

“BEYOND RATIONAL BELIEF”:
EVALUATING HEALTH-JUSTIFIED ABORTION
RESTRICTIONS AFTER *WHOLE WOMAN’S HEALTH*

CATHREN COHEN[∞]

ABSTRACT

In *Planned Parenthood of Se. Penn. v. Casey*, the Supreme Court reaffirmed the constitutional right to abortion established in *Roe v. Wade*, but changed the standard by which restrictions on the right were evaluated. In doing so, the Court authorized states to regulate abortion in order to protect the health and safety of women seeking abortions. In response, many states passed abortion laws that were allegedly aimed at protecting women’s health. However, medical evidence shows that many of these laws do not improve health outcomes for women, and in some cases harm women’s health. In 2016, the Supreme Court’s decision in *Whole Woman’s Health v. Hellerstedt* clarified that “health-justified” regulations on abortion must be supported by evidence showing that the law actually promotes improved health outcomes. Several common forms of abortion restrictions currently in effect fail to meet this standard, such as certain informed consent laws, restrictions on medication abortion, and laws limiting the performance of abortion to physicians only. This article analyzes the medical evidence (or lack thereof) behind such regulations, and argues that such restrictions fail to meet the evidence-based standard of *Whole Woman’s Health*.

I. INTRODUCTION 174

II. LESSER SCRUTINY AND BLENDED JUSTIFICATIONS: THE NEED TO CLARIFY
THE STANDARD 176

 A. From *Roe*’s “Fundamental Right” to *Casey*’s “Undue Burden”
 Standard 176

 B. *Gonzales v. Carhart* Further Confuses the Standard 180

III. *WHOLE WOMAN’S HEALTH*: CLARIFICATION OF THE STANDARD AND
STRATEGY FOR ADVOCATES 185

 A. Disagreement over the Standard in the Lower Courts 186

 B. The Supreme Court Provides Clarification 188

 C. The Practical Importance of *Whole Woman’s Health*’s Evidence-
 Based Standard 190

[∞] Cathren Cohen, Law Fellow, Lambda Legal. J.D., New York University School of Law, 2017; B.A., University of California, Los Angeles, 2014. I am very grateful for the guidance of Professor Sylvia Law, who oversaw and assisted with the first versions of this article. Thank you to all of the editors at the *N.Y.U. Review of Law & Social Change*, especially Elizabeth Harrington, Heather Stoloff, Arletta Bussiere, and Angela Galdamez, for your immense help in the development of this article. All opinions and errors are my own.

IV. INFORMED CONSENT: CHALLENGING THE PROVISION OF INCORRECT OR MISLEADING INFORMATION TO ABORTION PATIENTS.....	196
A. Introduction to the Doctrine of Informed Consent	196
B. Distortion of Informed Consent in the Abortion Context.....	197
C. After <i>Whole Woman’s Health</i> : Application to Specific Informed Consent Provisions	201
1. Mental-Health-Justified Informed Consent Laws.....	201
2. Physical-Health-Justified Informed Consent Laws	203
3. Factually Dubious Claims about Abortion in Informed Consent.....	204
V. MEDICATION ABORTION: CHALLENGING ABORTION EXCEPTIONALISM IN THE REGULATION OF ABORTION MEDICATION.....	205
A. Introduction to Medication Abortion.....	205
B. Applying the Evidence-Based Standard to Medication Abortion Restrictions	209
1. Medication Abortion without Physicians Physically Present....	209
2. Laws Requiring Adherence to Outdated FDA Protocols.....	212
VI. PHYSICIAN-ONLY REQUIREMENTS: EMPHASIZING THE SAFETY OF NON-PHYSICIAN ABORTION PROVIDERS	214
A. Applying the Evidence-Based Standard to Physician-Only Requirements	214
B. Addressing <i>Mazurek v. Armstrong</i>	218
VII. CONCLUSION	220

I.

INTRODUCTION

Texas argues that H. B. 2’s restrictions are constitutional because they protect the health of women who experience complications from abortions. In truth, ‘complications from an abortion are both rare and rarely dangerous.’ Many medical procedures, including childbirth, are far more dangerous to patients, yet are not subject to ambulatory-surgical-center or hospital admitting-privileges requirements. Given those realities, it is beyond rational belief that H. B. 2 could genuinely protect the health of women, and certain that the law ‘would simply make it more difficult for them to obtain abortions.’¹

The right to obtain an abortion has been controversial ever since the Supreme

1. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2320–21 (2016) (Ginsburg, J., concurring) (quoting *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 912, 910 (7th Cir. 2015)) (internal citations omitted).

Court declared its constitutional protection in *Roe v. Wade*.² In recent years, this controversy has gained new life, as the number of state-enacted restrictions on abortion have ballooned.³ Such laws were made possible in part by the Court’s post-*Roe* decision, *Planned Parenthood of Southeastern Pennsylvania v. Casey*, which reaffirmed the abortion right, but changed the standard by which restrictions on the right were evaluated.⁴ Moreover, the Court reaffirmed the State’s power to impose restrictions on abortion to protect the health and safety of women seeking abortions.⁵ In the years since *Casey*, many states have directed specific restrictions at abortion clinics and medical facilities, known as “Targeted Regulation of Abortion Providers” or “TRAP” laws. TRAP laws “single out abortion for onerous forms of regulation not applied to procedures of equivalent or greater medical risk.”⁶

Under *Casey*, federal courts disagreed on the proper way to evaluate TRAP laws, which led to confusion over the proper standard of review. Despite the Supreme Court’s recognition that courts “retain[] an independent constitutional duty to review factual findings where constitutional rights are at stake,”⁷ some state and federal courts have declined to inquire into the factual basis behind TRAP laws, which are purportedly justified by an interest in protecting women’s health.⁸ The willingness of courts to defer to states’ purported reasoning for passing TRAP laws allowed a record number of abortion restrictions to be passed in recent years.⁹

In its 2016 decision *Whole Woman’s Health v. Hellerstedt*, the Supreme Court clarified that health-justified regulations on abortion must be supported by evidence that the laws actually promote women’s health.¹⁰ The Court’s opinion

2. 410 U.S. 113, 154 (1973) (holding that under the Fourteenth Amendment, the right of personal privacy extends to abortion decisions).

3. See *Last Five Years Account for More than One-Quarter of All Abortion Restrictions Enacted Since Roe*, GUTTMACHER INST. (Jan. 13, 2016), <https://www.guttmacher.org/article/2016/01/last-five-years-account-more-one-quarter-all-abortion-restrictions-enacted-roe> [<https://perma.cc/GKA7-YKDG>] (describing the large increase in state-enacted abortion restrictions since 2010).

4. 505 U.S. 833 (1992) (rejecting *Roe*’s trimester framework and applying an “undue burden” standard through which to evaluate abortion restrictions).

5. *Id.* at 878. While not all persons who seek or obtain abortions identify as women, I have chosen to use the words “woman” and “women” throughout this article in order to remain consistent with the vocabulary typically used by the courts.

6. Linda Greenhouse & Reva B. Siegel, *The Difference a Whole Woman Makes: Protection for the Abortion Right After Whole Woman’s Health*, 126 YALE L.J. F. 149, 151 (2016) [hereinafter Greenhouse & Siegel, *The Difference a Whole Woman Makes*].

7. *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007).

8. See *infra* Section II.B, for a description of how courts have not evaluated the factual basis behind laws burdening abortion, particularly after *Gonzales*.

9. Since *Roe* was decided in 1973 through 2016, states have enacted 1,074 restrictions on abortion. Of these, 288 (or twenty-seven percent) were enacted since 2010. See GUTTMACHER INST., *supra* note 3.

10. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016).

made clear that lower courts must evaluate the factual bases for health-justified laws, and that such restrictions are subject to an evidence-based standard of review.¹¹ Although *Whole Woman's Health* struck down admitting-privileges and ambulatory-surgical-center requirements, several categories of TRAP laws remain in effect across the country. These laws are not based on empirical research or medical fact, and thus must fail the scrutiny required by the new evidence-based standard of review under *Whole Woman's Health*.

Part II of this article describes how the standard of review for health-justified abortion regulations has become unclear since *Casey* was decided. As a result of the ambiguity in the law, many states enacted regulations purporting to protect women's health, but which were actually motivated by moral disapproval of abortion. Part II also discusses how the Supreme Court's lack of clarity on the standard of review, particularly in *Gonzales v. Carhart*, led to a division among the courts on whether or not to evaluate the factual basis for health-justified laws. Part III describes how *Whole Woman's Health* clarified the applicable standard by stating that health-justified laws must be supported by medical evidence. Part III also explores the importance of this clarification as a tool for legal advocates to challenge abortion regulations that do not actually improve women's health.

Parts IV through VI describe three categories of abortion regulations that this article argues would not survive a constitutional challenge under *Whole Woman's Health's* evidence-based standard: Part IV discusses informed consent provisions, Part V discusses restrictions on medication abortion, and Part VI discusses requirements that only physicians provide abortion care. Laws in these categories are purportedly justified by states' interest in protecting women's health, but such claims are not based on empirical evidence. In fact, these laws can often lead to adverse health outcomes for women seeking abortions.

II.

LESSER SCRUTINY AND BLENDED JUSTIFICATIONS: THE NEED TO CLARIFY THE STANDARD

A. From Roe's "Fundamental Right" to Casey's "Undue Burden" Standard

The *Roe v. Wade* decision clearly stated that the right to access abortion was included in the "fundamental right" to privacy¹² and that it therefore was subject to strict scrutiny: "[w]here certain 'fundamental rights' are involved, the Court has

11. *Id.*

12. *Roe v. Wade*, 410 U.S. 113, 152–53 (1973) ("In a line of decisions . . . the Court has recognized that a right of personal privacy, or a guarantee of certain areas or zones of privacy, does exist under the Constitution . . . These decisions make it clear that only personal rights that can be deemed 'fundamental' or 'implicit in the concept of ordered liberty' are included in the guarantee of personal privacy . . . This right of privacy, whether it be founded in the Fourteenth Amendment's concept of personal liberty and restrictions upon state action, as we feel it is, or, as the District Court determined, in the Ninth Amendment's reservation of rights to the people, is broad enough to encompass a woman's decision whether or not to terminate her pregnancy.") (citation omitted).

held that regulation limiting these rights may be justified only by a ‘compelling state interest,’ and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake.”¹³ Additionally, *Roe* created a trimester framework, forbidding restrictions on access to abortion during the first trimester and permitting more stringent restrictions only as the pregnancy progressed.¹⁴ While *Planned Parenthood v. Casey* reaffirmed *Roe*, the language of the plurality decision, penned by Justice O’Connor, appeared to modify *Roe* significantly. *Roe* identified abortion as a “fundamental” right, suggesting the application of strict scrutiny,¹⁵ but *Casey* invoked language that suggested judges use a lesser level of scrutiny.

Casey’s characterization of the holding in *Roe* demonstrates how the Court changed the standard. The *Casey* Court articulated the “essential holding” of *Roe* as having three parts: first, the right of a woman to choose to have an abortion before fetal viability; second, the power of a state to restrict abortion after viability; and third, the legitimacy of a state’s interest in protecting the health and safety of the woman, as well as the potential life of the fetus, throughout the pregnancy.¹⁶ *Casey* rejected *Roe*’s trimester system and instead made viability of the fetus the critical point of development for abortion regulations.¹⁷ At the same time, by recognizing a legitimate state interest in both potential life and the woman’s health “throughout pregnancy,” *Casey* allowed states to pass regulations that restricted abortion prior to fetal viability so long as they did not constitute an “undue burden.”¹⁸ Describing this new standard, the *Casey* decision stated that “[a]n undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an

13. *Id.* at 155 (internal citations omitted); see Lucy E. Hill, *Seeking Liberty’s Refuge: Analyzing Legislative Purpose Under Casey’s Undue Burden Standard*, 81 *FORDHAM L. REV.* 365, 377 (2012).

14. *Roe*, 410 U.S. at 164–65 (“(a) For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman’s attending physician. (b) For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health. (c) For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate and even proscribed abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”).

15. See, e.g., *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985) (“[T]hese laws are subjected to strict scrutiny and will be sustained only if they are suitably tailored to serve a compelling state interest. Similar oversight by the courts is due when state laws impinge on personal rights protected by the Constitution.”) (internal citations omitted); *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965) (“The present case, then, concerns a relationship lying within the zone of privacy created by several fundamental constitutional guarantees. . . . Such a law cannot stand in light of the familiar principle, so often applied by this Court, that a ‘governmental purpose to control or prevent activities constitutionally subject to state regulation may not be achieved by means which sweep unnecessarily broadly and thereby invade the area of protected freedoms.’”) (quoting *NAACP v. Alabama*, 377 U.S. 288, 307 (1964)).

16. *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 846 (1992).

17. *Id.* at 872.

18. *Id.* at 878.

abortion before the fetus attains viability.”¹⁹

The language of the undue burden standard in *Casey* suggested a lesser form of scrutiny than what was advanced in *Roe*. First, where *Roe* described the abortion right as a fundamental right, *Casey* replaced this language with that of a “liberty” interest.²⁰ The opinion rejects several purported state interests, such as moral interests, which would have passed rational basis scrutiny, suggesting that infringements on a liberty interest are subject to some heightened form of scrutiny.²¹ However, the changed language appeared to lower the level of scrutiny that applies to restrictions; in fact, in his dissent to the *Casey* opinion Chief Justice Rehnquist derides the plurality opinion for departing from the established standard of *Roe*.²² Some legal scholars and lower court judges agree with Chief Justice Rehnquist and believe that *Casey*’s undue burden standard “effectively demote[d] abortion from the status of fundamental right to something less.”²³

Second, while *Casey* allowed for abortion restrictions to affect earlier stages of pregnancy, the decision made clear that such restrictions must still be aimed at promoting one of the two legitimate state interests first iterated in *Roe*. First, states may enact regulations designed to “persuade [a woman] to choose childbirth over abortion,”²⁴ which this article will refer to as “potential-life-justified” regulations.²⁵ *Casey* made clear that restrictions motivated by the state’s interest

19. *Id.*

20. *Id.* at 846; Hill, *supra* note 13, at 381.

21. Hill, *supra* note 13, at 365, 403 (“[T]he plurality [in *Casey*] rejected several ‘legitimate’ state interests sufficient to pass rational basis review.”). It is worth noting that *Casey* categorically rejected moral arguments as sufficient to justify abortion restrictions. *Id.* at 406 (“*Casey* explicitly foreclosed the argument that a moral justification alone is important enough to limit the abortion rate.”) (citing *Casey*, 505 U.S. at 850–51).

22. *Casey*, 505 U.S. at 954 (Rehnquist, J., dissenting) (“*Stare decisis* is defined in Black’s Law Dictionary meaning ‘to abide by, or adhere to, decided cases.’ Whatever the ‘central holding’ of *Roe* that is left after the joint opinion finishes dissecting it is surely not the result of that principle. While purporting to adhere to precedent, the joint opinion instead revises it. *Roe* continues to exist, but only in the way a storefront on a western movie set exists: a mere façade to give the illusion of reality. Decisions following *Roe*, such as *Akron v. Akron Center for Reproductive Health*, and *Thornburg v. American College of Obstetricians and Gynecologists* are frankly overruled in part under the ‘undue burden’ standard expounded in the joint opinion.”).

23. Michael Dorf, *Symposium: Abortion is Still a Fundamental Right*, SCOTUSBLOG (Jan. 4, 2016, 11:28 AM), <http://www.scotusblog.com/2016/01/symposium-abortion-is-still-a-fundamental-right/> [<https://perma.cc/TR2C-6ST6>].

24. *Casey*, 505 U.S. at 877. As this article will primarily focus on health-justified regulations on abortion, potential-life-justified regulations are mostly beyond the scope of this article. However, such regulations will be mentioned occasionally, such as where states defend abortion restrictions using both or a combination of these justifications. Additionally, some scholars have argued that *Whole Woman’s Health*’s critical evaluation of the evidence supporting abortion restrictions will apply in challenges to potential-life-justified abortions restrictions as well. See Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6.

25. While some commentators refer to such regulations as “fetal-life” justified restrictions, I have chosen to use the term “potential-life-justified” to avoid the misapplication of the word “fetus.” Approximately eighty percent of abortions occur during early pregnancy when the appropriate term

in potential life "must be calculated to inform the woman's free choice, not hinder it,"²⁶ and will be upheld only if they are "reasonably related" to the goal of encouraging childbirth over abortion.²⁷ Second, states may pass abortion restrictions that are justified by efforts to protect women's health, which this article will refer to as "health-justified" regulations. In promoting this interest, "the State may enact regulations to further the health or safety of a woman seeking an abortion."²⁸ However, *Casey* made clear that "[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right."²⁹ The undue burden standard permits states to pass laws "which serve[] a valid purpose, one not designed to strike at the right itself,"³⁰ even where such laws "ha[ve] the incidental effect of making it more difficult or more expensive to procure an abortion."³¹

By emphasizing the ability of states to pass abortion regulations for both of these purposes, *Casey* "expand[ed] the ability of states to promote fetal life in the context of women's decision-making about whether to continue a pregnancy."³² While the *Casey* opinion was clear that laws passed for this purpose "must be calculated to inform the woman's free choice, not hinder it,"³³ misapplication of the decision by lower courts allowed states to pass even more intrusive laws, which limited women's decision-making and allowed TRAP laws to proliferate. "An unfortunate result was to encourage states to impose even more intrusive mandatory delays, 'counseling,' and testing requirements (such as mandatory ultrasounds) that increase costs and delays and stigmatize and demean women."³⁴ After *Casey* recognized the ability of states to pass laws for both of these purposes, anti-choice lawmakers began to pass potential-life-justified abortion restrictions beyond what was permissible, despite the fact that "[t]he Court was clear to treat separately regulations necessary to protect women's health. *Casey* plainly does not allow states to discourage abortion or make it difficult to obtain under the guise of protecting women's health."³⁵ However, until *Whole Woman's Health* clarified the distinction between these two motivations, many states passed such laws, and

is "embryo." See Ian Vandewalker, *Abortion and Informed Consent: How Biased Counseling Laws Mandate Violations of Medical Ethics*, 19 MICH. J. GENDER & L. 1, 9 n.37 (2012).

