



NOTE

Taking Abortion Rights Seriously: Toward a Holistic Undue Burden Jurisprudence

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Abstract. Women's right to access abortion remains one of the most hotly contested legal issues in the United States. The current constitutional test states that an abortion regulation is unconstitutional under the Fourteenth Amendment if it imposes an "undue burden" on the right to an abortion. But determining whether a burden is undue confounds legislatures and courts alike. And scholarship on the undue burden standard has, for the most part, focused on offering critiques of the standard rather than discussing how the existing standard should be understood and applied.

This Note fills that gap. It argues, first, that the way the undue burden standard currently operates—considering each challenged provision in isolation—allows incremental encroachment on the right to access abortion. States can chip away at the right by passing regulations that individually do not impose an undue burden because the current understanding of the standard does not allow consideration of the landscape of abortion regulations in its entirety. It then proposes an alternative reading of the undue burden standard that avoids this problem: The standard should ask whether women seeking abortions face an undue burden by considering the entire regulatory regime around abortion. The standard, it argues, should compare the burdens imposed on abortion access to those imposed on other medical procedures based on analogous state interests. Deviations based on state interests unique to abortion must be assessed against that baseline. It concludes by exploring the benefits of this approach, namely, that it prevents states from chipping away incrementally at abortion rights, improves administrability of the standard, centers the rightholder in the analysis, and provides clearer rules for regulators and courts alike.

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Introduction

Since the landmark decision in *Roe v. Wade* established that the Fourteenth Amendment’s “right of personal privacy includes the abortion decision,”¹ courts and advocates have grappled with balancing women’s privacy rights and the state’s interests in women’s health and safety,² the integrity of the medical profession,³ and fetal life.⁴ Two decades later, in *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court established the standard for considering abortion regulations under the Fourteenth Amendment: whether the law imposes an “undue burden” on women seeking abortion care.⁵ But the potential power of the Supreme Court’s chosen standard, the undue burden test first announced in *Casey*, has never been fully realized.

The undue burden standard has been the subject of numerous scholarly discussions and critiques.⁶ Recent critiques generally focus on alternative constitutional arguments litigants might make beyond an undue burden challenge,⁷ potential problems with the doctrine’s foundational assumptions,⁸ and its application to particular types of abortion restrictions.⁹ But much less has been written as to how the standard should be applied—and very little that addresses the rearticulation of the standard in *Whole Woman’s Health v. Hellerstedt*.¹⁰

This Note helps fill that gap. It proposes an understanding of the undue burden standard that corrects the balance between these competing interests. On that understanding, the standard tethers abortion access to comparable

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1. 410 U.S. 113, 153-54 (1973).
 2. See, e.g., *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2309-10 (2016).
 3. See, e.g., *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (citing *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)).
 4. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 876 (1992) (opinion of O’Connor, Kennedy & Souter, JJ.).
 5. *Id.* at 874.
 6. See generally, e.g., Khiara M. Bridges, *Capturing the Judiciary: Carhart and the Undue Burden Standard*, 67 WASH. & LEE L. REV. 915 (2010); Thomas J. Molony, *Fulfilling the Promise of Roe: A Pathway for Meaningful Pre-abortion Consultation*, 65 CATH. U. L. REV. 713 (2016); Jeffrey A. Van Detta, *Constitutionalizing Roe, Casey and Carhart: A Legislative Due-Process Anti-discrimination Principle That Gives Constitutional Content to the “Undue Burden” Standard of Review Applied to Abortion Control Legislation*, 10 S. CAL. REV. L. & WOMEN’S STUD. 211 (2001); Elizabeth A. Schneider, Comment, *Workability of the Undue Burden Test*, 66 TEMP. L. REV. 1003 (1993).
 7. See, e.g., Caitlin E. Borgmann, *Abortion Exceptionalism and Undue Burden Preemption*, 71 WASH. & LEE L. REV. 1047, 1056-68 (2014) (examining other arguments sounding in equal protection and bodily integrity).
 8. See, e.g., Bridges, *supra* note 6, at 920.
 9. See, e.g., Molony, *supra* note 6, at 733-34.
 10. 136 S. Ct. 2292 (2016).

medical procedures and holistically assesses whether there is an undue burden. This approach prevents states from chipping away incrementally at abortion rights, improves administrability of the standard, centers the rightholder in the analysis, and provides clearer rules for regulators and courts alike.

