body and health.[145] Third, the woman on whom the menstrual extraction is performed is a full participant in the activity, not a passive consumer of a service. There is no sense in which she is not only consenting but participating in a fully informed manner to the procedure and any attendant risks. Indeed, the very premise of self-help gynecological care is antithetical to the buyer/seller model of health care that underlies the anti-fraud justification for medical practice acts in the first place.

Arguments based on a presumed lack of pecuniary motive are contingent on the self-help model of menstrual extraction. Arguably, however, the danger of prosecution is more acute where self-helpers are performing menstrual extractions for women outside of the group. While this is not the usual practice, it does happen, most often (if not solely) when a good friend of one or

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of the terms *diagnose* and *treat*, is arguably dicta, since the case was reversed and remanded for a new trial, on other grounds, due to prejudicial error.

140. Lambert v. State, 77 So. 2d 869 (Fla. 1955).

141. *See, e.g.*, AMERICAN MEDICAL ASSOCIATION, OPINIONS AND REPORTS OF THE JUDICIAL COUNCIL 14-17 (1971) (prohibiting association with "irregulars" [nonphysicians] in order to "maintain[] the dignity of medicine" and thereby prevent "tragic results").

142. 232 So. 2d 381.

143. *Id.* at 383.

144. *See supra* part I.

145. If, at some point in the future, menstrual extractions were performed specifically to circumvent onerous laws restricting abortion, different issues might be implicated. *See* the discussion of abortion restrictions *infra* part III.B.

more of the group members requests a menstrual extraction.[146] This fact standing alone, however, neither supports the comparison of self-helpers to charlatans or quacks nor implies a similar public danger. If the self-helpers are ethically consistent, the menstrual extractions they perform for women outside the group will still entail the active participation of the woman, facilitating her control over the entire procedure. Similarly, ethical self-helpers would not undertake any procedure if there is any doubt whatsoever as to the woman's voluntariness.

For some, the assumption of an ethical self-help group is an insufficient response to the "slippery slope" objection. According to that critique, it would be impossible to restrict the practice of menstrual extractions to *ethical* self-help groups, once there was, effectively, an additional exception to medical practice statutes for menstrual extractions performed within the self-help context. Such arguments underestimate the ability of judges and legislators to draft opinions or statutes carefully and intelligently. Indeed, some medical practice acts explicitly require a pecuniary interest.[147] Moreover, there remain other avenues of recourse available to potential victims of "unethical" self-helpers, including deceptive trade practice and other anti-fraud statutes, as well as traditional tort remedies.

The argument that concern with *public* threats should guide interpretation of the Florida medical practice statute is underscored by the statutory provision that broadly exempts the "domestic administration of recognized family remedies,"[148] presumably regardless of their nature. There have been no cases in Florida construing this language, thus leaving some leeway for arguing that menstrual extraction falls within the exception. Menstrual extraction is, after all, always performed in the home by people who know one another very well.[149] In determining what constitutes a "family" remedy, should there be a requirement that the parties actually be legally related? Presumably, the original purpose of this exception was to maintain a private sphere, protected from government intervention, in much the same way that parents are left free to make many decisions for their children.[150] Given this purpose, there seems to be no clear reason why this protected private sphere should be limited to persons who are actually related to one another. More-

146. I am assuming that even in such circumstances, the group would not charge the woman for the menstrual extraction. I do know of one self-help group that has requested renumeration to help cover the cost of the instruments used. In keeping with the "Jane" tradition, however, these are only requests, and the group would not refuse a woman for whom they would otherwise feel comfortable performing a menstrual extraction simply because she could not pay.

147. *See, e.g.*, MISS. CODE ANN. § 73-25-33 (1989) ("The practice of medicine shall mean [list of specific acts] after having received, or with the intent of receiving therefor, either directly or indirectly, any bonus, gift, profit or compensation . . . .").

148. FLA. STAT. ANN. § 458.303 (West 1991).

149. *See supra* text accompanying notes 82.

150. *See, e.g.*, Wisconsin v. Yoder, 406 U.S. 205 (1972) (granting broad discretion to parents to determine education of their child); *see also* Pierce v. Society of Sisters, 268 U.S. 510 (1925); Meyer v. Nebraska, 262 U.S. 390 (1923).

over, as the legal and social definition of family changes to include extended friendship networks,[151] surely the definition of "family remedies" must evolve as well.

The most important obstacle to this argument is determining what it means for a family remedy to be "recognized" and from whom the recognition must come. Menstrual extraction as practiced in self-help groups and promoted by Chalker and Downer has been around for roughly twenty years. Home abortions of one kind or another are much older, arguably of the same vintage as pregnancy. Menstrual regulation—the form of menstrual extraction often practiced in developing countries—is recognized and approved by medical practitioners.[152] Menstrual extraction has been "recognized" as a legitimate practice by many in the broader women's health movement, including by the Boston Women's Health Book Collective.[153] If the family remedy exception is construed as requiring that a given treatment be recognized literally as a *family* remedy, self-helpers can muster a persuasive historical argument: as noted above, there is a long tradition of women attending to their daughters' reproductive health needs, including the provision of home abortion.[154] Fertility control has always been a family matter. Finally, the ever-increasing cost of clinical care generally and the concomitant decrease in access to such care have led many people to turn to less expensive, home-based preventive care techniques. In this context, the line between "recognized family remedy" and medical practice appears fuzzy at best.

It should be noted that in Florida, two attorney general opinions have given a broad reading to "medical practice" and "surgery" without reference to the dangers of quackery or charlatanism. In finding that a heat-induced

151. *See, e.g.*, Baehr v. Lewin, 852 P.2d 44 (Haw. 1993) (holding government prohibition on same-sex marriage subject to strict scrutiny analysis under state constitution's equal protection clause); Braschi v. Stahl Assocs., 543 N.E.2d 49 (N.Y. 1989) (stating *family* in rent control laws includes gay partners and other long-term members of the same household); *see also* Kris Franklin, *"A Family Like Any Other Family:" Alternative Methods of Defining Family In Law*, 18 N.Y.U. REV. L. & SOC. CHANGE 1027 (1990-91) (analyzing changing legal definitions of *family*).

152. *See* CHALKER & DOWNER, *supra* note 12, at 123-27.

153. THE BOSTON WOMEN'S HEALTH BOOK COLLECTIVE, *supra* note 16, at 358. Opposition to recognizing the legitimacy of menstrual extraction comes most often from physicians, who have a financial and cultural stake in the outcome. *See* Kay W. Graves, *Another Plan—Preparations Begin for Roe's Repeal*, CHI. TRIB., Mar. 29, 1992, at 1 (" 'No matter how you look at it, operating on ourselves is a step backward.' ") (quoting Dr. Michael Policar, National Medical Director, Planned Parenthood Federation of America); Mimi Hall, *Some Groups Teaching Do-It-Yourself Abortions*, USA TODAY, Jan. 29, 1992, at 5A (" 'Abortion . . . should be performed by a trained physician.' ") (quoting Kate Ruddon, spokesperson for the American College of Obstetricians and Gynecologists); *id.* (" 'Unconscionable.' ") (quoting Barbara Radford, Director of the National Abortion Federation, an organization representing abortion providers). In contrast, many other experienced physicians believe that menstrual extraction is an uncomplicated procedure and is safe when performed by someone who is properly trained. *E.g.*, Japenga, *supra* note 17, at 57 (quoting Dr. Grant Bagley, Director, Utah Women's Health Center); Brenna, *supra* note 23, at C13 (quoting Dr. Cheryl Gibson, Associate Medical Director, Planned Parenthood of Northern New England).