26. *Casey*, 505 U.S. at 877.

27. *Id.* at 878.

28. *Id.*

29. *Id.*

30. *Id.* at 874.

31. *Id.*

32. Dawn Johnsen, *Symposium: Health-Justified Abortion Restrictions Are Not Exempt from Casey's Heightened Scrutiny*, SCOTUSBLOG (Jan. 7, 2016, 11:47 AM), <http://www.scotusblog.com/2016/01/symposium-health-justified-abortion-restrictions-are-not-exempt-from-caseys-heightened-scrutiny/> [<https://perma.cc/EWF2-QUB5>].

33. *Casey*, 505 U.S. at 877.

34. Johnsen, *supra* note 32.

35. *Id.*

many courts, including the Fifth Circuit Court of Appeals, used lesser scrutiny and allowed for the blending of these justifications.³⁶

B. *Gonzales v. Carhart Further Confuses the Standard*

The Supreme Court's decision in *Gonzales v. Carhart* also substantiated state governments' perceived ability to pass more expansive restrictions meant to discourage abortion. First, the Court's language further confused the proper level of scrutiny to apply to abortion restrictions. Rather than *Roe*'s fundamental rights language or *Casey*'s liberty interest, the *Gonzales* Court invoked the language of rational basis.³⁷ Rational basis scrutiny, the least stringent standard of review, requires only that the law be rationally related to the government's legitimate purpose.³⁸ Typically courts will not do a full analysis of the state's purpose under the standard,³⁹ such as in *Gonzales*, where "the Court nonetheless determined that Congress articulated a legitimate purpose for the law without doing a full purpose analysis."⁴⁰ Thus, by equating the undue burden standard with a rational basis standard, *Gonzales* suggested that courts should accept a state's purported reasons for passing abortion restrictions at face value.⁴¹ This opened the door to a blending of justifications and the proliferation of TRAP laws.

Gonzales involved a challenge to the federal "Partial-Birth Abortion Ban Act,"⁴² which prohibited the performance of abortions using the intact dilation and evacuation procedure, or "intact D&E."⁴³ Prior to *Gonzales*, intact D&E was

36. See, e.g., *Whole Woman's Health v. Cole*, 790 F.3d 563, 587 (5th Cir. 2015) ("Under rational basis review, courts must presume that the law in question is valid and sustain it so long as the law is rationally related to the legitimate state interest."); *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott (Abbott II)*, 748 F.3d 583, 594 (5th Cir. 2014) ("Nothing in the Supreme Court's abortion jurisprudence deviates from the essential attributes of the rational basis test, which affirms a vital principle of democratic self-government. It is not the courts' duty to second guess legislative factfinding, 'improve' on, or 'cleanse' the legislative process by allowing relitigation of the facts that led to the passage of a law.").

37. *Gonzales v. Carhart*, 550 U.S. 124, 158 (2007). While the language of the Court in these cases suggests the application of different scrutiny levels, the Court in *Gonzales* did "explicitly identify a level of scrutiny." Hill, *supra* note 13, at 390.

38. See, e.g., *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985) ("The general rule is that legislation is presumed to be valid and will be sustained if the classification drawn by the statute is rationally related to a legitimate state interest.").

39. *Id.*

40. Hill, *supra* note 13, at 389; *Gonzales*, 550 U.S. at 156–58 ("A description of the prohibited abortion procedure demonstrates the rationale for the congressional enactment. . . . The Act expresses respect for the dignity of human life. . . . There can be no doubt the government 'has an interest in protecting the integrity and ethics of the medical profession.'").

41. See Dorf, *supra* note 23.

42. 18 U.S.C. § 1531(a) (2003).

43. By using the phrase "Partial-Birth Abortion," legislators demonstrate a lack of medical accuracy that is typical of most abortion restrictions. "Partial-Birth Abortion" is a purely political term designed to promote sympathy for the potential life. The medical community does not use the term "Partial-Birth Abortion," but refers to the procedure as "intact dilation and evacuation" or "intact D&E." This article will use the medically accurate term when describing this procedure.

the most popular method to perform second trimester abortions.⁴⁴ In passing the Act, Congress expressed concern that the intact D&E procedure, during which a fetus is partially delivered before the pregnancy is terminated, was too similar to “infanticide,” and justified the Act as expressing “respect for human life.”⁴⁵ In evaluating the potential-life-justified Act, the Court appeared to blend the undue burden standard with a rational basis standard:

Where it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn.⁴⁶

The *Gonzales* Court’s use of the language “legitimate interests” is also consistent with the application of the more deferential rational basis standard.⁴⁷

The infusion of the rational basis standard is clear in Justice Kennedy’s majority opinion upholding the Act. Despite stating both that “[t]he Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake,” and that “[u]ncritical deference to Congress’ factual findings in these cases is inappropriate,” Justice Kennedy demonstrated deference to the legislature in line with the rational basis standard.⁴⁸ The opinion relied on conflicting expert testimony at the District Court level to conclude that there was “medical uncertainty” about whether or not prohibiting intact D&E would impose health risks on women.⁴⁹ The Court stated that, in the face of such uncertainty, state and federal legislatures have wide discretion to regulate abortion, and concluded that the medical uncertainty “provides a sufficient basis to conclude . . . that the Act does not impose an undue burden.”⁵⁰

While deference to the legislature may be appropriate where true medical uncertainty exists, this was not the case with respect to the intact D&E procedure. As Justice Ginsburg emphasized in her dissent, several of the premises on which the majority opinion rested were contradicted by evidence and medical consensus.⁵¹ While the majority invoked medical uncertainty, Justice Ginsburg

44. *Gonzales*, 550 U.S. at 136.

45. Pub. L. No. 108-105, § 2(14)(G), 117 Stat. 1201, 1205 (2003), reprinted in 18 U.S.C.A. § 1531, Historical and Statutory Notes, Congressional Findings (2005) (“In addition to promoting maternal health, such a prohibition will draw a bright line that clearly distinguishes abortion and infanticide, that preserves the integrity of the medical profession, and promotes respect for human life.”).

46. *Gonzales*, 550 U.S. at 158 (emphasis added).

47. See, e.g., *City of Cleburne v. Cleburne Living Ctr.*, 473 U.S. 432, 440 (1985).

48. *Gonzales*, 550 U.S. at 165–66.

49. *Id.* at 161–63 (discussing the contradicting evidence presented in District Court cases regarding the safety and necessity of D&E procedures).

50. *Id.* at 164.

51. *Id.* at 175 (Ginsburg, J., dissenting) (“Many of the Act’s recitations are incorrect.”).

pointed out that the physicians who testified in favor of the Act had limited experience with abortion.⁵² In contrast, nine professional organizations, including the American College of Obstetricians and Gynecologists (“ACOG”), and testifying physicians with significant experience performing the challenged procedure, all concluded that “intact D & E carries meaningful safety advantages over other methods,” particularly for women with complicated pregnancies.⁵³

By failing to evaluate the credibility of the experts who testified before Congress and the District Court, the majority blindly accepted Congress’s fact-finding, even in the face of contradicting, better-supported evidence. As a result, *Gonzales* suggests to state governments and lower courts that, at least in the case of later-term abortions, the legislature’s judgment will be given broad deference, despite its statement that the courts have a “constitutional duty to review factual findings.”⁵⁴ This presumption of deference has created a problematic jurisprudence where laws purportedly enacted to promote women’s health are not struck down even where they fail to achieve that purpose.⁵⁵ The confusion caused by *Gonzales*’ addition of the rational basis test to the undue burden analysis also led to a lack of clarity over the proper standard to apply to abortion regulations generally.⁵⁶ Though *Casey*’s undue burden standard is not the same as a rational basis standard,⁵⁷ *Gonzales*’ discussion of these standards enabled courts to apply the less rigid test to abortion restrictions, “requiring only that Congress have had

52. *Id.* (quoting *Planned Parenthood Federation of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 1019 (N.D. Cal. 2004) (“[N]one of the six physicians who testified before Congress had ever performed an intact D & E. Several did not provide abortion services at all; and one was not even an [OB/GYN] . . . [T]he oral testimony before Congress was not only unbalanced, but intentionally polemic.”)).

53. *Id.* at 176–78.

54. *Id.* at 165 (majority opinion) (Because *Gonzales* involved a regulation that only affected abortions performed later in pregnancy, it is unclear whether its deferential standard applies to restrictions affecting the abortion right earlier in a woman’s pregnancy).

55. Perhaps the best example of courts disagreeing on how to apply the undue burden standard to the health-justified regulations is the line of lower court cases in what became *Whole Woman’s Health v. Hellerstedt*, which will be discussed, *infra*, at Part III.C.

56. See, e.g., Linda Greenhouse & Reva B. Siegel, *Casey and the Clinic Closings: When “Protecting Health” Obstructs Choice*, 125 YALE L.J. 1428, 1466–67 (2016) [hereinafter Greenhouse & Siegel, *Casey and the Clinic Closings*] (“The Fifth Circuit’s claims about rational basis are not entirely clear. In *Abbott II* [Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott, 748 F.3d 583 (5th Cir. 2014)], Judge Jones initially acknowledges that *Carhart* applied the undue burden framework, but she thereafter characterizes the undue burden framework as a rational-basis test, as does Judge Elrod in *Whole Woman’s Health v. Lakey*. The Fifth Circuit’s per curiam decision in *Whole Woman’s Health v. Cole* again goes out of its way to reaffirm *Abbot II*’s rational-basis reasoning. Sometimes the Fifth Circuit treats only the question of whether an abortion restriction serves the interests of women’s health as subject to rational-basis review. At other times, the circuit makes a broader claim: that the entirety of the undue burden framework is a form of rational-basis review. Whichever account the circuit embraces, its rational-basis claims flout both *Casey* and *Carhart*.”) (emphasis in original) (internal citations omitted).

57. *Id.* at 1467.

a 'rational basis to act.'"⁵⁸

Gonzales' rationale also caused some courts and judges to disregard *Casey*'s "purpose prong" and fixate on its "effect prong,"⁵⁹ which allows the application of "extravagant deference to the legislature."⁶⁰ The emphasis on the effect prong and disregard for the purpose prong is so strong in abortion jurisprudence that, during oral arguments in *Whole Woman's Health v. Hellerstedt*, Chief Justice Roberts asked why the state's purpose in enacting the law was even relevant to the determination of its constitutionality.⁶¹ Lower courts have echoed the Chief Justice's thinking, permitting states to pass "health-justified" restrictions on abortion access that neither promote health outcomes nor explain the actual impetus for passage of the law.⁶² These courts have held that the undue burden standard does not require the court to inquire into the validity of the medical purpose, instead accepting at face value the legislature's purported health

58. Caitlin E. Borgmann, *In Abortion Litigation, It's the Facts that Matter*, 127 HARV. L. REV. F. 149, 150 (2014).

59. These two prongs come from *Casey*'s description of the undue burden standard: "An undue burden exists, and therefore a provision of law is invalid, if its *purpose* or *effect* is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 878 (1992) (emphasis added).

60. Greenhouse & Siegel, *Casey and the Clinic Closings*, *supra* note 56, at 1467; Borgmann, *supra* note 58, at 149–50 ("Unfortunately, courts applying the undue burden standard established in *Planned Parenthood v. Casey* in 1992 have tended to focus mainly or exclusively on the effects of abortion restrictions, promoting judicial disregard for the facts underlying these laws The courts' primary inquiry in reviewing these laws is usually whether the restrictions have the *effect* of placing a substantial obstacle in the path of women seeking abortions.") (emphasis in original); *see generally* Hill, *supra* note 13; *see, e.g., Abbott II*, 748 F.3d at 594 ("A law 'based on rational speculation unsupported by evidence or empirical data' satisfies rational basis review.") (quoting *F.C.C. v. Beach Commc'ns*, 508 U.S. 307, 315 (1993)); Dorf, *supra* note 23.

61. Transcript of Oral Argument at 19, *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274) ("CHIEF JUSTICE ROBERTS: I don't—how is that logical. I mean, the question is whether there's an undue burden or a substantial obstacle. What—what difference does it make what the purpose behind the law is in assessing whether the burden is substantial or—or undue? It seems once you get past the—the assumption that the law has a rational basis and you haven't challenged that, then you look at the burden or the obstacle. And the purpose that the law is direct to, I would think, doesn't make a difference. It's either a substantial obstacle or an undue burden or it's not.").

62. *See* Borgmann, *supra* note 58, at 149 ("If states simply assert that laws are intended to protect women's health, keep women informed of their options, or protect integrity of the medical profession, for example, courts tend to agree, with minimal further inquiry. As a result, the country is replete with onerous, factually unjustified abortion laws Unless courts are willing to take a closer look at the factual premises states cite to justify these measures, factually unsupported abortion laws will continue to flourish."); *see, e.g., Abbott II*, 748 F.3d at 590 ("Planned Parenthood urges a stricter standard of review for the state's admitting privileges regulation than *Casey*'s undue burden standard because this regulation allegedly protects only the mother's health rather than fetal life. . . . This argument is wrong on several grounds. First, no such bifurcation has been recognized by the Supreme Court. . . . Fourth, the state's regulatory interest cannot be bifurcated simply between mothers' and children's health; every limit on abortion that further a mother's health also protects any existing children and her future ability to bear children even if it facilitates a particular abortion.").

justification for enacting the law.⁶³ Conversely, other courts have more vigorously evaluated health justifications, resulting in a circuit split on the proper way to apply the undue burden standard to abortion regulations.⁶⁴

Finally, although *Gonzales* involved a potential-life-justified restriction, courts have adopted its apparent rational basis standard in the context of health-justified restrictions as well, muddling the clear delineation between health- and potential-life-justified abortion restrictions that was drawn in *Roe* and reaffirmed in *Casey*.⁶⁵ These cases clearly delineated between health- and potential-life-justified restrictions, holding that states may only promote their interest in potential life by means “calculated to informed the woman’s free choice, not hinder it.”⁶⁶ As Linda Greenhouse and Reva B. Siegel phrase it, this means that “[u]nder *Casey*, states can protect potential life by persuading a woman to carry a pregnancy to term, but may not do so by obstructing her access to abortion.”⁶⁷

63. Borgmann, *supra* note 58, at 150 (“The [*Gonzales*] Court’s far-fetched conclusion that the ban was justified because women might come to regret their abortions was notoriously—and self-admittedly—unconcerned with scientific support.”); *Abbott II*, 748 F.3d at 593–94 (“The district court’s opinion took the wrong approach to the rational basis test. Nothing in the Supreme Court’s abortion jurisprudence deviates from the essential attributes of the rational basis test, which affirms a vital principle of democratic self-government. It is not the courts’ duty to second guess legislative factfinding, ‘improve’ on, or ‘cleanse’ the legislative process by allowing relitigation of the facts that led to the passage of a law.”).

64. *See, e.g.*, *Planned Parenthood of Ariz. v. Humble*, 753 F.3d 905, 914 (9th Cir. 2014) (“On the record before us, Arizona has presented no evidence whatsoever that the law furthers any interest in women’s health.”); *Planned Parenthood of Wis. v. Van Hollen*, 738 F.3d 786, 798 (7th Cir. 2013) (“The feebler the medical grounds, the likelier the burden, even if slight, to be ‘undue’ in the sense of disproportionate or gratuitous.”); *see also* *Planned Parenthood of Wis., Inc. v. Van Hollen*, 94 F. Supp. 3d 949, 953 (W.D. Wis. 2015), *aff’d sub nom* *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1378 (M.D. Ala. 2014).

65. *See* Greenhouse & Siegel, *Casey and the Clinic Closings*, *supra* note 56, at 1470–73 (“But *Casey* rejects this traditional view of women and instead insists that respect for women’s dignity requires giving women control over the decision whether to become a mother. That is *why* the undue burden test requires the means by which the government may protect unborn life: the government cannot prevent women from obtaining an abortion but instead must, if it chooses, seek to persuade women to bring a pregnancy to term through the provision of truthful, nonmisleading information.”). The District Court in *Whole Woman’s Health* criticized the state for blending together the standards for the health and fetal-life justifications for abortion restrictions when defending the challenged provisions. *Whole Woman’s Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014). (“The primary interest proffered for the act’s requirements relate to concerns over the health and safety of women seeking abortions in Texas. To the extent that the State argues that the act’s requirements are motivated by a legitimate interest in fetal life, the court finds those arguments misplaced. In contrast to the regulations at issue in *Casey*, the act’s challenged requirements are solely targeted at regulating the performance of abortions, not the decision to seek an abortion. Here, the only possible gain realized in the interest of fetal life, once a woman has made the decision to have a previability abortion, comes from the ancillary effects of the woman’s being unable to obtain an abortion due to the obstacles imposed by the act. The act creates obstacles to previability abortion. It does not counsel against the decision to seek an abortion.”).

66. *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 877 (1992).

67. Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 155.

However, courts have read *Gonzales* to permit the blending of the two justifications and analyzed dually-motivated statutes under a “fusion and scrambling of rationales.”⁶⁸ This enabled states to pass laws like those at issue in *Whole Woman’s Health*, alleging that the law’s purpose includes the protection of future life, despite the fact that *Casey* clearly states that restrictions under this justification cannot hinder a woman’s access to abortion.⁶⁹

III.

WHOLE WOMAN’S HEALTH: CLARIFICATION OF THE STANDARD AND STRATEGY FOR ADVOCATES

Perhaps the best demonstration of the differing applications of the undue burden standard can be seen by comparing the district and circuit court opinions for *Whole Woman’s Health*,⁷⁰ the case in which the Supreme Court finally clarified how health-justified abortion restrictions should be evaluated.⁷¹ The cases involved two health-justified abortion restrictions enacted by the State of Texas after the passage of House Bill 2 (“HB 2”).⁷² One provision, the “admitting-privileges requirement,” mandated that “[a] physician performing or inducing an abortion must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that is located not further than 30 miles from the location at which the abortion is performed or induced.”⁷³ The other provision,

68. Greenhouse & Siegel, *Casey and the Clinic Closings*, *supra* note 56, at 1472.

69. One example is Texas’ HB 2, the law at issue in *Whole Woman’s Health*, which is discussed in greater detail in the next section. The State of Louisiana enacted an analogous law, Act 620, which required physicians performing or inducing abortion to have admitting privileges at a hospital no more than thirty miles away and required abortion facilities to meet ambulatory surgical center requirements. See H.B. 388, 2014 Reg. Sess. (La. 2014). HB 388 became Act 620 when it was signed into law by Governor Bobby Jindal in 2014.