This Note proceeds in three Parts. Part I explores the creation and evolution of the Supreme Court's undue burden standard in its current form. Today, the Court applies an undue burden standard that asks whether a regulation or statute, "while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman's choice."¹¹

Part II offers a critique of this understanding of the undue burden standard. Today, advocates and courts approach abortion regulations in isolation rather than considering the legal landscape of abortion restrictions holistically. This approach allows states to put downward incremental pressure on abortion access. States can chip away at the right to an abortion by passing regulations that, individually, do not impose an undue burden. Because challenges are to individual regulations, not the regulatory regime overall, this incremental approach effectively insulates the whole regime from judicial review.

Part III proposes an alternative understanding of the undue burden standard to address this problem. Instead of inquiring whether a particular provision of a statute or regulation imposes an undue burden, courts should ask whether women who seek abortions face an undue burden as compared with the burdens imposed on access to analogous medical procedures. This framework better protects the constitutional right to abortion access by fully capturing the state's interest in women's health and the integrity of the medical profession and by avoiding downward incremental pressure on abortion access. These comparisons must be based on the interests motivating the state to implement the regulatory regime. For regulatory regimes motivated by state interests not unique to abortions—women's health and the integrity of the medical profession¹²—there is no reason to treat abortion differently from these analogous medical procedures.¹³ And deviations based on the state interest unique to abortion—the asserted interest in potential life—must be

11. *Id.* at 2309 (alteration in original) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (opinion of O'Connor, Kennedy & Souter, JJ.)).

12. *See Gonzales v. Carhart*, 550 U.S. 124, 157 (2007); *see also, e.g., Whole Woman's Health*, 136 S. Ct. at 2315 ("[A]bortions taking place in an abortion facility are safe—indeed, safer than numerous procedures that take place outside hospitals and to which [the state] does not apply its surgical-center requirements.").

13. The Supreme Court has never identified a valid reason to restrict access to abortion beyond the three considerations already discussed: the health of the woman, the integrity of the medical profession, and the interest in fetal life. *See Gonzales*, 550 U.S. at 157-58 (discussing the interest in the integrity of the medical profession); *Casey*, 505 U.S. at 846 ("[T]he State has legitimate interests . . . in protecting the health of the woman and the life of the fetus that may become a child.").

assessed against the baseline of the treatment of those analogous procedures. I explore how this alternative model would operate in practice by analyzing its implications for the reasoning in *Casey* and *Whole Woman's Health*. Finally, I explain what judicial remedies under this approach would entail.

I. Overview of Abortion Jurisprudence

A. Early Development of the Doctrine

A woman's right to terminate a pregnancy has its roots in the U.S. Supreme Court's earliest cases establishing a "zone of privacy."¹⁴ Most notably, *Griswold v. Connecticut* established the right of married couples to use contraceptives.¹⁵ The Court soon extended this right to unmarried individuals in *Eisenstadt v. Baird*, and in doing so applied the right of privacy to the individual rather than to the marriage.¹⁶ This laid the groundwork for when, a year after *Eisenstadt*, the Court squarely confronted abortion in *Roe v. Wade*.¹⁷

In *Roe*, the Court struck down Texas's absolute ban on abortion, holding that it violated the Fourteenth Amendment's Due Process Clause.¹⁸ In doing so, the Court cautioned that "the right of personal privacy includes the abortion decision, but . . . this right is not unqualified."¹⁹ Under *Roe*, in the first trimester, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."²⁰ In the second trimester, the state may "regulate the abortion procedure in ways that are reasonably related to maternal health."²¹ And in the third trimester, the state may regulate or ban abortions "except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."²²

14. See, e.g., *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

15. See *id.* at 485-86 (holding that a law forbidding the use of contraceptives was "repulsive to the notions of privacy surrounding the marriage relationship").

16. 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the *individual*, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.").

17. 410 U.S. 113 (1973).

18. *Id.* at 162-66; see U.S. CONST. amend. XIV, § 1 ("No state shall . . . deprive any person of life, liberty, or property, without due process of law . . .").

19. *Roe*, 410 U.S. at 154.

20. *Id.* at 164.