154. *See supra* notes 44-46 and accompanying text.

tonsillectomy constituted surgery in 1952, the Florida Attorney General suggested adopting the California Supreme Court's definition of surgery as the "severing or penetrating of the tissues of human beings."[155] In 1956, the Attorney General proposed a very broad, practically all-inclusive, definition of medical practice: "[A]ny attempt to treat any human disease, pain, injury or physical condition, which would embrace human disability, by any means whatsoever, which would include massage, therapeutic exercises, and the physical, chemical and other properties of heat, light, water and electricity . . . ."[156] If this were the controlling definition of medical practice, advocates for the legality of menstrual extraction would be hard put to escape its scope. However, the Florida Supreme Court has found attorney general opinions in this area persuasive but not binding[157] and has articulated a rule of strict construction for medical practice acts generally.[158]

The awkward language of many medical practice statutes would seem to invite a due process challenge on vagueness grounds. Indeed, the most common defense asserted by those charged with the unauthorized practice of medicine is that the statute gives insufficient notice of exactly what behavior is proscribed.[159] Unfortunately, such defenses have been uniformly rejected. A Westlaw search revealed not a single successful vagueness challenge to a medical practice act in any state court in the last fifteen years.[160] But the argument for vagueness may be stronger where the services are not remunerated and the other trappings of traditional physician practice are absent. Application of

155. 1951-52 Op. Att'y Gen. 579 (No. 052-183) (Fla. 1952) (quoting People v. Fowler, 84 P.2d 326, 333 (Cal. 1938)).

156. 1955-56 Op. Att'y Gen. 467, 469 (No. 056-12) (Fla. 1956).

157. Lambert v. State, 77 So. 2d 869, 871 (Fla. 1955).

158. *Id.*

159. *See, e.g.*, State v. Cantrell, 558 A.2d 639 (Vt. 1989).

160. Search of Westlaw, AllStates and AllFeds databases (May 1993) (search for cases employing the terms "vague! & date(>1977) & to(299k6)" (Westlaw topic key code for "Physicians and Surgeons—Practice without authority")); *see, e.g.*, Foster v. Georgia Bd. of Chiropractic Examiners, 359 S.E.2d 877, 884 (Ga. 1987) (stating "drugs" and "medicine" not vague as applied to chiropractor's recommendation of nonprescription nutritional supplements); Stetina v. State *ex rel.* Medical Licensing Bd., 513 N.E.2d 1234, 1238 (Ind. Ct. App. 1987) (holding medical practice act not vague as applied to chiropractor/nutritionist); State *ex rel.* Mo. Bd. of Registration for Healing Arts v. Southworth, 704 S.W.2d 219, 224 (Mo. 1986) (finding "practice of midwifery" and "practice of medicine," otherwise undefined in statute, not unconstitutionally vague); Strandwitz v. Ohio Bd. of Dietetics, 614 N.E.2d 817, 824 (Ohio Ct. App. 1992) (holding dietician licensing statute not vague as applied to nutritionist); State v. Cantrell, 558 A.2d 639, 641 (Vt. 1989) (holding medical practice act not vague as applied to defendant's conduct in surgically removing a wart).

One challenge in federal court, still pending final review, has gone the other way. In *Peckmann v. Thompson*, the district court found the Illinois statute prohibiting the "practice of midwifery" unconstitutionally vague. 745 F. Supp. 1388, 1394 (C.D. Ill. 1990). The appellate court remanded the case for further proceedings, however, finding that the state had not been afforded an adequate opportunity to defend its statute. Peckmann v. Thompson, 966 F.2d 295, 298 (7th Cir. 1992). These challenges were brought under the federal constitution's due process clause, leaving open, in theory at least, the possibility of a challenge under a more protective state constitutional standard of vagueness. But unlike the privacy and equal protection contexts discussed below, the vagueness standard does not seem to vary from state to state.

medical practice acts to activities so far removed from what we generally think of as "medical practice" becomes, at some point, an absurd extension of the definition.

These formalistic arguments, which would exempt menstrual extraction from the definition of medical practice, are highly dependent on the relevant case law in a given state. It is interesting to note, however, that the most common interpretations of these laws assume that there exists a certain power differential between physician (or pretended physician) and patient that would justify state intervention to protect the latter. But the expert physician/ignorant patient model underlying that power differential is arguably less accurate today than it was in the past and certainly does not apply in the self-help menstrual extraction context. To the extent that advocates can demonstrate that menstrual extraction as practiced by self-help groups does not constitute a situation from which the public needs protection, they can undermine the presumed rationality of these statues.[161]

B. Abortion Law

Abortion restrictions have, of course, been litigated and discussed much more extensively than medical practice acts. Consequently, menstrual extraction advocates have substantially less leeway in their statutory construction arguments in this domain. Nevertheless, two basic statutory arguments are still available: first, menstrual extraction is not abortion either because there is no definitive diagnosis of pregnancy or because the requisite intent to terminate a pregnancy is lacking; second, even if menstrual extraction does constitute abortion, there is no proscription on abortions performed by nonphysician practitioners.

The first step in implementing either of these strategies is to ascertain the status of abortion law in the state, an undertaking which itself may not yield hard answers. In theory, the Supreme Court's decision in *Roe v. Wade*[162] invalidated the criminal abortion bans in every state. The reality, however, is much different. The legislatures of many states never repealed their pre-*Roe* abortion statutes, and many of these statutes were never specifically enjoined from enforcement.[163] Since the Supreme Court in *Planned Parenthood v. Casey*[164] relaxed the standard of review for abortion restrictions, the status of

161. This argument assumes a certain philosophical stance against government paternalism in so-called victimless contexts, including drug use and prostitution as well as menstrual extraction. Indeed, home health care generally depends upon an implicit critique of medical, legal, and governmental paternalism. Unfortunately, a full discussion of that critique is beyond the scope of this Article. For more on the rationality of medical practice acts in the equal protection context, see *infra* part IV.B.

162. 410 U.S. 113 (1973).

163. *See* Teresa L. Scott, *Burying the Dead: The Case Against Revival of Pre-*Roe *and Pre-*Casey *Abortion Statutes in a Post-*Casey *World*, 19 N.Y.U. REV. L. & SOC. CHANGE 355, 363 n.50 (1991-92).

164. 112 S. Ct. 2791 (1992).

these laws is in many jurisdictions unclear.[165] Moreover, since *Roe* (and at an increasing pace since *Webster*[166] and *Casey*), state legislatures have enacted innumerable restrictions on the provision of abortion.[167] These statutes themselves are often the subject of ongoing litigation or are arguably in conflict with the pre-*Roe* statutes.[168] Regardless of the law, enforcement patterns in many states give rise to arguments that existing abortion statutes have been implicitly repealed through lack of use.[169] Finally, there is an enormous volume of proposed abortion legislation currently pending in most state legislatures, as well as before Congress.[170]

The second step in this process is to determine whether there is a physician-only requirement for the performance of abortions. This too can be a frustrating endeavor, since the requirement might be statutorily explicit,[171] inferred from a combination of statutory requirements,[172] a binding judicial interpretation of the statute,[173] or entirely absent. Moreover, in at least two states—Montana and Vermont—nonphysicians regularly perform clinical abortions with no apparent fear of prosecution, but without official authorization either.[174]

The woman's participation in the performance of her own menstrual extraction raises yet another statutory question to which the answer varies widely from state to state: is the woman on whom an abortion is performed exempt from prosecution, specifically included in the scope of the law, or not mentioned at all?[175]

Finally, how has the existing statutory scheme been enforced? While enforcement patterns may be of limited usefulness in arguing the validity of a

165. For a general overview of the issues raised by the uncertain status of pre-*Roe* statutes, see Scott, *supra* note 163.