70. Compare *Whole Woman’s Health v. Lakey*, 46 F. Supp. 3d 673 (W.D. Tex. 2014), with *Whole Woman’s Health v. Cole*, 790 F.3d 563 (5th Cir. 2015).

71. The Commissioner of the Texas Department of State Health Services, the named respondent in the case, changed multiple times while the case was being litigated. As a result, the name of the case changed as it progressed. When the case was in the District Court, it was called *Whole Woman’s Health v. Lakey*, in the Fifth Circuit, it was called *Whole Woman’s Health v. Cole*, and at the Supreme Court, *Whole Woman’s Health v. Hellerstedt*. For clarity and convenience, the footnotes of this article will refer to the District Court decision as “*Lakey*,” the Fifth Circuit decision as “*Cole*,” and the Supreme Court opinion simply as “*Whole Woman’s Health*.”

72. As previously explained, potential-life-justified restrictions must not act by making it more difficult for women to access abortion, but only by attempting to convince her to carry a pregnancy to term. Therefore, although it may be apparent that Texas’ motivation for passing these two regulations was to make abortion harder to access—particularly given the law’s sponsorship by national anti-abortion organizations—this legal requirement perhaps is why Texas argued that the restrictions were attempts to improve the safety of women seeking abortions. See Gilad Edelman, *A Dishonest Attack on Abortion Rights*, THE NEW YORKER (June 19, 2015), <http://www.newyorker.com/news/news-desk/a-dishonest-attack-on-abortion-rights> [https://perma.cc/PV9R-XHXN] (“Texas can’t admit that H.B. 2’s real purpose is to make it harder for women to get an abortion; if it did, even the conservative Fifth Circuit would have to strike down the law.”).

73. TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a)(1) (2013).

the “ambulatory-surgical-center (“ASC”) requirement,” asserted that “the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [Texas Health & Safety Code] Section 243.010 for ambulatory surgical centers.”⁷⁴

A. Disagreement over the Standard in the Lower Courts

The district court opinion in *Whole Woman’s Health* is representative of courts that understood the undue burden standard to require the evaluation of whether the proffered health-related purpose of the law has beneficial effects for women’s health. Although it applied rational basis review, citing *Gonzales*,⁷⁵ the district court’s opinion, written by Judge Yeakel, found the two provisions violated the Constitution. Judge Yeakel did not accept that disagreement between expert witnesses constituted “medical uncertainty,” and thereby required deference to the legislature and upholding the law.⁷⁶ Rather, the court rejected the State’s proffered purpose of protecting women’s health, emphasizing that “before the act’s passage, abortion in Texas was extremely safe.”⁷⁷ Evaluating the ambulatory-surgical-center requirement, Judge Yeakel noted that “risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities,”⁷⁸ and pointed out that the law would likely make abortion less safe, as the law caused many clinics in Texas to close, greatly increasing women’s travel time and delaying their ability to access a legal abortion provider.⁷⁹ With respect to the admitting-privileges requirement, the court concluded that because physicians are often “denied privileges for reasons not related to clinical competency. . . . the heavy burden imposed on the women . . . is not appropriately balanced by a credible medical or health rationale.”⁸⁰

In addition to independently evaluating the factual basis for the law, the district court questioned and rejected the State’s purpose in enacting HB 2, concluding that the law violated both the purpose and effect prongs of the undue

74. TEX. HEALTH & SAFETY CODE ANN. § 245.010(a) (2013). “The requirement applies equally to abortion clinics that only provide medication abortion, even though no surgery or physical intrusion into a woman’s body occurs during this procedure.” *Lakey*, 46 F. Supp. 3d at 682.

75. *Lakey*, 46 F. Supp. 3d at 680 (“The Supreme Court added rational basis review to the judicial evaluation of abortion regulations in *Gonzales v. Carhart* Despite the finding of a rational-basis, however, this court must determine whether the act places an undue burden before a woman seeking a legal abortion.”).

76. *Id.* at 684.

77. *Id.*

78. *Id.*

79. *Id.* (“Higher health risks associated with increased delays in seeking early abortion care, risks associated with longer distance automotive travel on traffic-laden highways, and the act’s possible connection to the observed increase in self-induced abortions almost certainly cancel out any potential health benefit associated with the requirement.”).

80. *Id.* at 685.

burden standard. The court pointed to the State’s more lenient treatment of ambulatory surgery centers outside of the abortion context as suggestive that the State intended to reduce the number of abortion providers rather than promote health.⁸¹ Additionally, the Court emphasized a point undermining the State’s purpose argument that would later prove contentious during the Supreme Court oral argument.⁸² In defending the law, the State of Texas argued that residents faced with increased travel distances could obtain abortions in New Mexico.⁸³ However, New Mexico did not have an analogous ambulatory-surgical-center requirement, leading the court to conclude that “it is disingenuous and incompatible with [the goal of protecting women’s health] to argue that Texas women can seek abortion care in a state with lesser regulations.”⁸⁴ Following this evaluation, the court rejected the State’s purported reason for the law’s passage, concluding “that the ambulatory-surgical-center requirement was intended to close existing licensed abortion clinics,” and found the provision constituted an undue burden.⁸⁵

In contrast, the Fifth Circuit’s ruling found that the undue burden standard did not require courts to evaluate the factual basis for a health-justified abortion restriction. On appeal, the Fifth Circuit vacated the District Court of Western Texas’ ruling that had enjoined both the admitting-privileges requirement and the ambulatory-surgical-center requirement.⁸⁶ In so ruling, the appellate court not only declined to scrutinize the factual basis behind the State’s purpose in enacting the law, but reprimanded the district court for doing so, stating that “the district court erred by substituting its own judgment for that of the legislature.”⁸⁷ The

81. *Id.* (“Such disparate and arbitrary treatment, at a minimum, suggests that it was the intent of the State to reduce the number of providers licensed to perform abortions, thus creating a substantial obstacle for a woman seeking to access an abortion. This is particularly apparent in light of the dearth of credible evidence supporting the proposition that abortions performed in ambulatory surgical centers have better patient health outcomes compared to clinics licensed under the previous regime.”).

82. Transcript of Oral Argument at 30, *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274) (“JUSTICE GINSBURG: That’s—that’s odd that you point to the New Mexico facility. New Mexico doesn’t have any surgical—ACS [ambulatory-surgical-center] requirement, and it doesn’t have any admitting requirement. So if your argument is right, then New Mexico is not an available way out for Texas because Texas says to protect our women, we need these things. But send them off to Mexico—New Mexico—New Mexico where they don’t get it either, no admitting privileges, no ASC. And that’s perfectly all right. Well, if that’s all right for the—the women in the El Paso area, why isn’t it right for the rest of the women in Texas?”).

83. *Lakey*, 46 F. Supp. 3d at 685–86.

84. *Id.* at 686.

85. *Id.* at 685.

86. *Whole Woman’s Health v. Cole*, 790 F.3d 563, 580–81 (5th Cir. 2015) The *Cole* court spends little time on the admitting-privileges requirement, holding that the challenge to that provision of the law had already been settled in an earlier case regarding the Texas law. *Id.* (citing *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott (Abbott II)*, 748 F.3d 583 (5th Cir. 2014) (involving earlier challenge to the same Texas law at issue in *Cole*)).

87. *Id.* at 587; see *Greenhouse & Siegel, The Difference a Whole Woman Makes*, *supra* note 6, at 153–54 (“[I]n a series of opinions the Fifth Circuit reversed and rebuked the district judge for

Fifth Circuit found that “legislatures have ‘wide discretion to pass legislation in areas where there is medical and scientific uncertainty’”⁸⁸ and that courts should “not assume unconstitutional legislative intent even when statutes produce harmful results.”⁸⁹ In evaluating the effects of the law, the Fifth Circuit rejected the district court’s conclusion that the law was unconstitutional because it did not actually further the state’s purported interests.⁹⁰ The court wrote:

It is not the courts’ duty to second guess legislative factfinding, improve on, or cleanse the legislative process by allowing regulation of the facts that led to the passage of a law. Under rational basis review, courts must presume that the law in question is valid and sustain it so long as the law is rationally related to a legitimate state interest. As the Supreme Court has often stressed, the rational basis test seeks only to determine whether any conceivable rationale exists for an enactment. Because the determination does not lend itself to an evidentiary inquiry in court, the state is not required to prove that the objective of the law would be fulfilled.⁹¹

B. The Supreme Court Provides Clarification

In addition to clarifying the undue burden standard in its final opinion, the Supreme Court hinted at the need to investigate actual outcomes under health-justified abortion restrictions during oral argument. In a notable exchange, Justice Breyer asked Texas Solicitor General Keller to provide an example of women whose health and safety would be protected by the law.⁹² Mr. Keller was unable to provide such an example.⁹³ Justice Breyer echoed this concern about the lack

interfering with the prerogatives of the legislature It forbade the trial court from examining the evidence supporting the stat’s reasons for regulating: ‘The first-step in the analysis of an abortion regulation, however, is *rational* basis review, not *empirical* basis review.’”) (alteration in original) (quoting *Abbott II*, 748 F.3d at 596).

88. *Cole*, 790 F.3d at 585 (quoting *Gonzales v. Carhart*, 550 U.S. 124, 163 (2007)).

89. *Id.* (quoting *Mazurek v. Armstrong*, 520 U.S. 968, 972 (1997)).

90. *Id.* at 586.

91. *Id.* at 587 (quoting *Abbott II*, 748 F.3d at 594).

92. Transcript of Oral Argument at 47, *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016) (No. 15-274) (“JUSTICE BREYER: Okay. So I want to know, go back in time to the period before the new law was passed, where in the record will I find evidence of women who had complications, who could not get to a hospital, even though there was a working arrangement for admission, but now they could get to a hospital because the doctor himself has to have admitting privilege? Which were the women? On what page does it tell me their names, what the complications were, and why that happened? MR. KELLER: Justice Breyer, that is not in the record.”); *see also Whole Woman’s Health*, 136 S. Ct. at 2311–12 (“We add that, when directly asked at oral argument whether Texas knew of a single instance in which the new requirement would have helped even one woman obtain better treatment, Texas admitting that there was no evidence in the record of such a case.”).

93. *Id.*

of health benefits promoted by the “health-justified” law in his majority opinion.

Justice Breyer began his analysis by clarifying *Casey*’s undue burden standard and stated that the Fifth Circuit’s articulation of the standard, which could “be read to imply that a district court should not consider the existence or nonexistence of medical benefits when considering whether a regulation of abortion constitutes an undue burden” was “incorrect.”⁹⁴ The Justice clarified that the undue burden standard demands such an analysis, stating that *Casey* “requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer.”⁹⁵ The Court appeared to reject *Gonzales*’ call for rational basis scrutiny, stating that the Fifth Circuit incorrectly evaluated the restriction of the constitutional right to abortion under “the less strict review applicable where, for example, economic legislation is at issue.”⁹⁶ The Court additionally rejected *Gonzales*’ call for deference in the face of medical uncertainty, instead emphasizing the part of the opinion stating, “the ‘Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.’”⁹⁷ While rejecting the Fifth Circuit’s view about the role of courts in evaluating the health justifications for a law, the Supreme Court explicitly stated that the district court acted properly in evaluating the evidence for and against the law.⁹⁸

Under this clarified standard, the Court struck down both the admitting-privileges and ambulatory-surgical-center requirements of the Texas law.⁹⁹ With respect to the admitting-privileges requirement, the Court found that, despite the claimed purpose of “ensur[ing] that women have easy access to a hospital should complications arise during an abortion procedure,” the law “brought about no such health-related benefit.”¹⁰⁰ Relying on the collection of evidence from peer-

94. *Whole Woman’s Health*, 136 S. Ct. at 2309.

95. *Id.*

96. *Id.* at 2309–10 (“And the second part of the test is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue The statement that legislatures, and not courts, must resolve questions of medical uncertainty is also inconsistent with this Court’s case law. Instead, the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon the evidence and argument presented in judicial proceedings.”) (citing *Williamson v. Lee Optical of Okla., Inc.*, 348 U.S. 483, 491 (1955)); see *Greenhouse & Siegel, The Difference a Whole Woman Makes*, *supra* note 6, at 156.

97. *Whole Woman’s Health*, 136 S. Ct. at 2310 (emphasis omitted) (quoting *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007)). As an example, the Court pointed to the *Casey* opinion, in which the district court’s findings with respect to domestic violence were relied upon to strike down the law’s spousal provision requirement. *Id.* (citing *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 888–94 (1992)).

98. *Id.* (“[The District Court] did not simply substitute its own judgment for that of the legislature. It considered the evidence in the record—including expert evidence, presented in stipulation, depositions, and testimony. It then weighed the asserted benefits against the burdens. We hold that, in so doing, the District Court applied the correct legal standard.”).

99. *Id.* at 2300.

100. *Id.* at 2311.

reviewed studies and expert witnesses presented to the district court at fact finding,¹⁰¹ Justice Breyer concluded that there is “nothing in Texas’ record evidence that shows that . . . the new law advanced Texas’ legitimate interest in protecting women’s health.”¹⁰² Similarly, the Court found that the evidentiary record provided significant support for the district court’s conclusion that the ambulatory-surgical-center requirement “does not benefit patients and is not necessary.”¹⁰³ The Court emphasized that prior to enactment of the ambulatory-surgical-center requirement, Texas already held abortion facilities to such high health and safety standards that the new law did not make the facilities safer for abortion patients, and may have actually increased the risk of danger to women’s health.¹⁰⁴ Additionally, the Court found that many of the requirements for ambulatory surgical centers were “inappropriate” for abortion facilities and that some of the rules “ha[d] such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary.”¹⁰⁵

The lack of factual justifications for the “health-justified” provisions of HB 2 was further emphasized in Justice Ginsburg’s short, blunt concurring opinion. Citing amicus briefs from several medical organizations, including the American College of Obstetricians and Gynecologists (“ACOG”), Justice Ginsburg concluded that, given the realities of abortion care, “it is beyond rational belief that H. B. 2 could genuinely protect the health of women, and certain that the law ‘would simply make it more difficult for them to obtain abortion.’”¹⁰⁶ Her concurrence concluded with a warning to states enacting laws analogous to Texas’ statute: “Targeted Regulation of Abortion Providers laws like H. B. 2 that ‘do little or nothing for health, but rather strew impediments to abortion,’ cannot survive judicial inspection.”¹⁰⁷

C. The Practical Importance of Whole Woman’s Health’s Evidence-Based Standard

Whole Woman’s Health’s discussion of the proper standard of review for

101. The Court provides a detailed list of the studies and experts providing evidence before the district court. Much of this evidence emphasized the extreme safety of abortion procedures and the ways in which the admitting-privileges requirement would fail to promote health even where complications arise. *See id.*

102. *Id.*

103. *Id.* at 2315.

104. *Id.* at 2314–15; *see* Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 158 (“A ‘commonsense inference,’ [Justice Breyer] observes, is that the effect of the Texas law ‘would be harmful to, not supportive of, women’s health.’”) (quoting *Whole Woman’s Health*, 136 S. Ct. at 2318).

105. *Whole Woman’s Health*, 136 S. Ct. at 2315–16 (quoting *Whole Woman’s Health v. Lakey*, 46 F. Supp. 3d 673, 684 (W.D. Tex. 2014)).

106. *Id.* at 2320–21 (Ginsburg, J., concurring) (quoting *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 910 (7th Cir. 2015)).

107. *Id.* at 2321 (quoting *Schimel*, 806 F.3d at 910).

abortion regulations is significant because it clarified to the lower courts how to analyze such restrictions, and corrected courts that were applying an incorrect standard. After the decision was released, it was instantly useful to strike down similar admitting privilege and ambulatory surgical center requirements in other states.¹⁰⁸ However, the value of the decision goes beyond legal clarity. *Whole Woman’s Health* also emphasized the importance of evidence-based laws and directed lower courts to actually analyze and interrogate the legislature’s purpose in determining whether abortion restrictions can stand. The decision’s critical interrogation of health justifications shows the Court’s willingness to accept medical and purpose-determinative evidence as relevant to legal analysis. Thus, the decision provides a litigation strategy for advocates who seek to strike down other laws restricting abortion access. Now, advocates can expect the courts to be responsive to arguments showing the actual purpose behind regulations, comparisons between regulations on abortion and those on other medical treatments, and evidence from peer-reviewed research and professional medical organizations.

By rejecting blind deference to the legislature, the Court’s decision reflected the way in which many abortion restrictions are actually enacted.¹⁰⁹ Many state abortion restrictions are drafted by organizations whose purpose is to get rid of abortion, not to make it safer. The Texas law at issue in *Whole Woman’s Health* was drafted by Americans United for Life (“AUL”), an anti-abortion organization “dedicated to ending abortion through its incremental regulation,” and which “provides states model legislation that it claims will protect life and protect women’s health.”¹¹⁰ Legislators who share these anti-abortion sentiments promote the statutes through their state legislatures. On the day the Texas State

108. For example, when *Whole Woman’s Health* was decided, the State of Louisiana was defending a similar law in the federal courts. See Kevin Litten, *Supreme Court Abortion Ruling Has Implications for Louisiana*, NOLA.COM (Jun. 27, 2016), http://www.nola.com/politics/index.ssf/2016/06/abortion_supreme_court_admitti.html [<https://perma.cc/3VV2-PS32>]. The law was struck down by the District Court for the Middle District of Louisiana in mid-2017, citing to *Whole Woman’s Health*’s rejection of the Fifth Circuit’s interpretation of the undue burden test and holding that courts could not consider the evidentiary basis for the law. See *June Med. Servs. v. Kliebert*, 250 F. Supp. 3d. 27, 31–32 (M.D. La. 2017) (“Since this Court issued a preliminary injunction in this matter, the Supreme Court has held that the Fifth Circuit’s interpretation of the undue burden test was incorrect. . . . Rather, under the undue burden analysis, a restriction must be shown to actually ‘further’ its purported interest, and is constitutional only if its benefits outweigh its burdens.”).

109. See Hill, *supra* note 13, at 401 (“[C]ourts need not be blind to the fact that many of these laws are proposed and supported by anti-abortion activists in an attempt to narrow the abortion right.”).

110. Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 152; see also Zoë Carpenter, *The Big Lie at the Heart of the Texas Abortion Clinic Case*, THE NATION (Mar. 1, 2016), <https://www.thenation.com/article/the-big-lie-at-the-heart-of-the-texas-abortion-clinic-case/> [<https://perma.cc/69T4-BVMT>] (“A year after he signed the legislation into law, former Texas Governor Rick Perry thanked AUL for playing ‘a key role in developing and promoting legislation.’”).

Senate approved the admitting-privileges and ambulatory-surgical-center requirements, “then-Lieutenant Governor David Dewhurst tweeted a photo of a map that showed all of the abortion clinics that would close as a result of the bill. ‘We fought to pass S.B. 5 thru the Senate last night, & this is why!’”¹¹¹ The Governor of Mississippi made a similar statement on the day the State enacted its own admitting-privileges requirement: “This is a historic day to begin the process of ending abortion in Mississippi.”¹¹² These comments suggest that preventing abortion was the true impetus for the restriction, not protecting women’s health.¹¹³

Prior to *Whole Woman’s Health*, such evidence was insufficient to condemn anti-abortion regulations under the purpose prong. In *Mazurek v. Armstrong*,¹¹⁴ “[t]he Court rejected as insufficient to prove improper purpose the fact that an anti-abortion-rights group drafted the law, and that no evidence supported its patient-safety rationale.”¹¹⁵ But as scholar Caitlin Borgmann argues, stigma around the abortion right should make efforts to restrict it subject to more scrutiny, not less:

Four decades after *Roe v. Wade*, abortion remains a controversial constitutional right. Many state legislatures are eager to curb the procedure as much as possible. It stands to reason that some legislators will promote abortion restrictions on pretextual purposes. It is also predictable that their zeal to harass abortion providers or restrict abortion access will overwhelm their interest in the real facts.¹¹⁶

Without directly accusing the Texas legislature of enacting the law with an improper purpose, Justice Breyer’s opinion suggests that the law must have been

111. Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 153 (quoting David Dewhurst, (@DavidHDewhurst), TWITTER (June 19, 2013, 7:41 AM), <https://twitter.com/davidhdewhurst/status/347363442497302528?lang=en> [<https://perma.cc/J8AM-7KEU>]).

112. Borgmann, *supra* note 58, at 151; Rich Phillips, “Law Could Force Mississippi’s Only Abortion Clinic to Close,” CNN (June 30, 2012, 6:50 PM), <http://www.cnn.com/2012/06/30/us/mississippi-abortion-clinic/> [<https://perma.cc/QN2M-3Z3Y>].

113. Hill, *supra* note 13, at 401 (“[S]ome legislators appear unwilling to respect current Supreme Court precedent, as shown by their willingness to propose unconstitutional legislation such as the personhood bills or heartbeat bills. Therefore, in the context of abortion laws, such deference to the legislature is not warranted.”).

114. 520 U.S. 968 (1997).

115. Borgmann, *supra* note 58, at 150. In his dissenting opinion, Justice Thomas acknowledges that the *Mazurek* decision is vulnerable under *Whole Women’s Health*. See *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2324–25 (2015) (Thomas, J., dissenting) (“The Court in [*Mazurek*] had no difficulty upholding a Montana law authorizing only physicians to perform all abortions—even though no legislative findings supported the law, and the challengers claimed that ‘all health evidence contradict[ed] the claim that there is any health basis for the law. . . .’ Today, however, the majority refuses to leave disputed medical science to the legislature.”) (quoting *Mazurek v. Armstrong*, 520 U.S. 968, 973 (1997)) (internal citations omitted).

116. Borgmann, *supra* note 58, at 152.

motivated by an improper purpose by noting “the virtual absence of any health benefit.”¹¹⁷ Requiring that health-justified restrictions be supported by evidence will likely make it more difficult for states to blend health- and potential-life justifications, which was made easier by *Gonzales*. In requiring evidence to support a health-justified law, the Court treated abortion care as a form of health care, rather than a separate category that the legislature can regulate without regard to actual health outcomes.

Pro-choice scholars have labeled the willingness of legislatures and courts to treat abortion care differently than other forms of health care “abortion exceptionalism.”¹¹⁸ *Gonzales* shows a clear example of such exceptionalism, holding abortion care to a different standard than other medical care:

Gonzales v. Carhart was the first time in history the Court determined a physician could be prohibited from performing a medical procedure the physician found necessary to ensure the woman’s health. The longstanding tradition of the Court had been to defer to the medical profession to define what was medically necessary.¹¹⁹

In fact, the *Gonzales* Court specifically acted against ACOG’s recommendations, whose official “policy on abortion stated that only a physician, in consultation with a woman, could make the medical decision regarding the appropriate medical procedure to use to terminate a pregnancy.”¹²⁰

The permissibility of blending health- and potential-life justifications left states free to practice abortion exceptionalism.¹²¹ In the context of health-justified

117. *Whole Woman’s Health*, 136 S. Ct. at 2313; Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 158 (“Judges are extremely reluctant to accuse the government of acting with an unconstitutional purpose. But *Whole Woman’s Health* provides a textbook illustration of how a court can show unconstitutional purpose without explicitly asserting it.”).

118. See Greenhouse & Siegel, *Casey and the Clinic Closings*, *supra* note 56, at 1446 (“Such regulations impose requirements on abortion providers that are not imposed on other medical practices of similar or even greater risk.”); Vandewalker, *supra* note 25, at 6–8 (2012); Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047, 1048 (2014).

119. Jennifer L. George, *The United States Supreme Court Failed to Follow over Thirty Years of Precedent by Replacing Individualized Medical Judgment with Congressional Findings*, 41 CREIGHTON L. REV. 219, 262 (2008) (internal citations omitted) (citing George J. Annas, *The Supreme Court and Abortion Rights*, 356 NEW ENG. J. MED. 2201 (2007)); see also R. Alta Charo, *The Partial Death of Abortion Rights*, 356 NEW ENG. J. MED. 2127 (2007) (stating the tradition has been to permit the medical community to define the meaning of ‘medically necessary’).

120. George, *supra* note 119, at 263–64 (citing AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (ACOG), ACOG STATEMENT OF POLICY (July 2007)).

121. Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 155 (“Even when the state was not expressly invoking its interest in protecting unborn life, it made that goal apparent in the way it singled out abortion for health regulation. Texas engaged in what we have called ‘abortion exceptionalism,’ treating the health regulation of abortion differently from other forms of health regulation.”); see also Greenhouse & Siegel, *Casey and the Clinic Closings*, *supra* note 56, at 1446–49.

exceptions, the permissibility of abortion exceptionalism represents a failure to treat abortion as what it is: an ordinary health care decision.¹²² Like other health decisions, both patients and physicians are better situated to make decisions that are best for a woman's life and health. Allowing private health care decisions to be regulated because of the state's interest in something other than health outcomes, such as potential life, clearly demonstrates how pregnant women are prevented from making their own medical decisions, a situation which is rare in the provision of other forms of health care.

The fact that special regulations on abortion providers represent a departure from standard medical practice is made more apparent by the safety of standard abortion procedures. Women are fourteen times more likely to die while carrying a pregnancy to term than from obtaining an abortion.¹²³ Additionally, states already closely monitor and regulate abortion facilities, to the point that additional regulations do not improve outcomes for women's health.¹²⁴ An extensive report by Rewire, which drew on information from thirty-eight state attorneys general and thirty-two state health departments found "no support for . . . new restrictions on abortion."¹²⁵

The Court's evidence-based standard repudiated such state actions, and instead treated abortion as a form of health care,¹²⁶ and expressed an honest concern for the conditions in which women receive abortion care.¹²⁷ Justice Ginsburg's concurring opinion went a step further, recognizing that TRAP laws will not prevent women from having abortions, but will simply make abortion more dangerous: "When a State severely limits access to safe and legal procedures,

122. See *Abortion Is a Common Experience for U.S. Women, Despite Dramatic Declines in Rates*, GUTTMACHER INST. (Oct. 19, 2017), <https://www.guttmacher.org/news-release/2017/abortion-common-experience-us-women-despite-dramatic-declines-rates> [https://perma.cc/CM75-DMJB] (stating that 23.7% of women in the United States will have an abortion by age 45); see also 1 IN 3 CAMPAIGN, <http://www.1in3campaign.org/> [https://perma.cc/DH6E-QAJV?type=image] (last visited Dec. 30, 2017).

123. See Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 217 (2012).

124. See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2315 (2016) ("There is considerable evidence in the record supporting the District Court's findings indicating that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary. . . . The record also contains evidence that abortions taking place in an abortion facility are safe—indeed, safer than numerous procedures that take place outside hospitals and to which Texas does not apply its surgical-center requirements.").

125. Sharona Coutts, *Exclusive: Results of Congressional 'Fishing Expedition' Show Abortion Already Highly Regulated, Overwhelmingly Safe*, REWIRE (Aug. 21, 2013, 12:01 AM), <https://rewire.news/article/2013/08/21/exclusive-results-of-congressional-fishing-expedition-show-abortion-is-already-highly-regulated-overwhelmingly-safe/> [https://perma.cc/X2MX-BZT4].

126. See generally B. Jessie Hill, *Abortion as Health Care*, 10 AM. J. OF BIOETHICS 48 (2010) (arguing that reproductive rights activists should argue for abortion as an aspect of health care in order to benefit from public attitudes towards and legal protections for health care generally).

127. Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 161. ("To this Court it matters not only whether women can ultimately manage to get an abortion, but also how the state degrades the conditions in which women must make and act on decisions about abortion.").

women in desperate circumstances may resort to unlicensed rogue practitioners, *faute de mieux* [for want of a better alternative], at great risk to their health and safety.”¹²⁸ A global study by the World Health Organization and the Guttmacher Institute supports this idea, finding that “the legal status of abortion does not influence a woman’s decision whether to have an abortion.”¹²⁹ If lawmakers regulating abortion truly aim to protect women’s health, they must take this fact into consideration. The failure to do so, as the majority noted in *Whole Woman’s Health*, “would be harmful to, not supportive of, women’s health.”¹³⁰ This harm has already been demonstrated: according to the Texas Policy Evaluation Project at the University of Texas, in Texas, which has passed several abortion restrictions over the last decade, at least 100,000 women have attempted to induce their own abortions.¹³¹ Lawmaker or voter disapproval of abortion does not justify making necessary medical care so unattainable that women resort to unsafe alternatives.¹³² Aside from the necessity of protecting recognized rights,¹³³ “[i]t is the courts’ job to protect unpopular constitutional rights from legislative encroachment. They can only do this job well if they examine carefully the factual premises supposedly justifying burdensome abortion laws.”¹³⁴

Whole Woman’s Health represents a step towards preventing moral opposition to abortion from swallowing up the constitutional right and condemning women to inferior health care options.¹³⁵ The Court’s decision additionally provides a litigation strategy map for advocates seeking to challenge similar TRAP laws and expand access to abortion. The fact that Justice Breyer

128. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2321 (2015) (Ginsburg, J., concurring).

129. George, *supra* note 119, at 219 (citing Elizabeth Rosenthal, *Legal or Not, Abortion Rates Compare*, N.Y. TIMES (Oct. 12, 2007), <http://www.nytimes.com/2007/10/12/world/12abortion.html> [<https://nyti.ms/2klidXg>]).

130. *Whole Woman’s Health*, 136 S. Ct. at 2318.

131. Daniel Grossman, Kari White, Liza Fuentes, Kristine Hopkins, Amanda Stevenson, Sara Yeatman & Joseph E. Potter, *Research Brief: Knowledge, Opinion, and Experience Related to Abortion Self-Induction in Texas*, TEX. POL’Y EVALUATION PROJECT (Nov. 17, 2015), <https://utexas.app.box.com/v/KOESelfInductionResearchBrief> [<https://perma.cc/T6XZ-S4TA>]. The study suggests that attempts to self-induce abortion are more common in Texas than in the rest of the country: while a national 2008 study found that less than two percent of abortion patients had attempted to end their current pregnancy prior to coming to the clinic, the Texas study found seven percent of patients reported such actions.

132. Hill, *supra* note 13, at 406 (2012) (“Casey explicitly foreclosed the argument that a moral justification alone is important enough to limit the abortion rate.”) (citing *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 850–51 (1992)).

133. Greenhouse & Siegel, *Casey and the Clinic Closings*, *supra* note 56, at 1469 (internal citations omitted) (“If appellate courts can justify deference to the legislature by invoking medical uncertainty that is untethered from facts found and credibility determinations made by the trial court, they can easily erode protections for constitutional rights.”).

134. Borgmann, *supra* note 58, at 152.

135. In arguing about the importance of legally accessible abortion, Jennifer George provides a vivid image of abortion care and its horrific health results for women who attempted to obtain in abortion pre-*Roe v. Wade*. See George, *supra* note 119, at 220–22.

found it significant that other more dangerous medical procedures were less regulated than abortion indicates the Court's responsiveness to arguments highlighting and challenging abortion exceptionalism. Additionally, the Supreme Court's direction that lower courts must interrogate the factual bases for health-justified laws indicates that arguments couched in evidence for peer-reviewed research from professional organizations will be successful in challenging other restrictions.

As will be discussed in the following sections, "Justice Breyer's unusually close examinations of the facts as he identifies and balances the benefits and burdens of the Texas law models a kind of scrutiny that few TRAP laws could withstand."¹³⁶ In the following sections, I describe three categories of abortion regulations that I argue are susceptible to challenge under *Whole Woman's Health's* evidence-based standard, and which can be challenged by utilizing medical studies and reports, as well as evidence of abortion exceptionalism. Not only will the use of these kinds of evidence allow advocates to strike at restrictive regulations, but it will also be a step towards treating abortion care like all other forms of health care.

IV.

INFORMED CONSENT: CHALLENGING THE PROVISION OF INCORRECT OR MISLEADING INFORMATION TO ABORTION PATIENTS

Currently, thirty-five states have laws requiring informed consent before an abortion is performed, with twenty-nine of these states specifically detailing the information that must be provided to abortion patients.¹³⁷ Many of these laws depart from the medical doctrine of informed consent by requiring pregnant women to be provided with inaccurate or uncertain information designed to discourage abortion. This section will first introduce the legal background of informed consent and then describe how, in another incidence of abortion exceptionalism, standard medical practice has been distorted in an effort to prevent abortions. Finally, the section will describe various informed consent laws that are not supported by medical evidence and thus fail to satisfy the scrutiny required after *Whole Woman's Health*.

A. Introduction to the Doctrine of Informed Consent

Based in tort law, the doctrine of informed consent was developed to protect patients' bodily autonomy and ability to make their own decisions about their health care. This is evidenced by the first statement of the doctrine by then-Judge Cardozo in *Schloendorff v. Society of New York Hospitals*: "Every human being

136. Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 157.

137. *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (Jan. 1, 2018) [hereinafter GUTTMACHER Counseling], <https://www.guttmacher.org/state-policy/explore/counseling-and-waiting-periods-abortion> [<https://perma.cc/RE3K-PSZB>].

of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits assault."¹³⁸ In order for consent to medical treatment to be "informed," health care professionals must provide sufficient information to patients "to allow them to make an intelligent decision as to whether to undergo a medical intervention."¹³⁹ The determination of what is "material," and thus must be disclosed to the patient, varies by state, with about half of states defining the risks as "those that a reasonable person would likely find significant" and the other half defining them as "what a reasonable physician would disclose."¹⁴⁰

The rationale behind informed consent reasons that "patients who are unaware of the risks, benefits and alternatives to a particular treatment cannot effectively render their consent to treatment."¹⁴¹ It is thus essential to informed consent that the information provided be medically accurate and unbiased.¹⁴² In fact, early informed consent cases explicitly stated that a physician is prohibited from "substitut[ing] his own judgment for that of the patient by any form of artifice or deception."¹⁴³

B. Distortion of Informed Consent in the Abortion Context

While the doctrine of informed consent is based on bodily autonomy, informed consent and counseling laws in the abortion context have clearly departed from this foundation.¹⁴⁴ A study by Rutgers University concluded that one third of women who seek abortions are provided with misleading information.¹⁴⁵ Misleading or flatly inaccurate information is commonly provided under informed consent laws requiring the provision of incorrect statements that

138. 105 N.E. 92, 93 (1914).

139. Vandewalker, *supra* note 25, at 2.

140. *Id.* at 5; see Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223, 238–39 (2009) [hereinafter Manian 2009] ("Canterbury [*v. Spence*] held that the disclosure must include unbiased information on all 'material' risks, defining material risk as when 'a reasonable person, in what the physician knows or should know to be the patient's position, would likely attach significance to the risk in deciding whether or not to forego the proposed therapy.'") (quoting *Canterbury v. Spence*, 464 F.2d 772, 781 (D.C. Cir. 1972)).

141. Manian 2009, *supra* note 140, at 237.

142. *Id.* at 239 ("Most significantly, informed consent law compels the disclosure only of accurate medical information consistent with expert knowledge of the medical community.").

143. *Id.* at 237 (quoting *Natanson v. Kline*, 350 P.2d 1093, 1104 (Kan. 1960)).

144. In addition to representing a departure from standard medical practice, scholars have argued that permitting informed consent laws to be used in this way represents a violation of physician's free speech rights. See generally Vandewalker, *supra* note 25. Other scholars have argued that this use of informed consent laws, which only affects the decision-making ability of women, is based in paternalism or constitutes a form of sex discrimination. See *id.* at 8; see also Manian 2009, *supra* note 140, at 252.