21. *Id.*

22. *Id.* at 164-65; see also Borgmann, *supra* note 7, at 1054 & n.37, 1055 (discussing the standard in *Roe*); Valerie J. Pacer, Note, *Salvaging the Undue Burden Standard—Is It a Lost Cause?: The Undue Burden Standard and Fundamental Rights Analysis*, 73 WASH. U. L.Q. 295, 296-97 (1995) (same).

But this three-trimester framework did not last long. In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Court upheld *Roe*'s "essential holding" but entirely altered the *Roe* standard, replacing the trimester test with a viability framework.²³ The Court stated:

[T]he right of the woman [is] to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure.²⁴

But after fetal viability, the state has the "power to restrict abortions . . . if the law contains exceptions for pregnancies which endanger the woman's life or health."²⁵

Subsequent litigation has primarily focused on the restrictions imposed prior to viability.²⁶ In evaluating the constitutionality of these restrictions, the Court has crafted a test to determine whether a regulation imposes an "undue burden" on the right to a pre-viability abortion.²⁷ Under this rubric, the "finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."²⁸ The test thus requires consideration of two separate issues: the burden placed in the path of a woman seeking an abortion and the legitimacy of the interest asserted by the state in imposing that burden.²⁹ In evaluating this second consideration, the Court has articulated three distinct interests a state may assert in justifying an abortion restriction: protection of "the health of the woman,"³⁰ preservation of "the

23. See 505 U.S. 833, 846 (1992).

24. *Id.*

25. *Id.*; see also Alan Brownstein, *How Rights Are Infringed: The Role of Undue Burden Analysis in Constitutional Doctrine*, 45 HASTINGS L.J. 867, 879-81 (1994) (discussing the undue burden standard articulated in *Casey*).

26. See, e.g., *Isaacson v. Horne*, 716 F.3d 1213, 1217 (9th Cir. 2013) (holding unconstitutional a law that prohibited abortions after twenty weeks, "before the fetus is viable"); *McCormack v. Hiedeman*, 694 F.3d 1004, 1007, 1015-16 (9th Cir. 2012) (holding that subjecting a woman to criminal sanctions for inducing an abortion "in a manner not authorized by statute" created an undue burden on the woman's right to seek an abortion of a nonviable fetus).

27. *Casey*, 505 U.S. at 877 (opinion of O'Connor, Kennedy & Souter, JJ.).

28. *Id.*

29. See *id.* at 846 (majority opinion); see also Karen A. Jordan, *The Emerging Use of a Balancing Approach in Casey's Undue Burden Analysis*, 18 U. PA. J. CONST. L. 657, 717 (2015) (discussing the two-part balancing approach taken in *Casey*).

30. *Casey*, 505 U.S. at 846.

integrity and ethics of the medical profession,”³¹ and promotion of “the life of the fetus.”³²

Since *Casey*, the Court has continued to apply the undue burden standard. First, in *Stenberg v. Carhart*, the Court considered a law in Nebraska that banned a particular type of abortion procedure called “dilation and extraction” that the legislature titled “partial birth abortion.”³³ Applying the undue burden standard, the Court struck down the ban.³⁴ The Court observed that the ban, which applied to both pre- and post-viability abortions, lacked a maternal health exception pre-viability and thus did not adequately preserve women’s right to access pre-viability abortions,³⁵ though the Court left open the possibility that a similar ban that included such an exception might pass constitutional muster.³⁶ The analysis presented by both the parties and the Court focused exclusively on whether the Nebraska partial-birth abortion statute violated women’s right to privacy³⁷ and whether abortion providers had “safe alternatives” to the banned procedure.³⁸ The Court concluded that the law, which banned dilation and extraction procedures in all circumstances, ignored medical “uncertainty” as to whether that procedure would be necessary in some circumstances.³⁹ This, the Court determined, created a “significant health risk” that rendered the law, at least in its absolute form without a health exception, an undue burden on abortion access.⁴⁰ Notably, this analysis made no reference to any other abortion restrictions in Nebraska that might have interacted with the procedure-specific ban in creating a burden on women’s access to abortion.⁴¹

31. *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (quoting *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)).

32. *Casey*, 505 U.S. at 846.

33. *See* 530 U.S. 914, 922, 927 (2000).

34. *See id.* at 930.

35. *Id.* at 938.