166. Webster v. Reproductive Health Servs., 492 U.S. 490 (1989).

167. *See supra* note 27.

168. It is not uncommon for a pre-*Roe* abortion ban to coexist in the same statute book with a reporting requirement assuming that abortion is completely legal. *See* discussion of Vermont's statutes *infra* part III.B.

169. On the doctrine of desuetude in the abortion context, see generally Scott, *supra* note 163, at 381-84.

170. *See, e.g.*, Freedom of Choice Act, H.R. 25, 103d Cong., 2d Sess. (1993). According to the Center for Reproductive Law & Policy, an organization that monitors state legislative activity in this area, bills that would have restricted access to abortion were introduced in every state legislature in session in 1992-93. Interview with Janet Crepps, Staff Attorney, Center for Reproductive Law and Policy, in Brooklyn, N.Y. (Sept. 21, 1993).

171. *See, e.g.*, FLA. STAT. ANN. § 390.001(3) (West 1993) ("No termination of a pregnancy shall be performed at any time except by a physician.").

172. *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 32-1401(17) (1992) (defining "practice of medicine"); 36-2152, 36-2301.01 (Supp. 1992) (suggesting that abortion is a medical procedure).

173. *See, e.g.*, Connecticut v. Menillo, 423 U.S. 9 (1975).

174. Olmstead, *supra* note 32, at 307; Complaint, Armstrong v. Esch, No. 93-060-GF-PGH (D. Mont. filed May 17, 1993). Physician's assistants performed abortions in Montana for several years before a threat of prosecution was ever raised. *Id.* at 3, 6, 10-11.

175. This Article leaves aside the question of prosecutions based on solicitation or other accessory liability, since those would be predicated on a preliminary finding that menstrual extraction is illegal.

statute,[176] as a practical matter, in many places they will be the best indicator for advising self-help groups of the risks they run in performing menstrual extractions.

1. Vermont Abortion Law

The combined abortion jurisprudence of Vermont and Florida exhibits almost all the variations alluded to above. Vermont is one of the many states with a pre-*Roe* abortion statute still on the books.[177] In 1972 in *Beecham v. Leahy*,[178] this statute was found invalid under the state constitution and the common law through a peculiar logic that raises some of the central legal issues surrounding menstrual extraction. The plaintiffs were a pregnant woman and her physician who together brought an action seeking an injunction declaring the abortion law invalid. The Vermont Supreme Court held that the physician lacked standing to challenge the law since he had not performed the requested abortion and was under no compulsion to do so. Consequently, the court found that the statute's harm was, as to him, speculative.[179]

The statute specifically exempts the woman seeking an abortion from any penalty.[180] In the absence of an explicit legislative decision to limit a woman's right "to be aborted,"[181] the court found that the woman retained whatever related rights she possessed at the time the Vermont Constitution was adopted. Since there were no common law proscriptions of abortion, at least before "the fetus had 'quickened,' "[182] the woman was found to have retained a residual right to have an abortion performed.

The next step in the court's logic is crucial to the discussion of menstrual extraction: because the statute criminalizes a *physician's* act in performing an abortion, "tragically, unless [the pregnant woman's] life itself is at stake, the law leaves her only to the recourse of attempts at self-induced abortion, uncounselled and unassisted by a doctor, in a situation where medical attention

176. Scott, *supra* note 163, at 381 ("Desuetude [implicit repeal of a statute through disuse] in its purest form has been rejected as a valid legal doctrine in America.").

177. VT. STAT. ANN. tit. 13, § 101 (1991), which provides for the prosecution of abortion providers:

> A person who wilfully administers, advises or causes to be administered anything to a woman pregnant, or supposed by such person to be pregnant, or employs or causes to be employed any means with intent to procure the miscarriage of such woman, or assists or counsels therein, unless the same is necessary to preserve her life, if the woman dies in consequence thereof, shall be imprisoned in the state prison not more than twenty years nor less than five years. If the woman does not die in consequence thereof, such person shall be imprisoned in the state prison not more than ten years nor less than three years. However, the woman whose miscarriage is caused or attempted shall not be liable to the penalties prescribed by this section.

178. 287 A.2d 836 (Vt. 1972).

179. *Id.* at 839.

180. VT. STAT. ANN. tit. 13, § 101 (1991); for the text of the statute, see *supra* note 177.

181. 287 A.2d at 839.

182. *Id.* at 839. "Quickening" referred to the point at which a woman experienced some movement by the fetus, usually in the fifth or sixth month of pregnancy. LUKER, *supra* note 42, at 4.

is imperative."[183] The court found this "hypocrisy" an untenable result and consequently declared the statute invalid as applied to medical practitioners.[184]

The logic by which the Vermont Supreme Court in *Beecham v. Leahy* found the state's abortion statute invalid as applied to physicians may void its potential application to self-helpers as well. The court invalidated the statute because without any compelling justification, it deprived a woman of the only means to safely effectuate her common law right to an abortion. Given that reasoning, it would seem that the abortion statute should be invalid regardless of what kind of *safe* medical assistance the woman chooses. The theory of the opinion is premised on the objectively inaccurate assumption that in order for an abortion to be safe, "medical attention is imperative."[185] If the inaccuracy of that assumption is proven, then the opinion should be understood to mean that a safe procedure is imperative, regardless of whether it is provided by a physician.

It could be objected that one can distinguish the context of abortion practice when *Beecham* was decided in 1972—where it was assumed that there would be no safe abortions unless doctors were allowed to perform them—from the current context—where safe and legal abortions are already available to Vermont women. Arguably, a court today would not face the same Hobson's choice between maintaining a status quo of rampant unsafe illegal abortions or invalidating the prohibition so as to allow safe legal procedures. In retrospect, it seems likely that the Vermont Supreme Court, a year before *Roe*, was trying to put an end to a situation that was causing untold injury and death to women in the state. What the justices perceived as a state of emergency compelled them to twist logic and to inject what is essentially a public interest mandate into their normal practice of statutory construction. Absent a much more severe restriction of abortion availability than currently exists, advocates will be unlikely to persuade the court that a similar emergency still exists such that women's health and safety depends on legalizing menstrual extraction.

If, on the other hand, *Beecham* is read as a simple rational basis review of the abortion prohibition—finding it irrational to allow women a right to abortion without permitting a safe way to effectuate it—then the analysis shifts to an assessment of the rationality of the distinctions made among several kinds of safe procedures. By law, physicians can perform abortions; in practice, physician's assistants perform them;[186] why exclude self-helpers who perform menstrual extraction? This argument would depend of course on the compilation of a safety record for menstrual extraction. Any serious attempt to liti-

183. *Beecham*, 287 A.2d at 839.

184. *Id.* at 840.

185. *Id.* at 839; *see supra* notes 61, 62, 77 and accompanying text (discussing safety of abortions and menstrual extractions performed by self-help groups).