145. Sebastian Malo, *One-Third of U.S. Women Seeking Abortions Get Misleading Information: Study*, REUTERS (Feb. 29, 2016, 6:21 PM), <http://www.reuters.com/article/us-usa-abortion-study-idUSKCN0W22T6> [<https://perma.cc/5GF8-MDM8>].

abortion can be reversed if the woman acts quickly;¹⁴⁶ inaccurate information about the risk to fertility from abortion;¹⁴⁷ inaccurate information that abortion is linked to breast cancer;¹⁴⁸ largely inaccurate or unproven information that abortion causes the fetus to experience pain;¹⁴⁹ and misleading information about negative psychological effects for women who have abortions.¹⁵⁰

146. Currently, Arkansas, South Dakota, and Utah require women be told inaccurate information on reversing medication abortion. *See* ARK. CODE ANN. § 20-16-1703(b)(8) (2016) (“At least forty-eight (48) hours before an abortion that is being performed or induced utilizing abortion-inducing drugs, the physician who is to perform the abortion, the referring physician, or a qualified person informs the pregnant woman, orally and in person, that: (A) It may be possible to reverse the effects of abortion if the pregnant woman changes her mind, but that time is of the essence; and (B) Information on reversing the effects of abortion-inducing drugs is available in materials prepared by the department.”); S.D. CODIFIED LAWS § 34-23A-10.1(1)(h)-(i) (2017) (Stating that no abortion may be performed until the physician obtains informed consent, including providing the pregnant woman with information “(h) That even after a pregnant mother takes Mifepristone it is still possible to discontinue a drug-induced abortion by not taking the prescribed Misoprostol; and (i) That information on discontinuing a drug-induced abortion is available on the Department of Health website.”); UTAH CODE ANN. § 76-7-305.5(5)(e) (2017) (requiring printed informed consent material to “include the following statement ‘Research indicates that mifepristone alone is not always effective in ending a pregnancy. You may still have a viable pregnancy after taking mifepristone. If you have taken mifepristone but have not yet taken the second drug and have questions regarding the health of your fetus or are questioning your decision to terminate your pregnancy, you should consult a physician immediately.’”). A similar law in Arizona is no longer in effect after a permanent injunction. *See* *Planned Parenthood Ariz., Inc. v. Brnovich*, 172 F. Supp. 3d 1075 (D. Az. 2016).

147. Arizona, Kansas, South Dakota, and Texas provide inaccurate information on fertility risk to women seeking abortions. *See* GUTTMACHER Counseling, *supra* note 137; *see also, e.g.*, S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(iv) (requiring the provision of information on “[a]ll other known medical risks to the physical health of the woman, including the risk of infection, hemorrhage, danger to subsequent pregnancies, and infertility.”); TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(1)(B)(ii) (Stating that consent to abortion is only voluntary and informed if the physician provides information on “the potential danger to a subsequent pregnancy and of infertility.”).

148. Alaska, Kansas, Mississippi, Oklahoma, and Texas provide inaccurate information about the link between abortion and breast cancer to women seeking abortion. *See* GUTTMACHER Counseling, *supra* note 137; *see also, e.g.*, KAN. STAT. ANN. § 65-6709(a)(3) (requiring for informed consent “a description of risks related to the proposed abortion method, including . . . risk of breast cancer”); TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(1)(B)(iii) (requiring informed consent include information on “the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer.”).

149. Alaska, Arkansas, Georgia, Indiana, Kansas, Louisiana, Minnesota, Missouri, Oklahoma, South Dakota, Texas, Utah, and Wisconsin include medically disputed information about fetal pain during informed consent. *See* GUTTMACHER Counseling, *supra* note 137; *see also, e.g.*, GA. CODE ANN. § 31-9A-3(2)(D) (stating that no abortion may take place until the woman is informed of her right to view materials which “contain information on fetal pain.”); MINN. STAT. ANN. § 145.4242(a)(2)(iii) (requiring the physician to inform the pregnant woman that she has the right to view printed materials, which “contain information on fetal pain.”).

150. Of the twenty-two states which require women be given information about the psychological effects of abortion, eight specifically describe negative emotional responses. These eight states are Kansas, Louisiana, Michigan, Nebraska, North Carolina, South Dakota, Texas, and West Virginia. *See* GUTTMACHER Counseling, *supra* note 137; *see also, e.g.*, MICH. COMP. LAWS § 333.17015(11)(b)(iii) (requiring the Department of Community Health to provide documents for abortion patients which “[s]tate that as the result of an abortion, some women may experience depression, feelings of guilt, sleep disturbance, loss of interest in work or sex, or anger, and that if

Prior to *Whole Woman’s Health*, such provisions appeared to be supported by the case law, including *Casey*, which upheld a Pennsylvania informed consent requirement.¹⁵¹ The statute in *Casey* required that women be provided with information about “the nature of the procedure, the health risks of the abortion and of childbirth,” as well as information about services to support the woman if she chose to have the child rather than an abortion.¹⁵² In upholding the provision, the *Casey* Court permitted the future proliferation of biased informed consent laws, despite the presence of language that can be read to limit such laws.¹⁵³

Comparing Pennsylvania’s informed consent law provision to the doctrine as applied to other medical procedures, specifically kidney transplants, the *Casey* Court concluded that the provision “conforms to the general regulation of the practice of medicine outside the abortion context.”¹⁵⁴ Additionally, the Court emphasized the need for medically accurate informed consent, stating that “[i]f the information the State requires to be made available to the woman is truthful and not misleading, the requirement may be permissible.”¹⁵⁵ At the same time though, *Casey* appeared to permit the blending of health and potential-life rationales for informed consent laws, noting that states may require the provision of information “relating to the consequences to the fetus, even when those consequences have no direct relation to her health.”¹⁵⁶

In so ruling, the Court departed from general medical standards and permitted the use of informed consent laws to promote moral values rather than to assure informed medical choice. In fact, the Court even went so far as to suggest that biased informed consent provisions could promote women’s health by protecting against future mental health problems.¹⁵⁷ However, the *Casey* Court did not base

these symptoms occur and are intense or persistent, professional help is recommend.”); S.D. CODIFIED LAWS § 34-23A-10.1(1)(e) (requiring informed consent materials to include a description of all known medical risks, including “(i) Depression and related psychological distress; (ii) Increased risk of suicide ideation and suicide.”); see also Maya Manian, *Lessons from Personhood’s Defeat: Abortion Restrictions and Side Effects on Women’s Health*, 74 OHIO ST. L.J. 75, 83–85 (2013) (describing “so-called ‘informed consent laws’” which require women to be given biased information).

151. For a detailed analysis of jurisprudence on informed consent laws for abortion prior to *Casey*, see Manian 2009, *supra* note 140, at 242–48.

152. *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 881 (1992).

153. *Id.* at 877 (“[T]he means chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it.”).

154. *Greenhouse & Siegel, Casey and the Clinic Closings*, *supra* note 56, at 1446.

155. *Casey*, 505 U.S. at 882.

156. *Id.* The informed consent provision at issue in *Casey* included the requirement that women be given “information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion.” *Id.* at 881. In addition to not being related to women’s health, such statements are irrelevant and insulting for some women.

157. *Id.* at 882 (“In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.”); see Manian 2009, *supra* note 140, at 254.

its reasoning on factual support, which opened the door for *Gonzales* to further depart from the established principles of informed consent.¹⁵⁸ Although the case did not involve an informed consent provision, *Gonzales* invoked the concept of informed consent to justify the prohibition of the intact D&E procedure, reasoning that a woman who later regrets her abortion will “struggle with grief more anguished and sorrow more profound” when she learns the means by which the abortion was performed.¹⁵⁹ Like in *Casey*, the *Gonzales* Court was permitted to reach such a conclusion without scrutinizing any medical evidence. In fact, the Court explicitly states that there was no support for Court’s speculations about harm.¹⁶⁰

By divorcing informed consent in the abortion context from the generally applicable medical doctrine, *Casey* and *Gonzales* permit yet another form of abortion exceptionalism. While informed consent is rooted in respect for patient autonomy, in the abortion context, informed consent laws permit states to question the decision-making capacity of women seeking abortions, and allow biased, inaccurate information to persuade them against making their own medical decisions. While states are permitted to pass laws aimed at persuading women to choose childbirth over abortion, such laws must be defended by the potential-life justification, rather than by pretending that such laws are aimed at promoting women’s health or assuring accurately informed consent.¹⁶¹ Under *Whole Woman’s Health*’s evidence-based standard, health-justified informed consent provisions are unconstitutional if they are not supported by medical evidence.¹⁶²

158. Manian 2009, *supra* note 140, at 254 (“This rationale invokes ‘informed consent’ as a justification for a decision that is antithetical to informed consent law.”).

159. *Gonzales v. Carhart*, 550 U.S. 124, 159–60 (2007).

160. *Id.* (“While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude that some women come to regret their choice to abort the infant life they once created and sustained It is self-evident that a mother who comes to regret her choice to abort must struggle with more anguish and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.”).

161. Vandewalker, *supra* note 25, at 10 (“*Casey* treats the state’s disapproval of abortion as if it were as relevant as the medical risks. Even if the state has a legitimate interest in discouraging abortion, that does not entail that it is appropriate to use the informed consent process to express that interest or intrude upon the relationship between doctor and patient.”).

162. Greenhouse & Siegel, *The Difference a Whole Woman Makes*, *supra* note 6, at 159–60 (“Evidence-based balancing of this kind will guide courts in evaluating the state interest in enacting health-justified restrictions on abortion such as laws in Texas and Kansas requiring scientifically inaccurate warnings that abortion causes breast cancer. Courts must also weigh scientific evidence when evaluating counseling laws in at least nine states requiring abortion providers to inform women that they are more likely to experience psychological harm if they obtain abortions than if they carry their unplanned pregnancies to term – claims that social scientists have debunked.”) (citing APA Task Force on Mental Health & Abortion, *Report of the Task Force on Mental Health and Abortion*, *infra* note 165; M. Antonia Biggs, Brenly Rowland, Charles E. McCulloch & Diana G. Foster, *Does Abortion Increase Women’s Risk for Post-Traumatic Stress? Findings from a Prospective Longitudinal Cohort Study*, 6 *BMJ OPEN* (2016) [hereinafter Biggs 2016] (finding that women who received abortions were at no higher risk of PTSD than women denied an abortion)).

C. *After Whole Woman's Health: Application to Specific Informed Consent Provisions*

Not all informed consent provisions are justified by protecting women's health, and it is possible that potential-life-justified informed consent laws could continue to stand even after *Whole Woman's Health*. However, health-justified informed consent provisions will fail to satisfy the clarified undue burden standard if empirical research does not support their purported health benefit. In addition, those that are justified by the state's interest in potential life should be found unconstitutional if, rather than simply seeking to persuade women against seeking an abortion, they bar women's access to abortion.

1. *Mental-Health-Justified Informed Consent Laws*

Informed consent provisions justified by the concept of "abortion regret," while impliedly authorized by *Casey*, fail the standard of review established in *Whole Woman's Health*. The rationale that women come to regret their abortion has been used to justify abortion restrictions for many years. However, empirical research does not support this conclusion.¹⁶³ In 2008, the American Psychological Association ("APA") released a detailed report after its Task Force on Mental Health and Abortion collected and examined seventy-three peer-reviewed studies on the subject.¹⁶⁴ The report ultimately concluded that "among women who have a single, legal, first-trimester abortion of an unplanned pregnancy for nontherapeutic reasons, the relative risks of mental health problems are not greater than the risks among women who deliver an unplanned pregnancy."¹⁶⁵

Two additional studies published in the last few years have found that the overwhelming majority of women who obtain abortions do not regret their decision. One of these is a recent longitudinal study conducted by researchers at the University of California, San Francisco ("UCSF") and the associated organization Advancing New Standards in Reproductive Health ("ANSIRH").¹⁶⁶ They surveyed women having either first-trimester abortions or abortions within two weeks of the facility's gestational age limit. Over the course of three years, 99% of women in both groups consistently reported that having an abortion was

163. Brandy Zadronzy, *Study: Abortion Doesn't Harm Women's Mental Health, but Denying One Does*, THE DAILY BEAST (Dec. 14, 2015, 11:00 AM), <http://www.thedailybeast.com/articles/2016/12/14/study-abortion-doesn-t-harm-women-s-mental-health-but-denying-one-does.html> [<https://perma.cc/9VTX-2NZ5>].

164. See Heather Boonstra, *Comprehensive Evidence Review Concludes Abortion Does Not Harm Women's Mental Health*, 11 GUTTMACHER POL'Y REV. 20 (2008) [hereinafter Boonstra 2008].

165. APA Task Force on Mental Health & Abortion, *Report of the Task Force on Mental Health and Abortion*, AM. PSYCHOLOGICAL ASS'N 92 (2008), <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf> [<https://perma.cc/7GX9-U3FX>].

166. Nash Jenkins, *Hardly Any Women Regret Having an Abortion, a New Study Finds*, TIME (July 14, 2015), <http://time.com/3956781/women-abortion-regret-reproductive-health/> [<http://perma.cc/EQQ3-PTB8>].

the right decision.¹⁶⁷ The study also concluded that the women thought about their abortions less over time, with both negative and positive emotional responses decreasing as the study went on.¹⁶⁸

Another study conducted by researchers at UCSF reached similar conclusions.¹⁶⁹ Researchers at UCSF collected information both from women who obtained abortions and from women who were denied them because their pregnancies had progressed beyond the gestational age at which their states banned abortions. In addition to concluding that “abortion does not adversely affect women’s mental health over five years,” the researchers found that being denied an abortion leads to greater mental health issues than having one.¹⁷⁰ Where the study authors saw “a general improvement in women’s mental health and well-being over time” after having an abortion, “[t]he women who were turned away and ultimately did give birth reported the most anxiety, and lowest self-esteem and life satisfaction one week after being denied an abortion.”¹⁷¹ The study authors concluded that informed consent laws seeking to protect women from the emotional distress that supposedly results from having an abortion are unjustified.¹⁷²

Based on this empirical research, state laws requiring the provision of inaccurate information about abortion regret are not evidence-based. The standard delineated in *Whole Woman’s Health* also suggests that prior court decisions upholding informed consent provisions with dubious information about mental health outcomes could be overturned.¹⁷³

167. Corinne H. Rocca, Katrina Kimport, Sarah C. M. Roberts, Heather Gould, John Neuhaus & Diana G. Foster, *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, PLOS ONE 1 (July 8, 2015), <http://journals.plos.org/plosone/article/file?id=10.1371/journal.pone.0128832&type=printable> [<https://perma.cc/6MTG-W92Y>].

168. *Id.*

169. M. Antonia Biggs, Ushma D. Upadhyay, Charles E. McCulloch & Diana G. Foster, *Women’s Mental Health and Well-being 5 Years After Receiving or Being Denied an Abortion: A Prospective, Longitudinal Cohort Study*, 74 JAMA PSYCHIATRY 169, 177 (Feb. 1, 2017), <http://jamanetwork.com/journals/jamapsychiatry/article-abstract/2592320> [<https://perma.cc/5G2V-XA48>] [hereinafter Biggs 2017] (finding that the psychological well-being of women who obtained abortions improved over time).

170. Zadronzy, *supra* note 163.

171. *Id.*

172. Biggs 2017, *supra* note 169, at 169 (“These findings do not support policies that restrict women’s access to abortion on the basis that abortion harms women’s mental health.”).

173. *See, e.g.*, Planned Parenthood Minn. v. Rounds, 686 F.3d 889 (8th Cir. 2012) (upholding South Dakota’s state statute which required that women seeking abortions be told that the procedure could cause “[i]ncreased risk of suicide ideation and suicide”) (quoting S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(ii) (West 2011)). For additional discussion regarding the *Rounds* case see Maya Manian, *Perverting Informed Consent: The South Dakota Court Decision*, REWIRE (Aug. 1, 2012, 10:08 PM), <https://rewire.news/article/2012/08/01/perverting-informed-consent-south-dakota/> [<https://perma.cc/8ED5-V3SP>].

2. Physical-Health-Justified Informed Consent Laws

In addition to informed consent laws that purportedly seek to protect women’s mental health, several states require physicians to provide women with inaccurate information that abortion is linked to detrimental physical health results, such as breast cancer or infertility.¹⁷⁴ In many cases, such laws rely on debunked or methodologically problematic studies.¹⁷⁵ While some states only require the provision of information about abortion and fertility when it is medically accurate, other states do not limit the impact of their informed consent laws.¹⁷⁶

Links between abortion and breast cancer have been repeatedly rejected by the scientific community.¹⁷⁷ The American Cancer Society explains the correlation between pregnancy and breast cancer risks on its website, explaining that a woman’s risk of breast cancer decreases as the number of full-term pregnancies she experiences increases.¹⁷⁸ Additionally, women who have more menstrual periods over their lifetime have a slightly elevated risk of breast cancer, and pregnancy causes a woman to have fewer menstrual periods.¹⁷⁹ Despite these connections, the American Cancer Society concludes that there is no causal link between abortion and breast cancer risk, as do the National Cancer Institute and the American College of Obstetricians and Gynecologists.¹⁸⁰

174. *See supra* notes 147, 148; *see, e.g.*, KAN. STAT. ANN. § 65-6709(a)(3) (requiring for informed consent “a description of risks related to the proposed abortion method, including . . . risk of breast cancer”); TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(1)(B)(iii) (requiring informed consent include information on “the possibility of increased risk of breast cancer following an induced abortion and the natural protective effect of a completed pregnancy in avoiding breast cancer.”).

175. Teddy Wilson, *Texas Government Pamphlet Rife With Debunked Anti-Choice Myths*, REWIRE (Dec. 6, 2016, 3:28 PM), <https://rewire.news/article/2016/12/06/texas-government-pamphlet-rife-debunked-anti-choice-myths/> [<https://perma.cc/Y4CR-S3EF>] (describing Texas’ “A Woman’s Right to Know” packet which is “filled with medically dubious claims about abortion care, including discredited information linking abortion to cancer”); Joyce Arthur, *How Deeply Flawed Studies on Abortion and Breast Cancer Become Anti-Choice Fodder*, REWIRE (Jan. 9, 2014, 9:51 AM), <https://rewire.news/article/2014/01/09/how-deeply-flawed-studies-on-abortion-and-breast-cancer-become-anti-choice-fodder/> [<https://perma.cc/XJN8-HK8J>] (“[T]he study’s methodology and data appear seriously flawed, with the results likely reflected ‘recall bias.’ This would invalidate the study’s findings.”).

176. While twenty-five states require pre-abortion counseling to include information about future fertility after abortion, only four of those states (Arizona, Kansas, South Dakota, and Texas) inaccurately portray the risk. GUTTMACHER Counseling, *supra* note 137.

177. *See Vandewalker, supra* note 25, at 19 n.90 (citing several studies concluding that there is no link between breast cancer and abortion).