36. *Id.* (“This is not to say . . . that a State is prohibited from proscribing an abortion procedure By no means must a State grant physicians ‘unfettered discretion’ in their selection of abortion methods.” (quoting *id.* at 969 (Kennedy, J., dissenting))).

37. *See id.* at 944 (majority opinion) (discussing the “constitutional problem” at issue in the case); *see also, e.g.*, Brief of Respondent at 1, *Stenberg*, 530 U.S. 914 (No. 99-830), 2000 WL 340275 (arguing that the Nebraska ban “attempts to eviscerate women’s privacy rights”).

38. *See Stenberg*, 530 U.S. at 931 (quoting Brief of Petitioners at 29, *Stenberg*, 530 U.S. 914 (No. 99-830), 2000 WL 228615).

39. *Id.* at 937.

40. *See id.* at 931-32, 937-38.

41. Both parties framed their questions presented to the Court as regarding only the procedure ban, not Nebraska’s overall abortion framework. *See* Brief of Petitioners, *footnote continued on next page*

Less than a decade later, Congress enacted a similar ban on dilation and extraction abortions nationwide in the Partial-Birth Abortion Ban Act of 2003.⁴² In analyzing the burden this law imposed, the Court in *Gonzales v. Carhart* specifically contrasted the statute at issue with the ban in *Stenberg* and approved of Congress's efforts to satisfy the Court's concerns in *Stenberg*.⁴³ And as in *Stenberg*, the *Gonzales* Court considered the question before it, taking the regulation in isolation and asking whether the specific law imposed health risks on women, not whether women actually experienced an undue burden.⁴⁴ In other words, the focus was on the impact of the statute in isolation, not on the impact felt by those affected by the regulatory scheme generally.⁴⁵

Following the Supreme Court's example, lower courts and the advocates before them have continued to analyze provisions in isolation when determining whether women face an undue burden on their access to abortion. For example, when advocates brought a class action challenging a provision of Idaho law that "ma[de] it a felony for any woman to undergo an abortion in a manner not authorized by statute,"⁴⁶ they alleged, generally, that "[w]omen residing in southeast Idaho seeking to terminate a pregnancy currently must travel outside southeast Idaho to obtain elective abortions."⁴⁷ Yet their complaint alleged not that the system overall imposed an undue burden, but rather that the discrete challenged provision imposed an undue burden.⁴⁸ Following that lead, in striking down the statute, the Ninth Circuit held that "[w]omen challenging an abortion statute must demonstrate that *the challenged abortion statute* places an 'undue burden' on a woman's ability to decide whether to terminate her pregnancy."⁴⁹ In other words, the plaintiffs asked for a granular inquiry, and that is what they received.

supra note 38, at i (framing the questions presented only in terms of the "ban on partial-birth abortion"); Brief of Respondent, *supra* note 37, at i (same).

42. Pub. L. No. 108-105, 117 Stat. 1201 (codified as amended at 18 U.S.C. § 1531 (2016)).

43. See *Gonzales v. Carhart*, 550 U.S. 124, 152-53 (2007) ("Congress, it is apparent, responded to these concerns because the Act departs in material ways from the statute in *Stenberg*").

44. See *id.* at 161.

45. The Court also clarified the third potential justification for abortion restrictions: "protecting the integrity and ethics of the medical profession." *Id.* at 157 (quoting *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)).

46. See *McCormack v. Hiedeman*, 694 F.3d 1004, 1007 (9th Cir. 2012) (citing IDAHO CODE § 18-606, *invalidated by McCormack v. Herzog*, 788 F.3d 1017 (9th Cir. 2015)).

47. Complaint ¶ 10, *McCormack v. Hiedeman*, 900 F. Supp. 2d 1128 (D. Idaho 2013) (No. 4:11-cv-00433-BLW), 2011 WL 9158041.