186. See *infra* note 195 and accompanying text.

gate this issue must entail a thorough and impartial study of the safety and effectiveness of menstrual extraction performed by self-help groups, supported by ample testimony and other evidence. To date, this study has not been undertaken.[187]

The issue of menstrual extraction's legality in Vermont is complicated further by three attorney general opinions issued subsequent to *Beecham v. Leahy*,[188] which, when considered together, find some continuing validity in Vermont's abortion prohibition, but only in the following circumstances: where the abortion takes place after "quickening" or is not medically indicated to secure and preserve the physical and mental health of the woman,[189] except to the extent that this reading conflicts with the holding in *Roe*;[190] and where the abortion is performed by "unskilled or untrained persons."[191] Only the last two clauses can claim any support in a judicial opinion; the source for the restriction regarding post-"quickening" abortions and the requirement of medical necessity as a precondition remains unclear.[192]

Legislative activity appears to assume that at least some abortions are legal in the state. The Vermont Board of Health requires reports of fetal deaths resulting from "[a]ll therapeutic or induced abortions, as legally authorized to be performed."[193] Similarly, in the most recent state legislative session, five separate bills that would have restricted the provision of abortion were introduced (although none were passed).[194]

Finally, actual abortion practice in Vermont seems to assume the absence of any restrictions whatsoever. Several abortion providers operate in Vermont, and most importantly, physician's assistants have performed a substantial number of the abortions provided since at least 1982.[195]

In this convoluted context, advocates for menstrual extraction could reasonably argue that, apart from the reporting requirement, there are *no* restrictions on the provision of abortion in Vermont. If there are any restrictions,

187. *See supra* text accompanying note 77.

188. 287 A.2d 836.

189. 1972 Op. Att'y Gen. 431, 432 (No. 743) (Vt.).

190. 1973 Op. Att'y Gen. 241, 241 (No. 68) (Vt.).

191. 1975 Op. Att'y Gen. 1 (No. 48-75) (Vt.) (quoting Beecham v. Leahy, 287 A.2d 836, 839 (Vt. 1972)).

192. One commentator has called the accuracy of the entire legal basis for this attorney general's opinion "questionable." Olmstead, *supra* note 32 at 299-300.

193. VT. STAT. ANN. tit. 18, § 5222(a)(2) (1991) (enacted 1973). Self-helpers who perform pregnant menstrual extractions are in a double bind with regard to this requirement. If menstrual extraction is considered to be abortion, then self-helpers should report all menstrual extractions as an affirmative claim that they are "legally authorized to be performed." On the other hand, if they report them, then self-helpers foreclose their argument that they cannot be prosecuted because menstrual extraction is not abortion.

194. S. 114, 62d Gen. Assem. (Vt. 1993) (requiring parental notice for a minor's abortion); H.R. 363, 62d Gen. Assem. (Vt. 1993) (same); H.R. 364, 62d Gen. Assem. (Vt. 1993) (banning late term abortions); H.R. 412, 62d Gen. Assem. (Vt. 1993) (establishing informed consent standard for abortions); H.R. 424, 62d Gen. Assem. (Vt. 1993) (making doctor who performs abortion on minor without parental consent liable for expenses incurred by complications).

195. Olmstead, *supra* note 32, at 307.

the inference and consequent application of a physician-only requirement seems tenuous at best and subject to a strong vagueness challenge at the very least.[196]

The uncertain status of abortion law in Vermont makes it all but unnecessary to develop the argument that menstrual extraction is not abortion as defined in the state. Nevertheless, it may be instructive for self-helpers in states with similar statutes to examine the possible arguments were Vermont's law fully and clearly in effect. The statute requires that the woman be pregnant or "supposed by [the person performing the abortion] to be pregnant."[197] It further requires that the person "inten[d] to procure the miscarriage of such woman."[198] Finally, the statute exempts the woman herself from any penalty.[199]

Menstrual extraction is arguably outside the statute's purview for several reasons. First, menstrual extraction requires neither actual knowledge nor even supposition that the woman on whom it is performed is pregnant. It is usually performed from four to six weeks since the woman's last period, a time when there would be no conclusive evidence of pregnancy, even if the woman were pregnant.[200] Consequently, it would be all but impossible for the self-helpers who actually perform a menstrual extraction to *know* that the woman was pregnant.

Supposition, however, may present different issues. It cannot be denied that at least some menstrual extractions are performed for the purpose of terminating a possible pregnancy. Accordingly, prosecutors could argue persuasively that the very fact of the menstrual extraction implies a supposition of pregnancy. In such circumstances, self-helpers could make either of two responses. First, they could show that menstrual extractions are performed on group members on a regular basis, regardless of the possibility of pregnancy. In that context, an actual pregnancy termination would be accidental, not intentional. Second, they could try to substantiate a belief about the woman's condition that is inconsistent with pregnancy—that the self-helpers (as well as the woman, of course) believed only that the woman's period had been delayed due to factors other than pregnancy, such as stress. In such circumstances, the self-helpers might in fact have specifically believed that the woman was *not* pregnant.[201]

196. Such a challenge might be stronger than a vagueness challenge against medical practice acts. *See supra* note 160 and accompanying text.

197. VT. STAT. ANN. tit. 13, § 101 (1991).

198. *Id.*

199. *Id.*

200. According to gynecology textbooks, neither a positive urine test nor a positive blood test are *definitive* diagnoses of pregnancy but are only indicators of probable pregnancy. Either positive result could, in rare cases, be caused by a tumor or some other condition that would disrupt a woman's hormonal balance. A definitive diagnosis requires physical evidence of the presence of a fetus through sonogram or a manual pelvic exam. Neil K. Kochenour, *Normal Pregnancy and Prenatal Care, in* DANFORTH'S OBSTETRICS AND GYNECOLOGY 123, 129-32 (James R. Scott & David N. Danforth eds., 6th ed. 1990); DALE R. DUNNIHOO, FUNDAMENTALS OF GYNECOLOGY AND OBSTETRICS 277 (2d ed. 1992).

201. Additionally, regardless of knowledge or supposition about pregnancy, self-helpers

2. Florida Abortion Law

In Florida, the situation is much less complex, but far bleaker for self-help advocates. Florida no longer has any pre-*Roe* statutes on the books but has passed legislation since 1973 that attempts to regulate abortion to the extent permitted by the federal Constitution. Florida's law on the termination of pregnancy includes provisions regulating third trimester abortions,[202] establishing a standard of care for post-viability abortions in order to preserve the life of the fetus,[203] prohibiting fetal experimentation,[204] and most importantly in this context, requiring that only physicians perform abortions.[205] A separate requirement prohibits the performance of abortion outside a hospital, clinic, or physician's office, except in cases of emergency.[206] In addition, Florida has several requirements regulating the licensing of abortion clinics.[207]

The only statutory argument available in a state like Florida—whose statutory scheme is more representative of the "typical" state's abortion restrictions than is Vermont's[208]—is that self-helpers lack the requisite intent to produce an abortion. This already problematic argument[209] is further weakened by the way Florida's statutory scheme is drafted. Abortion is defined as "the termination of human pregnancy *with an intention other than to produce a live birth or to remove a dead fetus.*"[210] Thus, there is no specific intent requirement as to pregnancy termination; rather, the language approaches a strict liability standard. Whenever "abortion" is the operative word in Florida's statutory provisions, as it is in the hospital, clinic, or physician's office requirement,[211] the requisite "intent" is broad enough to encompass almost any intervention that results in the termination of a pregnancy.