178. *Abortion and Breast Cancer Risk*, AM. CANCER SOC’Y (June 19, 2014), <http://www.cancer.org/cancer/breastcancer/moreinformation/is-abortion-linked-to-breast-cancer> [<https://perma.cc/5YV7-RJ6H>].

179. *Id.*

180. *Id.* (citing *Abortion, Miscarriage, and Breast Cancer Risk: 2003 Workshop*, NAT’L CANCER INST. (Jan. 12, 2010), <https://www.cancer.gov/types/breast/abortion-miscarriage-risk> [<https://perma.cc/49NY-K9NZ>]); *Induced Abortion and Breast Cancer Risk, Committee Opinion No. 434*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (2015), <http://www.acog.org/Resources->

Similarly, there is no empirical evidence to support informing women that abortion is linked to future fertility problems. A literature review of studies on this subject concluded that “there is no association between induced abortion and later infertility.”¹⁸¹ Specifically for the most common first trimester abortion procedure, vacuum aspiration, “[t]he overwhelming scientific consensus” is that the procedure “poses virtually no long-term risk of infertility,” or other negative reproductive health outcomes.¹⁸² While complications from abortion “may implicate future reproduction,” such complications are rare, particularly when abortions are performed at an early gestational age.¹⁸³

Based on these conclusions, informed consent laws linking abortion with negative health outcomes like breast cancer and infertility are unconstitutional under *Whole Woman’s Health’s* evidence-based standard. One particularly ripe target for challenge is Texas’ “A Woman’s Right to Know” packet, which women in the state must receive twenty-four hours prior to an abortion being performed.¹⁸⁴ After the state published the packet online, it immediately came under fire for its fear-inducing and misleading claims, particularly those linking breast cancer and abortion.¹⁸⁵

3. Factually Dubious Claims about Abortion in Informed Consent

Finally, some states require women be provided with information that is factually disputed or flatly incorrect. The most common of these provisions are “fetal pain laws,” which require physicians to tell a woman that her fetus will experience pain from her abortion.¹⁸⁶ Because the vast majority of abortions occur in the first trimester, this information is inaccurate with respect to most abortion

And-Publications/Committee-Opinions/Committee-on-Gynecologic-Practice/Induced-Abortion-and-Breast-Cancer-Risk [https://perma.cc/26BM-E596]; Sandhya Somashekhar, *Texas Tells Women Abortion Might Cause Cancer. Science Says Otherwise.*, WASH. POST (Dec. 6, 2016), https://www.washingtonpost.com/news/post-nation/wp/2016/12/06/texas-tells-women-abortion-might-cause-cancer-science-says-otherwise/?utm_campaign=FB&utm_medium=urlshortener&utm_source=nar.al&utm_term=.59a184bc2aba [https://perma.cc/5BNY-X8FT].

181. Vandewalker, *supra* note 25, at 14 (citing Hani K. Atrash & Carol J. Rowland Hogue, *The Effect of Pregnancy Termination on Future Reproduction*, 4 BALLIÈRE’S CLINICAL OBSTETRICS & GYNECOLOGY 391, 392 (1990)).

182. Rachel Benson Gold & Elizabeth Nash, *State Abortion Counseling Policies and the Fundamental Principles of Informed Consent*, 10 GUTTMACHER POL’Y REV. 6, 11 (2007).

183. Vandewalker, *supra* note 25, at 14.

184. TEX. HEALTH & HUM. SERVS., A WOMAN’S RIGHT TO KNOW (2016), https://dshs.texas.gov/wrtk/pdf/16D0145_HHSC---COM---A-Woman-s-Right-to-Know-Accessible-FINAL.pdf [https://perma.cc/BAX8-Q495].

185. Teddy Wilson, *Texas Anti-Choice Advocates Push Back Against State’s Anti-Choice Pamphlet*, REWIRE (July 29, 2016, 2:09 PM), https://rewire.news/article/2016/07/29/texas-advocates-push-back-states-anti-choice-pamphlet/ [https://perma.cc/8GE8-X3YG]; see also Wilson, *supra* note 175; Somashekhar, *supra* note 180.

186. Thirteen states require physicians tell women about the ability of the fetus to feel pain, Alaska, Arkansas, Georgia, Indiana, Kansas, Louisiana, Minnesota, Missouri, Oklahoma, South Dakota, Texas, and Utah. GUTTMACHER Counseling, *supra* note 137.

patients, but states frequently do not limit this instruction to situations in which it may possibly be accurate.¹⁸⁷

The statement that fetuses can experience pain is based on scientific studies indicating that the neural pathways which allow fully developed humans to experience pain form in the fetus as early as the twentieth week of pregnancy.¹⁸⁸ However, other studies suggest that these pathways form as late in the pregnancy as thirty weeks.¹⁸⁹ Additionally, other scientists argue that the formation of these structures alone is not enough to suggest that pain can be experienced.¹⁹⁰ According to a literature review of studies on this subject published in the *Journal of the American Medical Association*, there is “limited” evidence that fetuses have the capacity to feel pain, and it is “unlikely before the third trimester.”¹⁹¹

While scientists may be in dispute about the later stages of pregnancy, it is clear that information about fetal pain is not factually supported prior to twenty weeks of pregnancy. Thus, requiring that informed consent laws include information about fetal pain will likely violate the *Whole Woman’s Health* evidence-based standard as applied to the vast majority of abortion patients. In addition, laws requiring doctors to administer anesthesia in order to perform abortions after 20 weeks, such as the law passed in Utah in 2016, may be ripe for challenge for lack of medical or factual support.¹⁹²

V.

MEDICATION ABORTION: CHALLENGING ABORTION EXCEPTIONALISM IN THE REGULATION OF ABORTION MEDICATION

A. Introduction to Medication Abortion

Medication abortion is usually performed via the prescription of two

187. See Vandewalker, *supra* note 25, at 21–24.

188. *Id.* at 23.

189. *Id.* (citing Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111, 143–48 (2008)).

190. See *id.* at 23–24; see also Adrian R. Lloyd-Thomas & Maria Fitzgerald, *For Debate: Reflex Responses Do Not Necessarily Signify Pain*, 313 BMJ 797, 798 (1996).

191. Susan J. Lee, Henry J. Peter Ralston, Eleanor A. Drey, John Colin Partridge & Mark A. Rosen, *Fetal Pain: A Systematic Multidisciplinary Review of the Evidence*, 295 JAMA 947, 947 (2005).

192. S.B. 234, Gen. Sess. (Utah 2016); Ashley Fantz, *Utah Passes ‘Fetal Pain’ Abortion Law Requiring Anesthesia*, CNN (Mar. 29, 2016, 3:24 PM), <http://www.cnn.com/2016/03/29/health/utah-abortion-law-fetal-pain/> [<https://perma.cc/3A6C-LFM6>] (“Experts in the medical community and abortion rights activists blasted the measure, saying it will interfere with the relationship between a physician and a patient and promotes the medically unproven theory about fetal pain.”); Samantha Allen, *Utah’s Pseudoscientific Anti-Abortion Law Could Actually Kill Women*, THE DAILY BEAST (Mar. 29, 2016, 3:15 PM), <http://www.thedailybeast.com/articles/2016/03/29/utah-s-pseudoscientific-anti-abortion-law-could-actually-kill-women.html> [<https://perma.cc/JE36-JTXE>] (“[F]etal anesthesia can pose a danger to patients and should only be provided if women understand the risks.”).

medications, mifepristone and misoprostol.¹⁹³ Mifepristone, which is commonly referred to by its trade name, Mifeprex, functions by blocking the hormone progesterone, without which a pregnancy cannot continue.¹⁹⁴ Six to forty-eight hours after taking mifepristone, a woman takes the second medication, misoprostol, which causes contractions and expels the contents of the woman's uterus.¹⁹⁵ It is worth noting that even when abortion medications are administered by a physician or in a clinic, the actual abortion will take place several hours later; according to the Mifeprex label, "most women will expel the pregnancy within 2 to 24 hours of taking misoprostol," the second medication.¹⁹⁶

While misoprostol has been used for years to complete spontaneous miscarriage or induce labor,¹⁹⁷ its pairing with mifepristone was revolutionary for abortion care. When Mifeprex, also known as RU-486, was first approved by the FDA in 2000, it was heralded as "the little white bombshell" that "may well reconfigure the politics and perception of abortion."¹⁹⁸ Activists hoped that the option for women to be prescribed a pill and have an abortion in the privacy of their own homes would reduce the ability of states to block access to abortion care. It was believed that the drug would be particularly beneficial for women living in rural areas, who often lack access to a physician of any kind, particularly one who is willing to perform an abortion.¹⁹⁹

Since its approval by the FDA, Mifeprex has largely changed the way in which abortion care is delivered, and medication abortions are now nearly as

193. *The Abortion Pill*, PLANNED PARENTHOOD (2016), <https://www.plannedparenthood.org/learn/abortion/the-abortion-pill> [<https://perma.cc/UN4W-38QW>].

194. *Questions and Answers on Mifeprex*, U.S. FOOD & DRUG ADMIN. (Mar. 30, 2016), <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm492705.htm> [<https://perma.cc/KQ5G-A6GW>].

195. See PLANNED PARENTHOOD, *supra* note 193; *How to Do an Abortion with Pills (Misoprostol, Cytotec)?*, WOMEN ON WAVES (last modified Oct. 10, 2017), <http://www.womenonwaves.org/en/page/702/how-to-do-an-abortion-with-pills—misoprostol—cytotec> [<https://perma.cc/DED7-L6BD>]. Women on Waves is an organization which sends abortion medication to women who live in countries where abortion is illegal.

196. *Mifeprex (Mifepristone) Tablets Label*, U.S. FOOD & DRUG ADMIN. 3 (Mar. 2016), https://www.accessdata.fda.gov/drugsatfda_docs/label/2016/020687s020lbl.pdf [<https://perma.cc/63QH-Z4GP>].

197. Shereen Chen-See, *Misoprostol: A Safe and Effective Way to Manage Miscarriage*, ABOUT KIDS HEALTH (May 14, 2010), <http://www.aboutkidshealth.ca/En/News/NewsAndFeatures/Pages/Misoprostol-a-safe-and-effective-way-to-manage-miscarriage.aspx> [<https://perma.cc/U9UA-AHHZ>] (discussing Jun Zhang, Jerry M. Gilles, Kurt Barnhart, Mitchell D. Creinin, Carolyn Westhoff & Margaret M. Frederick, *Management of Early Pregnancy Failure Trial. A Comparison of Medical Management with Misoprostol and Surgical Management for Early Pregnancy Failure*, 353 NEW ENG. J. MED 761 (2005)).

198. KATHA POLLITT, PRO: RECLAIMING ABORTION RIGHTS 6 (2014).

199. See *Health Disparities in Rural Women*, Committee Opinion No. 429, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (2009), <http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Health-Disparities-in-Rural-Women> [<https://perma.cc/4URC-4BWT>].

common as surgical abortions.²⁰⁰ In addition, Mifeprex and the increased use of medication abortion has been credited with the trend of abortions being performed earlier in pregnancy, thus making abortion care safer and more affordable.²⁰¹ The full potential of Mifeprex came another step closer to being realized in 2016, when the FDA updated its prescription protocol, allowing for the drug to be prescribed further into pregnancy and lowering the recommended dosage for the drug in light of information about its safety and effectiveness.²⁰² Public health experts lauded this decision, noting that the update brought the FDA protocol in line with evidence and clinical practice.²⁰³

Unfortunately, the benefit of medication abortion has been limited by several categories of state abortion regulations restricting the utilization of Mifeprex as it was originally imagined. Thirty-four states require that abortion medication only be administered by physicians.²⁰⁴ As will be discussed below, this physician-only requirement prohibits the prescription of Mifeprex by medical professionals such as physician’s assistants and nurse practitioners, both of whom are allowed to prescribe a wide range of medications, including controlled substances, in other contexts, and do so safely.²⁰⁵ Additionally, nineteen states require that the

200. Christina Cauterucci, *Pills Are Catching Up to Surgery as Most Common U.S. Abortion Method*, SLATE (Oct. 31, 2016, 1:24 PM), http://www.slate.com/blogs/xx_factor/2016/10/31/pills_are_catching_up_to_surgery_as_the_most_common_u_s_abortion_method.html?utm_source=nar.al&utm_medium=urllshortener [<https://perma.cc/Y7HB-C9JD>].

201. Rachel Jones & Heather Boonstra, *The Public Health Implications of the FDA’s Update to the Medication Abortion Label*, HEALTH AFFAIRS BLOG (June 30, 2016), <http://healthaffairs.org/blog/2016/06/30/the-public-health-implications-of-the-fdas-update-to-the-medication-abortion-label/> [<https://perma.cc/ZWU6-9U82>].

202. Sabrina Tavernise, *New F.D.A. Guidelines Ease Access to Abortion Pill*, N.Y. TIMES (Mar. 30, 2016), http://www.nytimes.com/2016/03/31/health/abortion-pill-mifeprex-ru-486-fda.html?_r=0 [<https://nyti.ms/2uKj5cQ>].

203. Jones & Boonstra, *supra* note 201; *Medication Abortion*, GUTTMACHER INST. (Dec. 1, 2016), <https://www.guttmacher.org/state-policy/explore/medication-abortion> [<https://perma.cc/Z2H6-GDEZ>] [hereinafter GUTTMACHER, *Medication Abortion*].

204. *See generally* GUTTMACHER, *Medication Abortion*, *supra* note 203; *see also, e.g.*, IND. CODE ANN. § 16-34-2-1(a)(1) (listing required circumstances for legal abortion, including that “(A) the abortion is performed by the physician”); TEX. HEALTH & SAFETY CODE § 171.063(a) (“A person may not knowingly give, sell, dispense, administer, provide, or prescribe an abortion-inducing drug to a pregnant woman for the purposes of inducing an abortion in the pregnant woman or enabling another person to induce an abortion in the pregnant woman unless: (1) the person who gives, sells, dispenses, administers, provides, or prescribes the abortion-inducing drug is a physician.”).

205. *See 12 States with Limits on Physician Assistant’s Prescribing Power*, BECKER’S HOSP. REV. (Aug. 1, 2014), <http://www.beckershospitalreview.com/hospital-physician-relationships/12-states-with-limits-on-physician-assistants-prescribing-power.html> [<https://perma.cc/HDY7-SVTA>] [hereinafter BECKER’S 2014] (describing state laws limiting the ability of physician assistants to prescribe medication and noting that “[i]n the remaining 38 states and Washington, D.C., the PA’s prescriptive power is determined by his or her supervising physician.”); Laura A. Stokowski, *APRN Prescribing Law: A State-by-State Summary*, MEDSCAPE (June 3, 2016), <http://www.medscape.com/viewarticle/440315> (providing a state-by-state summary of laws regulating the ability of nurses to prescribe medication).

physician be physically present when the medication is administered.²⁰⁶ These requirements prevent medication abortion from being prescribed remotely via telemedicine, which most directly affects women living in rural areas.²⁰⁷ Finally, three states, North Dakota,²⁰⁸ Ohio,²⁰⁹ and Texas,²¹⁰ require that Mifeprex is prescribed with strict adherence to the FDA approved label,²¹¹ despite the fact that many prescription medications are commonly prescribed “off label.”²¹² This

206. See generally GUTTMACHER, *Medication Abortion*, supra note 203; see also, e.g., IND. CODE ANN. § 16-34-2-1(a)(1) (2016) (“A physician shall examine a pregnant woman in person before prescribing or dispensing an abortion inducing drug. As used in this subdivision, ‘in person’ does not include the use of telehealth or telemedicine services.”); 63 OKLA. STAT. ANN. § 1-729a(G) (2016) (“An abortion-inducing drug must be administered in the same room and in the physical presence of the physician who prescribed, dispensed, or otherwise provided the drug to the patient.”)

207. Jones & Boonstra, supra note 201; see generally Lindsay D. Houser, *Hindering Webcam Outreach on the Women’s Healthcare Frontier: Why Abortion-Specific Restrictions on Telemedicine Are Unconstitutional*, 42 STETSON L. REV. 169 (2012) (arguing that abortion-specific restrictions on telemedicine place a substantial obstacle on the ability of rural women to access the abortion right).

208. See H.B. 1297, 66th Leg., Reg. Sess. (N.D. 2011), adding a new section, N.D.C.C. § 14-02.1-03.5(2) (“Abortion-inducing drugs”) (“It is unlawful to knowingly give, sell, dispense, administer, otherwise provide, or prescribe any abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion in that pregnant woman, or enabling another person to induce an abortion in a pregnant woman, unless the person who gives, sells, dispenses, administers, or otherwise provides or prescribes the abortion-inducing drug is a physician, and the provision of the prescription of the abortion-inducing drug satisfies the protocol tested and authorized by the federal food and drug administration and as outlined in the label for the abortion-inducing drugs.”).

209. See H.B. 126, 125th Leg., Reg. Sess. (Ohio 2004), amending R.C. 2919.123(A) (“No person shall knowingly give, sell, dispense, administer, otherwise provide, or prescribe RU-486 (mifepristone) to another for the purpose of inducing an abortion in any person or enabling the other person to induce an abortion in any person, unless the person who gives, sells, dispenses, administers, or otherwise provides or prescribes the RU-486 (mifepristone) is a physician, the physician satisfies all the criteria established by federal law that a physician must satisfy in order to provide RU-486 (mifepristone) for inducing abortions, and the physician provides the RU-486 (mifepristone) to the other person for the purpose of inducing an abortion in accordance with all provisions of federal law that govern the use of RU-486 (mifepristone) for inducing abortions.”).

210. See H.B. 2, 83rd Leg., 2nd Reg. Sess., (Tex. 2013), amending V.C.T.A., Health & Safety § 171.063 (“(a) A person may not knowingly give, sell, dispense, administer, provide, or prescribe an abortion-inducing drug to a pregnant woman for the purpose of inducing an abortion in the pregnant woman or enabling another person to induce an abortion in the pregnant woman unless . . . (2) except as provided by Subsection (b), the provision, prescription, or administration of the abortion-inducing drug satisfies the protocol tested and authorized by the United States Food and Drug Administration as outlined in the final printed label of the abortion-inducing drug. (b) A person may provide, prescribe, or administer the abortion-inducing drug in the dosage amount prescribed by the clinical management guidelines defined by the American Congress of Obstetricians and Gynecologists Practice Bulletin as those guidelines existed on January 1, 2013.”).