The "physician-only" requirement presents an even more difficult chal-

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could argue that they lacked the requisite "intent to procure a miscarriage." This would involve a technical argument regarding the statute's terms. Miscarriage is not defined in either Vermont statutes or Vermont case law, but its common definition is "the premature birth of a fetus, so that it does not live." WEBSTER'S TWENTIETH CENTURY UNABRIDGED DICTIONARY 1148 (2d ed. 1983). However, an embryo does not become a *fetus* by most medical and legal definitions until about seven or eight weeks after fertilization (nine or ten weeks since the last menstrual period). *See, e.g.*, J. WHITRIDGE WILLIAMS, WILLIAM'S OBSTETRICS 140 (Jack A. Pritchard, Paul C. McDonald & Norman F. Gant eds., 17th ed. 1985); BLACK'S LAW DICTIONARY 621 (6th ed. 1990). Consequently, there is little chance that a menstrual extraction would result in an abortion as so defined.

202. FLA. STAT. ANN. § 390.001(2) (West 1992).

203. *Id.* § 390.001(5) (West 1992).

204. *Id.* § 390.001(6) (West 1992).

205. *Id.* § 390.001(3) (West 1992) ("No termination of pregnancy shall be performed at any time except by a physician.").

206. *Id.* § 797.03 (West 1992).

207. *Id.* § 390.012-390.017 (West 1992).

208. *See, e.g.*, ARK. CODE ANN. § 5-61-101 (Michie 1988); DEL. CODE ANN. tit. 24, § 1790 (1987); HAW. REV. STAT. § 453-16 (1985); IDAHO CODE § 608 (1987).

209. *See supra* notes 200-01 and accompanying text.

210. FLA. STAT. ANN. § 390.011(1) (West 1992) (emphasis added).

211. *Id.* § 797.03(1) (West 1992) ("It is unlawful for any person to perform or assist in performing an *abortion* on a person, except in an emergency care situation, other than in a validly licensed hospital or abortion clinic or in a physician's office.") (emphasis added).

lenge. Rather than prohibiting "abortion," it instead proscribes the "*termination of pregnancy* . . . at any time except by a physician,"[212] thereby establishing a strict liability offense. Consequently, self-helpers in Florida cannot find recourse in the argument that they lack the requisite knowledge of the specific contents of the uterus they are extracting. As long as there is evidence that a pregnancy termination occurred, it appears that those who performed the menstrual extraction would be liable under this statute.[213]

These statutory arguments for the legality of menstrual extraction, under either the medical practice acts or the abortion restrictions, may strike nonlawyers as legalistic formulations—the kind of loophole-searching more often associated with tax lawyers than health lawyers. For advocates of menstrual extraction, such strategies, even if successful, might prove frustrating since they do not vindicate any basic right to control one's health care or, more broadly, to do with one's body as one chooses. In fact, it can be argued that to refrain from challenging the statutory framework as a whole is to support that framework. Carving out exceptions to medical practice acts or physician-only abortion requirements does nothing to challenge the expert-driven health care delivery structure that the core philosophy of self-help gynecological care seeks to undermine. For these reasons, menstrual extraction advocates may be more interested in raising the types of constitutional arguments discussed below, which more directly question the legitimacy of the physician monopoly.

IV
STATE CONSTITUTIONAL ARGUMENTS

In this Article, I do not discuss any arguments under the federal Constitution. The United States Supreme Court has already held in *Connecticut v. Menillo*[214] that there is no constitutional infirmity to physician-only abortion restrictions. That case is still good law, and arguments for overruling it do not seem likely to succeed in the near future, especially considering the current composition of the federal bench.[215] There are perhaps other arguments, not raised in *Menillo*, that might still be viable, such as challenging medical practice acts on vagueness grounds, or mounting an equal protection challenge against physician-only abortion requirements. Due in large part to the current federal judiciary's hostility to abortion, I have not pursued those possibilities,

212. *Id.* § 390.001(3) (West 1992) (emphasis added).

213. Of course, since the evidence of the extracted contents of the woman's uterus is entirely within the control of the self-helpers, as a practical matter, this may not be a concern. Even if a member of the group testified honestly as to what she had seen extracted, it can be extremely difficult at this early stage to distinguish between the blood extracted and anything else that may have been withdrawn from the uterus.

214. 423 U.S. 9, 11 (1975) (per curiam).

215. This situation does not appear likely to change any time in the near future, given President Clinton's revelation that, despite earlier promises, he may well appoint judges to the federal judiciary who believe that *Roe* was wrongly decided. Neil A. Lewis, *Clinton is Considering Judgeships for Opponents of Abortion Rights*, N.Y. TIMES, Sept. 18, 1993, at A1.

and instead examine analogous arguments under state constitutions.[216]

Of course, state constitutional arguments are also attractive for reasons having little or nothing to do with the federal judiciary. State constitutions provide, in most cases, legal and theoretical blank slates: in many states, on many individual rights issues, state charters have spawned only a sparse jurisprudence, if any at all. Moreover, an increasing number of state supreme courts have affirmatively declared that their constitutions are more protective of individual rights than is the federal constitution.[217] Some state constitutions employ very different wording from that of the federal constitution in their guarantees of individual rights,[218] and others explicitly protect some rights not guaranteed by our national charter.[219] Finally, each state constitution has its unique history, independent both of the federal government and of its sibling states. The interpretive possibilities are virtually limitless.[220]

A. Privacy Arguments

1. Florida

Florida is one of five states to provide an explicit constitutional right to privacy.[221] The protection was added to the state's charter in 1980 and consequently has yet to generate a large body of judicial interpretation. However, the limited construction it has received in the Florida courts has carved out a very broad realm of privacy protected from government regulation. While the enunciated state standard for measuring potential violations of an individual's right to privacy reads remarkably like the federal constitutional standard,[222] in fact, the Florida Supreme Court has reached much further than its federal counterpart. The Florida Supreme Court has explicitly held that "the [state]

216. *But see supra* notes 159-60 and accompanying text for a brief discussion of vagueness and medical practice acts.

217. *See, e.g.*, Commonwealth v. Wasson, 842 S.W.2d 487 (Ky. 1992) (privacy); People v. Harris, 570 N.E.2d 1051 (N.Y. 1991) (search and seizure); Davis v. Davis, 842 S.W.2d 588 (Tenn. 1992) (privacy).

218. *Compare* VT. CONST. ch. I, art. 7 ("common benefit") *with* U.S. CONST. amend. XIV, § 1 ("equal protection").

219. *See, e.g.*, FLA. CONST. art. I, § 23 (right to privacy).

220. There is a wealth of literature on state constitutional jurisprudence. For an introduction to the area, see William J. Brennan, Jr., *The Bill of Rights and the States: The Revival of State Constitutions as Guardians of Individual Rights*, 61 N.Y.U. L. REV. 535 (1986); William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489 (1977).

221. FLA. CONST. art. I, § 23 ("Every natural person has the right to be let alone and free from governmental intrusion into his private life except as otherwise provided herein. This section shall not be construed to limit the public's right of access to public records and meetings as provided by law."); ALASKA CONST. art. I, § 22; CAL. CONST. art. I, § 1; HAW. CONST. art. I, § 6; MONT. CONST. art. II, § 10.