211. GUTTMACHER, *Medication Abortion*, supra note 203.

212. Heather D. Boonstra, *Medication Abortion Restrictions Burden Women and Providers—and Threaten U.S. Trend Toward Very Early Abortion*, 16 GUTTMACHER POLICY REV. 18, 19 (2013) [hereinafter Boonstra 2013] (“In an examination of 160 commonly used medications, 21% of prescriptions were for ‘off-label’ use—and the practice may be even more common for certain populations or for specific conditions.”) (citing David C. Radley, Stan N. Finkelstein & Randall S. Stafford, *Off-Label Prescribing Among Office-Based Physicians*, 166 ARCHIVE OF INTERNAL MED. 1021 (2006)).

leniency allows physicians to prescribe medication according to the most recent standards of practice, rather than based on rigid rules that are infrequently updated.²¹³

In light of the evidence-based standard from *Whole Woman’s Health*, limitations on medication abortion prescriptions that are not based on medical evidence must be found unconstitutional. In particular, evidence suggests that medication abortion, and even later forms of abortion, can safely be performed by non-physicians and outside of a health care facility, as will be discussed in Part VI. In addition, state requirements that require physicians to prescribe Mifeprex according to an outdated FDA protocol are not supported by sufficient evidence under *Whole Woman’s Health*.

B. Applying the Evidence-Based Standard to Medication Abortion Restrictions

1. Medication Abortion without Physicians Physically Present

Requirements that physicians prescribe or be present for the administration of medication abortion pills were purportedly passed to protect women’s health. However, this insistence is disingenuous, particularly given the safety of Mifeprex and the ability of non-physicians to prescribe medication outside the abortion context.²¹⁴ In most states, physician assistants and registered nurses are permitted to prescribe drugs that are far more dangerous than abortion medication, such as narcotics and stimulants.²¹⁵ Additionally, professional medical organizations such as the ACOG, World Health Organization (“WHO”), the American Public Health Association (“APHA”), and the American Medical Women’s Association have all argued that non-physicians, such as nurse-midwives and nurse practitioners, should be permitted to provide medication abortion pills to women.²¹⁶

Support for the safety of medication abortion without having a physician physically present can also be found in the utilization of telemedicine for other forms of medical treatment, such as in Alaska, where rural health providers send test results to doctors in large cities for diagnosis and treatment plans.²¹⁷ According to medical ethicist Arthur Caplan of the University of Pennsylvania: “No one has ever said a negative word about the merits of telemedicine until Planned Parenthood used the technology to remotely open a drawer that contained

213. *See id.* at 19 (“Moreover, it is not unusual for off-label drug use to become widely entrenched in clinical practice, with the medications in question never taken back to the FDA for revised labeling. Antidepressants, for example, have never had FDA approval as treatment for neuropathic pain, yet this class of drugs is considered a first-line treatment option.”).

214. *Id.* at 18.

215. *See* BECKER’S 2014, *supra* note 205; Stokowski, *supra* note 205.

216. Boonstra 2013, *supra* note 212, at 19–20.

217. *Id.* at 20.

abortion drugs.”²¹⁸ Further, the FDA recently approved a new study in which abortion pills will be sent by mail to women seeking abortion, showing that the organization is open to the possibility of the medication being administered outside the presence of a physician.²¹⁹

Finally, the consequences of laws limiting medication abortion clearly rebuff arguments that such laws are designed to protect women’s health. It is well documented that stigma around abortion has led to a deficit of physicians willing to provide abortions, particularly in rural states. When states mandate that abortions only be performed by physicians, it is inevitable that “a woman seeking a medication abortion may have to wait a long time for an appointment and travel long distances to visit the clinic attended by a physician. The situation is made worse by provisions that require that physician to be physically present during the procedure.”²²⁰ These delays cause women to obtain abortions later in their pregnancy, when abortion is more dangerous.

The demonstrated safety of non-physician provision of abortion medication and the fact that laws prohibiting such administration decrease women’s access to early, safe abortion provide empirical evidence that medication abortion restrictions do not actually promote women’s health. As a result, such laws are unconstitutional under *Whole Woman’s Health*. This argument was made recently in a lawsuit filed by the American Civil Liberties Union (“ACLU”) Reproductive Freedom Project and ACLU of Hawaii seeking to expand access to Mifeprex outside the presence of a physician.²²¹ In *Chelius v. Wright*, the ACLU is challenging the FDA’s application of a Risk Evaluation and Mitigation Strategy (“REMS”) to Mifeprex, which requires that abortion patients “must be handed the medication at a clinic, medical office, or hospital under the supervision of a health care provider” who must first register with drug manufacturers, stock the drug, and meet other requirements.²²² Noting that FDA REMS may be imposed “when,

218. Arthur Caplan, *Attack on ‘Telemedicine’ Is Really About Squashing Women’s Rights*, NBC (July 20, 2011, 5:13 PM), <http://www.nbcnews.com/id/43830382/ns/health/t/attack-telemedicine-really-about-squashing-womens-rights/#.WGrSaLYrI1g> [<https://perma.cc/REX8-WAEA>].

219. Phil Galewitz, *Study Tests the Safety of Women Obtaining Abortion Pills Sent by Mail*, N.Y. TIMES (Nov. 10, 2016), <https://www.nytimes.com/2016/11/11/health/abortion-study-mail.html> [<https://nyti.ms/2jD1dPr>]. It is worth noting that the study was limited to women living in Hawaii, New York, Oregon, and Washington. *Id.* Nineteen states currently have prohibitions on the use of telemedicine in abortion, making women in those states ineligible for such services. *See id.*

220. Boonstra 2013, *supra* note 212, at 21.

221. *ACLU Challenges Federal Restrictions on Abortion Pill*, ACLU (Oct. 3, 2017), <https://www.aclu.org/news/aclu-challenges-federal-restrictions-abortion-pill> [<https://perma.cc/W678-L93T>].

222. Complaint at 4, *Chelius v. Wright*, No. 1:17-cv-00492 (D. Haw. Oct. 3, 2017), 2017 WL 4401999. More specifically, the REMS at issue in this case includes “elements to assure safe usage” or “ETASU,” “the most restrictive and burdensome type of REMS.” *Id.* at 15. According to the Food and Drug Control Act, the FDA may only impose such requirements where “‘necessary to assure safe use of the drug, because of its inherent toxicity or potential harmfulness’ [21 U.S.C.] § 355-1(f)(1) [], and only if the drug is ‘associated with a serious adverse drug experience,’ *id.* § 355-1(f)(1)(A), which is defined by statute as an adverse event associated with the use of the drug that

and only when, necessary to ensure that a drug’s benefits outweigh its risks,”²²³ the ACLU points to the safety of Mifeprex to argue that “this restriction is neither motivated nor supported by science.”²²⁴

While the *Chelius* Complaint specifically emphasizes the inappropriate application of a REMS to Mifeprex, its comments about the safety of the medication provide a compelling constitutional argument against laws requiring medication abortion pills be provided to a woman in the presence of a physician. At the outset, the Complaint notes that *Whole Woman’s Health* held that “an abortion restriction purportedly designed to protect patient health and safety must actually do so, and the medical benefit must outweigh the burden on patient access, or else the law is constitutionally invalid.”²²⁵ Ultimately, the ACLU argues that because the FDA protocol fails to satisfy this standard, it violates “patients’ right to liberty and privacy as guaranteed by the due process clause of the Fifth Amendment to the U.S. Constitution by imposing significant burdens on abortion access that are not justified by the law’s purported benefits, thereby imposing an undue burden on a woman’s right to abortion.”²²⁶

In support of this argument, the Complaint details conclusions of the medication’s safety, including by the FDA itself: “By the FDA’s own admission, major adverse events associated with Mifeprex are ‘exceedingly rare, generally far below 0.1% for any individual adverse event.’”²²⁷ In addition, the Complaint cites a letter from advocates such as ACOG, the American Public Health Association, the National Abortion Federation, and other medical professionals calling to end the Mifeprex REMs and allow its administration through retail pharmacies.²²⁸

In addition to demonstrating that the FDA rule is not justified by health outcomes, the Complaint also points out how requiring the provision of Mifeprex in the presence of a physician actually causes negative health implications by

results in death, the immediate risk of death, inpatient hospitalization, a persistent or significant incapacity or substantial disruption of the ability to conduct normal life function, a congenital anomaly or birth defect, or a medical or surgical intervention to prevent these outcomes, *id.* § 355-1(b)(4).” *Id.* at 15.

223. *Id.* at 3 (citing 21 U.S.C. § 355-1(a)(1) (2013)).

224. *Id.* at 7.

225. *Id.* at 7–8.

226. *Id.* at 59–60.

227. *Id.* at 35 (quoting U.S. FOOD & DRUG ADMIN., CTR. FOR DRUG EVALUATION & RESEARCH, *020687Orig1s020, Mifeprex Medical Review(s)* 47 (Mar. 29, 2016) https://www.accessdata.fda.gov/drugsatfda_docs/nda/2016/020687Orig1s020MedR.pdf [https://perma.cc/4M4F-79L8]).

228. *Id.* at 23–34 (“The [FDA] received three letters from representatives from academia and various professional organizations including [ACOG], [APHA], the National Abortion Federation (NAF), Ibis Reproductive Health and Gynuity Health [Health Projects]. . . . The advocates also requested that any licensed healthcare provider should be able to prescribe Mifeprex and that the REMS should be modified or eliminated, to remove the Patient Agreement and eliminate the prescriber certification, while allowing Mifeprex to be dispensed through retail pharmacies.”).

delaying access to abortion to later in the pregnancy, which increases the associated risks.²²⁹

Further, the Complaint demonstrates how the FDA's purported justification for the rule is indicative of abortion exceptionalism, rather than actual concern for women's health. The Complaint notes that the exact same medication, mifepristone, "is also FDA-approved under the brand name Korlym in 300 mg tablets for daily use by patients with endogenous Cushing's syndrome to treat high blood sugar," but that Korlym "is not subject to a REMS."²³⁰ As ACLU Reproductive Freedom attorney Julia Kaye notes, "[t]he FDA's unique restrictions on medication abortion are not grounded in science—this is just abortion stigma made law."²³¹ In addition, the Complaint describes several drugs which are more likely to cause adverse health outcomes than mifepristone—including Viagra—but which nonetheless are not subject to comparably strict FDA requirements.²³²

2. Laws Requiring Adherence to Outdated FDA Protocols

Because the FDA recently updated its recommended protocol for prescribing Mifeprex, the requirements in North Dakota,²³³ Ohio,²³⁴ and Texas²³⁵ that the drug be prescribed according to FDA protocols do not currently pose a risk to women's health. However, the state laws "do not allow for additional improvements in practice if further advances are made to the medication abortion regimen."²³⁶ As a result, women in these states will not benefit from future developments on the safest and most effective ways to prescribe Mifeprex. For example, there is some evidence that abortion medication can be used to facilitate some second trimester abortion procedures.²³⁷ States with laws requiring adherence to FDA protocols will not be able to benefit from such advances in medical knowledge, and women in those states will be prescribed medication under older standards of practice, which could cause harm to women seeking abortion.

The fact that adherence to outdated FDA protocols causes harm was clearly

229. *Id.* at 52.

230. *Id.* at 18.

231. *ACLU Challenges Federal Restrictions on Abortion Pill*, *supra* note 221.

232. Complaint, *supra* note 222, at 38 ("By contrast [to mifepristone's] fatality rate of 0.00068%, the fatality rate associated with phosphodiesterase type 5 inhibitors for the treatment of erectile dysfunction (*e.g.* Viagra), which are not subject to a REMS, is estimated at 0.0026% of users, roughly 4 times the Mifeprex-associated mortality rate.") (citing Gregory Low & Raymond A. Costabile, *10-Year Analysis of Adverse Event Reports to the Food and Drug Administration for Phosphodiesterase Type-5 Inhibitors*, 9 J. SEXUAL MED. 265, 268–69 (2012)).

233. See H.B. 1297, 66th Leg., Reg. Sess. (N.D. 2011).

234. See H.B. 126, 125th Leg., Reg. Sess. (Ohio 2004).

235. See H.B. 2, 83rd Leg., 2nd Reg. Sess. (Tex. 2013).

236. Jones & Boonstra, *supra* note 201.

237. Lynn Borgatta & Nathalie Kapp, *Clinical Guidelines. Labor Induction Abortion in the Second Trimester*, 84 CONTRACEPTION 4 (2011).

established by the effects of a 2011 Ohio state statute, which required Mifeprex be prescribed according to the FDA protocol. The law held physicians to the pill’s regime as approved in 2000, which required 600 milligrams of mifepristone followed two days later by 400 micrograms of misoprostol.²³⁸ The 2000 protocol also limited the use of Mifeprex to the first forty-nine days, or seven weeks, of pregnancy.²³⁹ (The 2016 update to the FDA protocol, which “aligned [the label] with standard medical practice, which has been proven safe and effective,”²⁴⁰ decreased the mifepristone dosage to 200 milligrams, and allowed Mifeprex to be prescribed up to 70 days into gestation.²⁴¹)

A detailed study of 2,783 women who obtained medication abortions in Ohio showed the harm of following an old protocol when new medical standards had developed.²⁴² According to the UCSF research team, women who obtained medication abortions after Ohio’s law went into effect were “three times as likely to need additional interventions to complete their abortion compared to women in the prelaw period.”²⁴³ The study’s principal author noted that the unnecessarily high dose of the medication caused almost double the amount of negative side effects, to the extent that “[w]omen got out to the parking lot, and they were vomiting and they had to come back [to the clinic] and take the dosage again.”²⁴⁴ The researchers cautioned that the updated FDA protocol may become outdated in the future, and that laws such as Ohio’s will prevent abortion providers from using the most up-to-date, evidence-based standards for Mifeprex.²⁴⁵

The medical evidence seems to clearly suggest that state laws requiring adherence to outdated FDA protocols do not further women’s health. As a result,

238. L.V. Anderson, *Medication Abortion Became Less Safe After Ohio Forced Doctors to Follow Outdated Protocol*, SLATE (Aug. 31, 2016, 12:59 PM), http://www.slate.com/blogs/xx_factor/2016/08/31/medication_abortion_became_less_safe_after_ohio_forced_doctors_to_follow.html [https://perma.cc/4Q8Z-JPLF?type=image]; see H.B. 126, 125th Leg., Reg. Sess. (Ohio 2004), amending R.C. 2919.123(A).

239. Jones & Boonstra, *supra* note 201.

240. *Id.* (citing *Medical Management of First-Trimester Abortion, Practice Bulletin No. 143*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (2014), <https://www.acog.org/~media/Practice%20Bulletins/Committee%20on%20Practice%20Bulletins%20--%20Gynecology/Public/pb143.pdf?dmc=1&ts=20140703T1932230602> [https://perma.cc/L84X-LN3X]).

241. *Mifeprex (Mifepristone) Information*, U.S. FOOD & DRUG ADMIN. (Mar. 2016), <https://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm111323.htm> [https://perma.cc/F9FG-NPX4]; Jones & Boonstra, *supra* note 201.

242. Ushma D. Upadhyay, Nicole e. Johns, Sarah L. Combellick, Julie E. Kohn, Lisa M. Keder & Sarah C. M. Roberts, *Comparison of Outcomes before and After Ohio’s Mandating Use of the FDA-Approved Protocol for Abortion: A Retrospective Cohort Study*, 13 PLOS MED. 1 (2016), <http://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1002110&type=printable> [https://perma.cc/GTK4-UEKQ].

243. Anderson, *supra* note 238.

244. *Id.* (citing Nicole Knight, *Patients “Throwing Up in the Parking Lot” Under Ohio Abortion Law*, REWIRE (Aug. 30, 2016, 2:23 PM), <https://rewire.news/article/2016/08/30/patients-throwing-parking-lot-ohio-abortion-law/> [https://perma.cc/FWF4-VGW8]).

245. *Id.*

the laws of North Dakota, Ohio, and Texas would likely fail to meet the *Whole Woman's Health* standard if they required doctors to prescribe medication abortion “on label” after medical practice had developed beyond the 2016 FDA protocol.

VI.

PHYSICIAN-ONLY REQUIREMENTS: EMPHASIZING THE SAFETY OF NON-PHYSICIAN ABORTION PROVIDERS

A. Applying the Evidence-Based Standard to Physician-Only Requirements

Recent scholarship also suggests that non-physicians can safely perform abortions later in pregnancy, such as aspiration abortions. Thus, state laws prohibiting medical professionals other than physicians from performing later abortions may not be supported by health outcomes, and therefore could be challenged under *Whole Woman's Health*. In response to concerns about the lack of abortion providers, organizations such as the ACOG,²⁴⁶ the American Public Health Association,²⁴⁷ the World Health Organization,²⁴⁸ and the National Abortion Federation²⁴⁹ have called for medical professionals, such as nurse-

246. *Abortion Training and Education, Committee Opinion No. 612*, AM. COLL. OF OBSTETRICIANS & GYNECOLOGISTS (2014, reaffirmed 2017), <https://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health-Care-for-Underserved-Women/Abortion-Training-and-Education> [<https://perma.cc/ZN7J-FCMJ>] (“Access to safe abortion hinges upon the availability of trained abortion providers. The American College of Obstetricians and Gynecologists supports education for students in health care fields as well as clinical training for residents and advanced practice clinicians in abortion care in order to increase the availability of trained abortion providers.”)

247. *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants*, Policy Statement No. 20112, AM. PUB. HEALTH ASS'N (2011), <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/28/16/00/provision-of-abortion-care-by-advanced-practice-nurses-and-physician-assistants> [<https://perma.cc/H2N7-E9YB>] (“There is evidence that with appropriate education and training, [Nurse Practitioners], [Nurse-Midwives], and [Physician Assistants] can competently provide all components of medication abortion care (pregnancy testing counseling, estimating gestational age by exam and ultrasound, medical screening, administering medications, and postabortion follow-up care) and can perform the added components of aspiration abortion (administering paracervical blocks, dilating the cervix, and evacuating or aspirating the contents of the uterus).”)