222. The right is "fundamental," and in order for a governmental restriction on the right to privacy to be upheld as constitutional, the state must show that it serves a "compelling state interest" through the "least intrusive means." Winfield v. Division of Pari-Mutuel Wagering, Dep't of Business Regulation, 477 So. 2d 544, 547 (Fla. 1985).

right [to privacy] is much broader in scope"[223] and "embraces more privacy interests, and extends more protection to the individual in those interests, than does the federal Constitution."[224]

More importantly for the current discussion, the Florida Supreme Court, in *In re T.W.*, explicitly held that the right to abortion is a protected privacy interest.[225] In contrast to the opinion in *Roe*, the court made no mention of the role physicians should play in that decision. However, other opinions of both the Florida Supreme Court and lower state courts[226] have construed the state's right to privacy as protecting a robust right of patient self-determination in medical treatment decisions. In *In re Guardianship of Browning*,[227] a case concerning the right to refuse a potentially life-saving blood transfusion, the Florida Supreme Court articulated its strongest statement to date[228] on medical autonomy: "[A] competent person has the constitutional right to choose or refuse medical treatment, and that right extends to all relevant decisions concerning one's health."[229] In a footnote, the court went still further, finding "no reason to qualify that right on the basis of the denomination of a medical procedure as major or minor, ordinary or extraordinary, life-prolonging, life-maintaining, life-sustaining, or otherwise."[230] This finding is consistent with an entire line of cases involving the right to refuse medical treatment[231] and seems to indicate a reluctance on the part of the Florida Supreme Court to allow any restrictions whatsoever on patient autonomy.[232]

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223. *Id.* at 548.

224. *In re* T.W., 551 So. 2d 1186, 1192 (Fla. 1989).

225. *Id.* at 1193 ("The Florida Constitution embodies the principle that '[f]ew decisions are more personal and intimate, more properly private, or more basic to individual dignity and autonomy, than a woman's decision . . . whether to end her pregnancy. A woman's right to make that choice freely is fundamental.' " (alteration in original) (quoting Thornburgh v. Am. College of Obstetricians and Gynecologists, 476 U.S. 747, 772 (1986)).

226. District court opinions are binding on *all* Florida courts unless overruled by the state supreme court. Weiman v. McHaffie, 470 So. 2d 682, 684 (Fla. 1985); Stanfill v. State, 384 So. 2d 141, 143 (Fla. 1980).

227. 568 So. 2d 4 (Fla. 1990).

228. In a recent decision the Florida Supreme Court reaffirmed *Browning* and reiterated its support for a strong right to medical treatment free of government interference. Matter of Dubreuil, 629 So. 2d 819 (Fla. 1993).

229. *Browning*, 568 So. 2d at 11.

230. *Id.* at 11 n.6.

231. *See* Public Health Trust v. Wons, 541 So. 2d 96, 98 (Fla. 1989) (upholding right of adult woman to refuse treatment); John F. Kennedy Memorial Hosp. v. Bludworth, 452 So. 2d 921, 926 (Fla. 1984) (upholding right of guardian of incompetent terminally ill adult to refuse further medical treatment for incompetent); Satz v. Perlmutter, 379 So. 2d 359, 360 (Fla. 1980) (upholding right of competent terminally ill adult to refuse medical treatment); Corbett v. D'Alessandro, 487 So. 2d 368, 371 (Fla. Dist. Ct. App.) (upholding right of husband to withhold forced feeding of wife in permanent vegetative state), *review denied*, 492 So. 2d 1331 (Fla. 1986); St. Mary's Hosp. v. Ramsey, 465 So. 2d 666, 668 (Fla. Dist. Ct. App. 1985) (upholding right of competent adult to refuse potentially life saving transfusion).

232. *See* David C. Hawkins, *Florida Constitutional Law: A Ten-Year Retrospective on the State Bill of Rights*, 14 NOVA L. REV. 693, 854 (1990) (noting that "no decision involving an infringement of a person's right of self-determination found the state's asserted interests sufficient to satisfy [the compelling interest] burden"); David C. Hawkins, *Florida Constitutional*

The strong language used by the court seems to invite a challenge to both the medical practice acts and the physician-only abortion requirement, as they would be applied to self-helpers practicing menstrual extraction. If a competent person has the right to "make all relevant decisions concerning one's health,"[233] then the state should not be able to circumscribe the range of available choices, especially where, as with menstrual extraction, concerns about safety are apparently unjustified. This argument, as with all legal arguments in support of menstrual extraction, depends on the development of a reliable body of evidence attesting to the safety of menstrual extraction.[234]

2. Vermont

Florida presents an ideal scenario for arguing that physician-only requirements in either abortion or medical practice statutes violate an individual's right to privacy. In most states, however, the privacy right under the state constitution is less clear. Vermont, for example, has no explicit privacy right. Moreover, the Vermont Supreme Court has never found a right to privacy either in the state constitution's procedural due process guarantee[235] or in its substantive due process provision.[236] In fact, the Vermont Supreme Court has squarely held that the procedural due process right "does not rise to the level of a fundamental privacy right" and has refused to infer such a privacy right from any other provision of the state constitution.[237]

This is not to say that arguments for a right to privacy in Vermont cannot be made. For example, a broader right to privacy might be inferred from Vermont's search and seizure provision.[238] Similarly, chapter 1, article 1 of the Vermont Constitution states the broad principle that "all men are born equally free and independent, and have certain natural, inherent and unalienable rights, amongst which are the enjoying and defending of life and liberty, acquiring, possessing and protecting property, and pursuing and obtaining happiness and safety."[239] The case in which the Vermont Supreme Court in-

Law: 1990 Survey of the State Bill of Rights, 15 NOVA L. REV. 1049, 1128 (1991) (arguing that "the court has accepted major responsibility for protecting personal rights from governmental excess"); *see also* David C. Hawkins, *Florida Constitutional Law: 1991 Survey of the State Bill of Rights*, 16 NOVA L. REV. 167, 224 (1991).

233. *Browning*, 568 So. 2d at 11.

234. *See supra* text accompanying notes 77, 187.

235. VT. CONST. ch. I, art. 4 ("Every person within this state ought to find a certain remedy, by having recourse to the laws, for all injuries or wrongs which he may receive in his person, property or character; he ought to obtain right and justice, freely, and without being obliged to purchase it; completely and without any denial; promptly and without delay; conformably to the laws.").

236. VT. CONST. ch. I, art. 10 ("[N]or can any person be justly deprived of his liberty, except by the laws of the land, or the judgment of his peers.").

237. Levinsky v. Diamond, 559 A.2d 1073, 1086 (Vt. 1989), *overruled on other grounds by* Muzzy v. State, 583 A.2d 82 (Vt. 1991); *see also* McHugh v. University of Vt., 758 F. Supp. 945, 953 (D. Vt. 1991), *aff'd*, 966 F.2d 67 (2d Cir. 1992).

238. VT. CONST. ch. I, art. 11.

239. VT. CONST. ch. I, art. 1.

validated its abortion ban, *Beecham v. Leahy*,[240] arguably stands for the proposition that one of those "natural, inherent and unalienable rights" is a general right of "personal integrity,"[241] not limited to the right to abortion. In *Beecham*, the court assumed that citizens retain residual rights that predate the Vermont Constitution to the extent that those rights have not been circumscribed by subsequent legislation.[242] Although the source of those rights is unclear, the court's citation to the statutory provision that incorporates prior common law into the state's jurisprudence[243] implies that such rights stem from the common law. Whether this common law right rises to the level of a constitutionally protected interest is an open question. If not, the legislature has clearly limited the common law right to personal integrity insofar as it includes the right to choose between medical interventions provided by physicians and nonphysicians, since the legislature has chosen to license only the former.