248. WHO, *Safe Abortion: Technical and Policy Guidance for Health Systems* 65 (2d ed. 2012), http://apps.who.int/iris/bitstream/10665/70914/1/9789241548434_eng.pdf?ua=1 [<https://perma.cc/3AEM-9HBW>] (“Abortion care can be safely provided by any properly trained health-care provider, including midlevel (i.e. non-physician) providers. The term ‘midlevel providers’ in the context of this document refers to a range of non-physicians clinicians (e.g. midwives, nurse practitioners, clinical officers, physician-assistants, family welfare visitors, and others) who are trained to provide basic clinical procedures related to reproductive health, including bimanual pelvic examination to determine age of pregnancy and position of the uterus, uterine sounding and other transcervical procedures, and who can be trained to provide safe abortion care.”)

249. Diana Taylor, Barbara Safriet, Grayson Dempsey, Beth Kruse & Courtney Jackson, *Providing Abortion Care: A Professional Toolkit for Nurse-Midwives, Nurse Practitioners, and*

midwives, nurse practitioners, and physician assistants to be trained to provide abortions. Even the FDA recognizes the safety and allows non-physician providers acting within their scope to dispense abortion medication.²⁵⁰ Some organizations have responded to these findings by seeking to train more abortion providers: the National Abortion Federation and Advancing New Standards in Reproductive Health, a program located at UCSF, have jointly created a toolkit to teach such professionals how they can expand their practice to include abortion care.²⁵¹ The toolkit emphasizes its evidence-based approach, and notes that when properly trained, the provision of abortion services by these clinicians results in improved patient safety, integration of abortion care into early pregnancy care, and reduced delays in obtaining abortions.²⁵²

A recently published six-year study demonstrates the safety of permitting non-physicians to perform non-medication-based abortions.²⁵³ In that study non-physician health care providers—nurse practitioners, certified nurse midwives, and physician assistants—were granted legal waivers to perform aspiration abortions in California.²⁵⁴ The study concluded that “[f]irst trimester abortions are just as safe when performed by trained nurse practitioners, physician assistants and certified nurse midwives as when conducted by physicians.”²⁵⁵ Emphasizing that minority and low-income women are more likely to obtain primary care from one of these non-physician professionals, the study’s authors concluded that allowing non-physicians to perform aspiration abortions would likely improve health outcomes for women by expanding access to abortion providers and moving abortions earlier in the pregnancy, thus “significantly decreasing the

Physician Assistants 16 (2009), http://apctoolkit.org/wp-content/themes/apctoolkit/PDFs/APCToolkit_COMPLETEBOOK.pdf [<https://perma.cc/XS4P-R92A>] [hereinafter *APC Toolkit*].

250. *Questions and Answers on Mifeprex*, *supra* note 194.

251. *APC Toolkit*, *supra* note 249, at 2.

252. *Id.* at 3 (citing *Abortion Provision in California: A Need for Expanded Access*, ADVANCING NEW STANDARDS IN REPRODUCTIVE HEALTH (2006), http://www.ansirh.org/_documents/research/pci/pci_facts10-2006.pdf [<https://perma.cc/BHM5-FLNH>]).

253. Tracy A. Weitz, Diana Taylor, Sheila Desai, Ushma D. Upadhyay, Jeff Waldman, Molly F. Battistelli & Eleanor A. Drey, *Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver*, 103 AM. J. PUB. HEALTH 454 (2013). Other states permit non-physicians to perform medication abortions, such as California. See Holly Yan, *Nurses, Other Non-Physicians Can Perform Abortions in California*, CNN (Oct. 10, 2013, 3:21 AM), <http://www.cnn.com/2013/10/10/politics/california-nurse-practitioners-abortions/> [<https://perma.cc/WA82-7D87>]. For a discussion regarding the safety of non-physician provision of medication abortion, see Part V.

254. Weitz, *supra* note 253, at 454. I adopt Dr. Weitz’s vocabulary in this context because I share her rationale: “We use the term *aspiration abortion* to refer to what is commonly called *surgical abortion* because the technique does not meet the technical definition of surgery.” *Id.*

255. Elizabeth Fernandez, *Study: Abortions Are Safe When Performed by Nurse Practitioners, Physician Assistants, Certified Nurse Midwives*, UCSF NEWS CTR. (Jan. 17, 2013), <https://www.ucsf.edu/news/2013/01/13403/study-abortion-are-safe-when-performed-nurse-practitioners-physician-assistants> [<https://perma.cc/DJC7-RQCB>].

overall risk of complications, which increases with gestational age.”²⁵⁶

In addition to the value of showing that non-physician practitioners can just as safely perform abortions, the study is ground-breaking “because it provides an example of how research can be used to answer relevant health care policy issues” says one of the co-authors, Diana Taylor, of UCSF School of Nursing.²⁵⁷ That is the goal of a recent lawsuit co-filed by the ACLU Reproductive Freedom Project and Planned Parenthood that seeks to reject the reasoning of lawmakers who claim that physician-only requirements protect women’s health.²⁵⁸ The ACLU’s Press Release about the case, *Jenkins v. Almy*, notes the significance of the study’s findings in light of the Supreme Court’s decision in *Whole Woman’s Health*, “which emphasized that states cannot burden patient access to abortion without proof of a valid medical justification.”²⁵⁹

Jenkins v. Almy challenges the state of Maine’s physician-only law which “prohibits, under threat of criminal prosecution, anyone other than a licensed physician from providing abortion services.”²⁶⁰ Much of the argument against the law’s constitutionality relies on showings that the physician-only law is “medically unjustified.”²⁶¹ The filed Complaint cites medical and public health studies spanning several decades, including the study described above, demonstrating the safety of non-physician practitioners providing both medication and aspiration abortions.²⁶² In addition, the Complaint references policy

256. Weitz, *supra* note 253, at 454, 459.

257. Fernandez, *supra* note 255.

258. *ACLU and Planned Parenthood Go on Offense in Maine*, ACLU (Sept. 20, 2017), <https://www.aclu.org/news/aclu-and-planned-parenthood-go-offense-maine> [<https://perma.cc/BRW6-5SZZ>].

259. *Id.*

260. Complaint at 2, *Jenkins v. Almy*, No. 2:17-cv-000366-NT (D. Me. Sept. 20, 2017), 2017 WL 4222679 (citing 22 M.R.S. § 1598).

261. *Id.* at 3.

262. *Id.* at 17–19 (quoting Marlene B. Goldman, Jane S. Occhiuto, Laura E. Peterson, Jane G. Zapka & R. Heather Palmer, *Physician Assistants as Providers of Surgically Induced Abortion Services*, 94 AM. J. PUB. HEALTH 1352, 1356 (2004) (concluding that advanced practice clinicians in Vermont “provided abortion services comparable in safety and efficacy to those of a physician service[]”); Shireen J. Jejeebhoy, Shveta Kalyanwala, Shuchita Mundle, Jaydeep Tank, A.J. Francis Xavier, Rajesh Kumar, Rajib Acharya & Nita Jha, *Can Nurses Perform Manual Vacuum Aspiration (MVA) as Safely and Effectively as Physicians? Evidence from India*, 84 CONTRACEPTION 615, 620 (2011) (finding aspiration abortion “can be provided with equal safety and effectiveness . . . by nurses as by physicians”); I.K. Warriner, O. Meirik, M. Hoffman, C. Morroni, J. Harries, N.T. My Huong, N. D. Vy & A. H. Seuc, *Rates of Complication in First-Trimester Manual Vacuum Aspiration Abortion Done by Doctors and Mid-Level Providers in South Africa and Vietnam: A Randomised Controlled Equivalence Trial*, 369 LANCET 1965, 1970 (2006) (“[F]irst-trimester abortions with manual vacuum aspiration are done equally safely by doctors and trained government-certified MLPs [mid-level practitioners]”); Mary Anne Freedman, David A. Jillson, Roberta R. Coffin & Lloyd F. Novick, *Comparison of Complication Rates in First Trimester Abortions Performed by Physician Assistants and Physicians*, 76 AM. J. PUB. HEALTH 550, 553 (1986) (“[T]here are no differences in complication rates between those women who had abortions performed by a physician assistant and those who had the procedure performed by a physician”); H.

statements by numerous professional medical organizations in support of expanding who can provide abortions, including ACOG, the APHA, the WHO, and the FDA.²⁶³

The challenge also points out abortion exceptionalism in Maine’s laws to demonstrate that the physician-only requirement is not supported by medical evidence. The *Jenkins* Complaint highlights the inconsistency of the law with standard medical practice, pointing out that Maine “does not single out any other health care service as beyond an [advanced practice registered nurse’s] [“APRN”] scope of practice.”²⁶⁴ It also notes that such practitioners can legally perform similar tasks outside of the abortion context; in Maine, “APRNs may ‘prescribe[], administer[], dispense[], or distribute any drug that is in the Maine formulary and that is ‘related to the the[ir] specialty area of certification,’”²⁶⁵ and “are authorized to prescribe potentially dangerous and addictive substances such as oxycodone, methadone, morphine, and codeine.”²⁶⁶ In fact, APRNs are legally permitted to perform the exact same procedure as aspiration abortion when a patient is experiencing a miscarriage, but may not perform that procedure in the often safer situation of a woman seeking an abortion.²⁶⁷ The law also allows APRNs to provide the medications misoprostol and mifepristone for miscarriage treatment, but not to induce abortion.²⁶⁸ The *Jenkins* Complaint utilizes both studies and evidence of abortion exceptionalism to show that the purpose is not medically

Kopp Kallner, R. Gomperts, E. Salomonsson, M. Johansson, L. Marions & K. Gemzell-Danielsson, *The Efficacy, Safety and Acceptability of Medical Termination of Pregnancy Provided By Standard Care by Doctors or By Nurse-Midwives: A Randomised Equivalence Trial*, 122 BRIT. J. OBSTETRICS & GYNECOLOGY 510, 515 (2014) (showing “the superior efficacy of nurse-midwife provision of early medical [termination of pregnancy] in health women, when compared with standard doctor provision.”) (citing Weitz, *supra* note 253, at 454–59; Shireen J. Jejeebhoy, Shveta Kalyanwala, Shuchita Mundle, Jaydeep Tank, A.J. Francis Xavier, Rajesh Kumar, Rajib Acharya & Nita Jha, *Feasibility of Expanding the Medication Abortion Provider Base in India to Include Ayurdic Physicians and Nurses*, 28 INT’L PERSPECTIVE ON SEXUAL & REPRODUCTIVE HEALTH 133, 139 (2012); I.K. Warriner, Duolao Wang, N.T. My Huong, Kusum Thapa, Anand Tamang, Iqbal Shah, David T. Bairs & Olav Meirik, *Can Midlevel Health-care Providers Administer Early Medical Abortion As Safely and Effectively as Doctors?*, 377 LANCET 1155, 1159–60 (2011)).

263. *Id.* at 19–21 (quoting *Abortion Training and Education*, *supra* note 246; *Provision of Abortion Care by Advanced Practice Nurses and Physician Assistants*, *supra* note 247; WHO, *Safe Abortion*, *supra* note 248; *Questions and Answers on Mifeprex*, *supra* note 194).

264. *Id.* at 2 (emphasis in original).

265. *Id.* at 12 (quoting 02-380 C.M.R. ch. 8 §§ 6(4)(C)-(D), 6(5)(B)(3), 7(1)(A)).

266. *Id.* at 12.

267. *Id.* at 15 (“Most significantly, if a patient is experiencing a miscarriage, APRNs in Maine including at PPNNE, can and do safely use vacuum aspiration to complete the miscarriage by fully evacuating the uterus (which reduces bleeding as well as the risk of infections and other complications). APRNs in Maine, including at PPNNE, also use this technique to remove any retained tissue in a patient’s uterus following an abortion. This procedure is *identical* to an aspiration abortion. Indeed, a patient experiencing a miscarriage, who may already be bleeding when she presents at the health center, faces a greater risk of complications than a patient receiving care in the controlled context of an abortion.”).

268. *Id.*

justified and thus, under the clarified standard of *Whole Woman's Health*, the law is an unconstitutional undue burden.²⁶⁹

B. Addressing Mazurek v. Armstrong

Arguments that physician-only requirements violate the undue burden standard will have to contend with the Supreme Court's 1997 opinion in *Mazurek v. Armstrong*,²⁷⁰ which upheld a Montana law limiting performance of abortion to licensed physicians. However, an argument can be made that *Whole Woman's Health*'s clarification of the standard has opened the door to a different result today. In *Mazurek*, the Ninth Circuit Court of Appeals struck down Montana's physician-only requirement after finding that the law was passed for an improper purpose.²⁷¹ Emphasizing the need to analyze the state legislature's purpose in order to determine the law's constitutionality, the court concluded that "[a] determination of purpose in the present case, then, may properly require an assessment of the totality of the circumstances surrounding the enactment of [the law], and whether that statute in fact can be regarded as serving a legitimate health function."²⁷² While this inquiry seems to be in line with what the Supreme Court would later hold to be required analysis in *Whole Woman's Health*, the Supreme Court's decision in *Mazurek* rejected this analysis, suggesting that the holding now rests on uneven footing.²⁷³ Reversing the Ninth Circuit, the Court "called into question whether an invalid purpose alone can constitute a justification for declaring a law unconstitutional."²⁷⁴ In doing so, the Court rejected arguments that "the Montana law must have had an invalid purpose because 'all health evidence contradicts the claim that there is any health basis for the law.'"²⁷⁵ The Court did so based on an understanding that *Casey* "reflect[s] the fact that the Constitution gives the States broad latitude to decide that particular functions may be performed only be licensed professionals, even if an objective assessment might suggest that those same tasks could be performed by others."²⁷⁶ However, given the discussion of health-justified abortion restrictions in *Whole Woman's Health*, the *Mazurek* decision appears to rest upon a misunderstanding of the scrutiny *Casey* requires. In fact, *Whole Woman's Health* seems to support the view put forward by Justice Stevens in his *Mazurek* dissent, in which he suggested that the lack of health benefits from the law suggested that it was passed for an

269. *Id.* at 33 ("The Act violates Plaintiffs' patients' right to liberty and privacy as guaranteed by the due process clause of the Fourteenth Amendment to the U.S. Constitution by imposing significant burdens on abortion access that are not justified by the law's purported benefits, thereby imposing an undue burden on a woman's right to decide to have an abortion.").

270. 520 U.S. 968 (1997).

271. See Hill, *supra* note 13, at 386.

272. *Armstrong v. Mazurek*, 94 F.3d 566, 567 (9th Cir. 1996).

273. Hill, *supra* note 13, at 386.

274. *Id.*

275. *Mazurek*, 520 U.S. at 973 (quoting Brief in Opposition at 7).

276. *Id.* (quoting *Planned Parenthood of Se. Penn. v. Casey*, 505 U.S. 833, 885 (1992)).

improper purpose, and thus unconstitutional.²⁷⁷

This analysis is in fact supported by Justice Thomas’ dissent in *Whole Woman’s Health*, where he emphasized that *Mazurek* may not be able to stand under the clarified standard. Justice Thomas noted that *Mazurek* “had no difficulty upholding” the Montana law “even though no legislative findings supported the law and the challengers claimed that ‘all health evidence contradict[ed] the claim that there is any health basis for the law.’”²⁷⁸ In Justice Thomas’ view, this is because *Casey* and *Gonzales* made clear that “[w]henver medical justifications for abortion restriction are debatable, that ‘provides a sufficient basis to conclude in [a] facial attack that the [law] does not impose an undue burden.’”²⁷⁹ However, in light of the *Whole Woman’s Health* decision, particularly the majority’s “refus[al] to leave disputed medical science to the legislature”²⁸⁰ and “require[ment that] laws . . . have more than a rational basis even if they do not substantially impede access to abortion,”²⁸¹ Justice Thomas believes that “the majority’s undue burden balancing approach risks ruling out even minor, previously valid infringements on access to abortion.”²⁸² In particular, Justice Thomas emphasizes that “by second-guessing medical evidence and making its own assessments of ‘quality of care’ issues . . . the majority reappoints this Court as ‘the country’s ex officio medical board with powers to disapprove medical and operative practices and standards throughout the United States.’”²⁸³

While advocates challenging physician-only requirements will have to contend with *Mazurek*’s precedent, challengers can point to Justice Thomas’ dissent to support an argument the decision relied on a misunderstanding of the undue burden standard. Now that *Whole Woman’s Health* has clarified that courts should inquire into the evidentiary support for laws regulating medical practices, challenges to the constitutionality of physician-only law could be successful despite *Mazurek*.

277. *Id.* at 979–80 (Stevens, J., dissenting) (“Today, the Court . . . concludes that the record is barren of evidence of any improper motive. As the discussion above indicates, this is not quite accurate; there is substantial evidence indicating that the sole purpose of the statute was to target a particular licensed professional. The statute removed the only physician assistant in the state who could perform abortions, yet there was no evidence that her practice posed any greater health risks than those performed by doctors with the assistance of unlicensed personnel. When only looks at the totality of circumstances surrounding the legislation, there is evidence from which one could conclude that the legislature’s predominant motive[] was to make abortions more difficult.”) (internal citations omitted).

278. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2324–25 (2016) (Thomas, J., dissenting).

279. *Id.* at 2325 (quoting *Gonzales v. Carhart*, 550 U.S. 124, 164 (2007) (alteration in *Whole Woman’s Health*)).

280. *Id.*

281. *Id.*

282. *Id.* at 2326.

283. *Id.* (quoting *Gonzales*, 550 U.S. at 164) (internal quotation marks omitted).

VII.
CONCLUSION

While *Casey* and *Gonzales* confused the standard of review for health-justified abortion restrictions, *Whole Woman's Health* made it clear that courts must evaluate the factual basis for such laws. Where empirical evidence does not support the health justification, courts must strike down the law as violating the undue burden standard. Under this evidence-based standard, states are clearly not permitted to pass laws that claim to seek to protect women's health, but actually make abortion more dangerous and difficult to access. Many existing informed consent provisions will fail this standard, as will limitations on the provision of medication abortion and who may provide abortion care. While abortion rights have been under particularly vigorous attack in recent years, the Supreme Court's most recent abortion decision is a powerful tool for advocates seeking to protect safe and legal access to abortion. By requiring that health-justified laws actually promote health outcomes, the Court rejects abortion exceptionalism and affirms that the controversial nature of abortion does not mean that women's health can be endangered—or that women's choices may be stifled under the pretext of protecting their health.