There is some indication, however, that the state's highest court might be solicitous of arguments inferring a constitutional right to privacy. In 1985, the Vermont Supreme Court specifically called for increased attention to its state constitution and invited development of a constitutional jurisprudence independent of federal precedent.[244] The court majestically intoned that "[t]his generation of Vermont lawyers has an unparalleled opportunity to aid in the formulation of a state constitutional jurisprudence that will protect the rights and liberties of our people, however the philosophy of the United States Supreme Court may ebb and flow."[245]

While the Vermont Supreme Court has perhaps been more explicit in encouraging the development of its constitutional jurisprudence, the attitude in other states may be similarly welcoming. The strategy for menstrual extraction advocates in such circumstances would involve mustering sufficient evidence from the state constitution's unique text, history, interpretive practice, and political theory to persuade the state supreme court that their own charter is significantly different from the federal constitution and consequently that the court should not slavishly rely on federal jurisprudence. Because such arguments would of necessity be markedly different in each state and would require intense and principled scholarship, I have not attempted to produce a detailed outline of any "model." Rather, regional advocates will be better versed in the traditions regarding privacy and the "right to be let alone" in their home states; after all, the very premise of state constitutional jurispru-

240. 287 A.2d 836 (Vt. 1972).

241. *Id.* at 839.

242. *Id.* ("The legislature . . . has not denied her the right to be aborted. As to her, her personal rights have been left to her, and there is no legislative declaration saying that her own concerns for her personal integrity are in an any way criminal or proscribed.").

243. VT. STAT. ANN. tit. 1, § 271 (1985).

244. State v. Jewett, 500 A.2d 233, 235 (discussing VT. CONST. ch. I, art. 2).

245. *Id.*

dence is that there are no generalizable arguments that apply in all contexts.[246]

B. Equal Protection Arguments

An equal protection argument challenging the application of medical practice acts or physician-only abortion requirements to menstrual extraction would, admittedly, be a difficult one to make. Most states have not developed their equal protection clauses very extensively and have relied instead on federal equal protection analysis, requiring either a suspect classification or an infringement of a fundamental right to invoke strict scrutiny of a statute.[247]

Unfortunately, given this analytic framework, the prospects of a successful equal protection challenge seem dim. There appears to be no suspect classification, except perhaps between those who perform menstrual extractions and those who perform clinical abortions. To render that classification "suspect," however, advocates would have to prove intentional discrimination against those performing menstrual extractions, a doubtful proposition.[248] A fundamental rights analysis would largely depend on the status of the right to privacy, since the only right involved is that of personal autonomy in medical decision making.

In the absence of either of the two traditional triggers for heightened scrutiny, advocates of menstrual extraction would be forced to argue under a rational basis review.[249] But this does not necessarily represent the kiss of

246. *See generally* Brennan, *supra* note 220, *passim*.

247. *See, e.g.*, DeAyala v. Florida Farm Bureau Casualty Ins., 543 So. 2d 204, 206 (Fla. 1989) ("In evaluating claims of statutory discrimination, a statute will be regarded as inherently 'suspect' and subject to 'heightened' judicial scrutiny if it impinges too greatly on fundamental constitutional rights flowing either from the federal or Florida Constitution, or if it primarily burdens certain groups that have been the traditional targets of irrational, unfair and unlawful discrimination."); Hodgeman v. Jard Co., 599 A.2d 1371, 1373 (Vt. 1991) ("Absent a suspect classification or violation of a fundamental right, a legislative distinction is valid if it rationally furthers a legitimate public purpose.") (footnote omitted).

248. In *Reams v. State*, 279 So. 2d 839 (Fla. 1973), where a nutritionist charged invidious discrimination, the Florida Supreme Court explicitly set out what would be required for a successful equal protection challenge to the medical practice statute:

> Reams would be required to show, primarily through expert testimony, first, that there is a generally accepted definition of the term nutritionist; second, that Reams falls within such category; third, that 'nutrition' or 'nutritionism' is a recognized medical or professional specialty in Florida; and last, that in spite of the recognition of such specialty, the state, through the Medical Practice Act, seeks to invidiously discriminate against it.

Id. at 842-43. Menstrual extraction advocates would be hard pressed to meet such a stringent test.

249. Professor Sylvia Law has proposed a third standard of review for equal protection cases involving reproductive biology that takes into account real gender differences without perpetuating gender stereotypes. She proposes that such legislation be scrutinized "to ensure that (1) the law has no significant impact in perpetuating either the oppression of women or culturally imposed sex-role constraints on individual freedom, or (2) if the law has this impact, it is justified as the best means of serving a compelling state purpose." Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955, 1008-09 (1984). In the menstrual extraction context, one could argue that the application of medical practice acts or physician-only abortion requirements to a traditionally woman-controlled procedure invokes exactly the kind

death constitutional litigators have come to fear. At least one state—Vermont—has adopted the view that rational basis review performed by *state* courts should involve more rigorous scrutiny than that of their federal counterparts. In *State v. Ludlow Supermarkets*,[250] the Vermont Supreme Court noted that courts stand in a different position vis-à-vis state legislation and consequently are not bound to the same level of deference required of federal courts due to federalism concerns.[251] Moreover, as the court noted, the state judiciary is more apt to have access to specific legislative history and other resources that make it more competent than federal courts to apply a searching rational basis evaluation to state laws.[252]

In addition, in several states, the text and history of the state equal protection provision differs substantially from its federal counterpart. For example, in Vermont, the text of chapter I, article 7 dates from 1777, a full century before adoption of the Fourteenth Amendment, and reads quite differently than the federal clause: "That government is, or ought to be, instituted for the common benefit, protection and security of the people, nation, or community, and not for the particular emolument or advantage of any single man, family, or set of men, who are a part only of that community[.]"[253] Such distinctive wording has been and should be allowed to spawn its own interpretive practice, independent of federal equal protection jurisprudence.[254] But even where the wording is similar, as in Florida where the equivalent provision proclaims that "[a]ll natural persons are equal before the law. . . ,"[255] courts should be encouraged to examine more closely any legislation arguably infringing on the rights of a politically powerless minority—here, self-helpers—to determine its rationality.

More generally, an equal protection argument for menstrual extraction could assert that the legislative distinction drawn between abortion procedures performed by physicians and those performed by others is an irrational classification depriving women of their choice of abortion method. It is irrational because it is both overinclusive and underinclusive: not all procedures performed by unlicensed practitioners (i.e., self-helpers) are unsafe, and not all procedures performed by licensed physicians are safe. To support the first

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of paternalistic legislation that reinforces cultural stereotypes about women's abilities to protect themselves. The argument clearly has some appeal, but in the nearly ten years since this standard was proposed, no court has adopted it in any form, although Supreme Court Justice Ginsburg, prior to joining the Court, hinted that she might favor a similar analysis. Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1204 (1992). Even if Professor Law's standard were adopted, it could still be argued that the medical practice acts, while paternalistic, represent an equal opportunity paternalism, affecting men as well as women.

250. 448 A.2d 791 (Vt. 1982).

251. *Id.* at 795.

252. *Id.*

253. VT. CONST. ch. I, art. 7.

254. *See* Hodgeman v. Jard Co., 599 A.2d 1371, 1373 (Vt. 1991) ("the Vermont Constitution is freestanding and may require this Court to examine more closely distinctions drawn by state government than would the Fourteenth Amendment.").

255. FLA. CONST. art. I, § 2.

assertion, it is once again crucial to develop a credible safety record for menstrual extraction. To support the second assertion, it would be helpful to assemble evidence of the inefficiency of medical practice acts in regulating the medical profession generally[256] and of the number of unsafe abortions preformed by licensed physicians.[257]

It would also be important to attack the "rationality" of physician-only requirements on another front: As noted earlier, there is a decreasing number of general practitioners and of physicians trained to perform abortions.[258] The asserted need for state support of a professional monopoly—the original rationale for medical practice acts—is seriously undermined in the presence of a shortage rather than a glut of physicians. Moreover, the fewer abortion providers there are, the less accessible abortion becomes, rendering the "right" to an abortion little more than a hollow promise.[259]

The success of these arguments will turn on whether the state has accepted the challenge to develop its own equal protection jurisprudence, independent of the federal government, as the Vermont Supreme Court claims to have done, or whether it has fairly mechanically applied federal standards, rarely distinguishing under which constitution it is measuring a given piece of legislation, as in Florida.

Unfortunately, even Vermont's high-minded claims to a robust rational basis review have yet to yield the promised results of invalidating irrational legislation. While the Vermont Supreme Court did strike down the Sunday closing laws at issue in *Ludlow Supermarkets*,[260] most other legislation has been carefully reviewed and then upheld.[261] In Florida, almost all legislation

256. *See, e.g.*, Charles H. Baron, *Licensure of Health Care Professionals: The Consumer's Case for Abolition*, 9 AM. J.L. & MED. 335 (1984).

257. For example, the notorious "Butcher of Avenue A," a New York City physician, fully licensed to practice in the state, botched several attempted abortions and injured many women. Russell Ben-Ali, *Abortion Doc Sentenced: 'Butcher of Avenue A' Gets up to 29 Years*, N.Y. NEWSDAY, June 15, 1993, at 3. This is a delicate argument politically, since anti-abortion activists often bolster their arguments with exaggerated claims about the purported dangers of abortion. Indeed, a group called Life Dynamics has produced a manual on "abortion malpractice" to encourage women to file such suits. The manual relies in large part on a flexible standard of "informed consent" that would place an unprecedented burden on physicians to warn women of even potential minor psychological consequences of an abortion, such as occasional depression. DAVID C. REARDON, ABORTION MALPRACTICE 39-41 (1993) (on file with the *New York University Review of Law and Social Change*). I strongly believe, however, that it does the pro-choice movement no credit—and it certainly does not further the interests of women generally—to ignore or gloss over the very real problem of bad or unqualified providers.

258. *See supra* notes 4, 22.

259. This is similar to the logic used by the Vermont Supreme Court to invalidate its abortion ban. *See supra* notes 177-87 and accompanying text.

260. State v. Ludlow Supermarkets, 448 A.2d 791, 796 (Vt. 1982).

261. *See, e.g.*, Riddel v. Department of Employment Sec., 436 A.2d 1086, 1089 (Vt. 1981) (holding statute denying unemployment benefits to both teacher's aides and teachers not violative of equal protection); Trivento v. Commissioner of Corrections, 380 A.2d 69, 73 (Vt. 1977) (finding no violation of equal protection in distinction between individuals in custody of Commissioner of Mental Health and those in custody of Commissioner of Corrections for purposes of good behavior reductions in sentences).

reviewed under rational basis has been upheld.[262] In only one case has the Florida Supreme Court clearly struck down legislation under rational basis analysis based solely on state equal protection grounds.[263] If equal protection arguments are to succeed, menstrual extraction advocates must insist that state courts keep their promises to grant an independent interpretive practice to their state constitutions. This is not necessarily an unrealistic expectation: sometimes the most unlikely legal arguments—for example, a state equal protection challenge to the ban on same-sex marriages[264]—actually meet with some success.

CONCLUSION

The types of arguments in support of the legality of menstrual extraction outlined in this Article are reducible to two basic strategies: on the one hand, leave the statutory abortion and medical practice schemes in place, but carve out a limited exception for menstrual extraction as practiced by self-help groups; on the other hand, challenge the validity of the laws outright, on fairness and privacy grounds. These strategies of course encompass very different political stances. The statutory tack is clearly the more conservative, "lawyerly" approach—it may be more likely to result in an acquittal in an individual case, but it will do nothing to further, and may even frustrate, the critique of the medical system embodied in the practice of menstrual extraction.

This is not to say that there will not be situations in which a practical outcome may take precedence over a political statement (and in any case, it would be foolish not to advance as many potential arguments as possible). Nonetheless, it seems naïve to imagine that a legal defense of menstrual extraction would ever be apolitical. Medical practice acts and abortion restrictions are inherently political regulatory schemes;[265] consequently, an analysis of the legal merits and the likelihood of success of a given type of challenge is inextricably tied to the relevant political climate. It is therefore virtually impossible to determine in the abstract which legal arguments might fare better than others. Menstrual extraction advocates and their lawyers will have to assess the merits of their case within the context of their particular situation.

It is important to note, however, that in constructing a defense of menstrual extraction, the deployment of legalistic statutory arguments would bespeak a particular irony. These are exactly the types of arguments to which trained lawyers bring a special expertise not shared by laypersons. In the con-

262. *See, e.g., In re* Estate of Gainer, 466 So. 2d 1055, 1059 (Fla. 1985) (holding statute's conclusive presumption that joint account vests in survivor not violative of equal protection); Rowe v. Pinellas Sports Auth., 461 So. 2d 72, 78 (Fla. 1984) (stating tourist development tax does not violate equal protection even though it does not apply to cooperatives).

263. Vildbill v. Johnson, 492 So. 2d 1047, 1050 (Fla. 1986) (striking down classification in wrongful death statute based on survivorship).

264. Baehr v. Lewin, 852 P.2d 44 (Haw. 1993).

265. *See generally supra* part II.

text of a critique of expert-driven and expert-controlled professions, a lawyer who highlights formalistic arguments may want to reflect on whether she has a response to the inevitable charges of hypocrisy, or at least inconsistency, that will surely be leveled against her.[266]

The research that led to this Article was instigated by my own work as a women's health activist and my experiences with self-help gynecological care. When speaking about menstrual extraction, both formally and informally, I have been repeatedly asked about its legal status. In addition, my friends involved in self-help groups live in an almost paranoid fear that their work will be "found out" and that they will be prosecuted. This Article attempts to answer the questions and quell the fears. Some may be disappointed that the answer, in typical lawyerly fashion, amounts to an extended version of "it all depends."

I would like to recommend that they not be disappointed. Arguments about legality assume the limited context of litigation and the constraints imposed by the trial process, real or supposed. But menstrual extraction and self-help advocates need not take such a defensive posture, waiting for the prosecutors to come to them. Public education about self-help gynecological care and home health care generally will provide the best arguments for their acceptance and ultimate legality.

At a time when health care reform is the buzz that fills the air, self-help advocates should add a voice that is seldom heard above the din of managed competition, cost containment, and the rest of the financial access jargon. For any health care reform to work, we must change how we see ourselves in relation to our own health maintenance and care. We as a society still have much to learn about empowerment and autonomy from the ongoing lessons of the women's health movement in general and the self-help advocates in particular.

266. Clearly, *any* legal defense of menstrual extraction, including the constitutional arguments, would likely require a trained lawyer, thus implicating the parties in the "expert-driven" system, rather than confronting it. The distinction here is one of degree, not of kind.