48. See *id.* ¶¶ 46-48 (detailing how two particular provisions unduly burdened women in southeast Idaho).

49. *McCormack*, 694 F.3d at 1015 (emphasis added) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992) (opinion of O'Connor, Kennedy & Souter, JJ.)); see also

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Similarly, when challenging a Mississippi law requiring that abortion clinics maintain hospital admitting privileges, the plaintiffs in *Jackson Women's Health Organization v. Currier* brought a challenge to *only* that provision.⁵⁰ And so the Fifth Circuit, in holding that the plaintiffs had demonstrated a likelihood of success on the merits as to the unconstitutionality of that law, held that the undue burden standard requires inquiry into whether a specific law imposes that burden.⁵¹

B. Revisiting the Undue Burden Standard: *Whole Woman's Health*

The Supreme Court again took up the issue of what constitutes an undue burden on the right to access abortion two Terms ago in *Whole Woman's Health v. Hellerstedt*.⁵² In *Whole Woman's Health*, the Court considered the constitutionality of two provisions of a Texas law known as "HB 2" mandating that abortion providers maintain "admitting privileges" at hospitals within thirty miles and that clinics meet the facility requirements required for "ambulatory surgical centers."⁵³

In striking down both restrictions, the Supreme Court breathed new life into the undue burden standard. In the proceedings below, the Fifth Circuit had articulated the test as asking whether the state law (1) has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus"⁵⁴ and (2) "is reasonably related to, or designed to further, a legitimate state interest."⁵⁵ The Supreme Court strongly rejected that articulation of the test.⁵⁶

Amended Complaint in Intervention ¶ 40, *McCormack*, 900 F. Supp. 2d 1128 (No. 4:11-cv-00433-BLW), 2012 WL 4506600 (asking the court to decide whether the individual law imposed an undue burden on women's rights).

50. See Second Amended Complaint ¶ 1, *Jackson Women's Health Org. v. Currier*, 878 F. Supp. 2d 714 (S.D. Miss. 2012) (No. 3:12-cv-00436-DPJ-FKB), 2013 WL 3482056.

51. See *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 458 (5th Cir. 2014) (declining to answer questions about other regulations "without reference to the factual context in which the regulation arose and operates").

52. 136 S. Ct. 2292 (2016).

53. *Id.* at 2300 (first quoting TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a)(1) (West 2015); and then quoting *id.* § 245.010(a)).

54. *Whole Woman's Health v. Cole*, 790 F.3d 563, 572 (5th Cir.) (per curiam) (quoting *Casey*, 505 U.S. at 877 (opinion of O'Connor, Kennedy & Souter, JJ.)), *modified*, 790 F.3d 598 (5th Cir. 2015), *rev'd sub nom.* *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

55. *Id.*

56. *Whole Woman's Health*, 136 S. Ct. at 2309-10 ("The Court of Appeals' articulation of the relevant standard is incorrect.").

With regard to the first prong, the Court emphasized that courts must “consider the burdens a law imposes on abortion access together with the benefits those laws confer”⁵⁷ and that courts “retain[] an independent constitutional duty to review factual findings where constitutional rights are at stake.”⁵⁸ In other words, a court may not simply rubber-stamp the decisions of a legislature, but instead must seriously consider whether a law imposes an undue burden on abortion access.⁵⁹

Likewise, the Court held:

[T]he second part of the [Fifth Circuit’s] test is wrong to equate the judicial review applicable to the regulation of a constitutionally protected personal liberty[, the right to abortion,] with the less strict review applicable where, for example, economic legislation is at issue. The [Fifth Circuit’s] approach simply does not match the standard that this Court laid out in *Casey*, which asks courts to consider whether any burden imposed on abortion access is “undue.”⁶⁰

The Court then proceeded to conduct an exhaustive, fact-intensive inquiry of the burdens imposed by the admitting privileges and surgical center requirements.⁶¹

In conducting this fact-intensive inquiry, the Court and the parties before it continued to emphasize the impacts of the *particular* provisions at issue rather than the body of abortion regulations as a whole.⁶² The petitioners argued that “each of the challenged requirements would impose significant obstacles on women seeking abortions.”⁶³ Indeed, both the parties and the Court considered the admitting privileges requirement and the surgical center requirement separately—not looking at whether the two challenged laws *together* might impose a greater burden on women than either of the two acting alone.⁶⁴ For instance, the Court credited the district court’s finding that attributed the closure of roughly half of Texas’s existing clinics to the admitting privileges requirement.⁶⁵ Separately, the Court relied on the parties’

57. *Id.* at 2309.

58. *Id.* at 2310 (emphasis omitted) (quoting *Gonzales v. Carhart*, 550 U.S. 124, 165 (2007)).

59. *See id.* (noting that “[u]ncritical deference to Congress’ factual findings . . . is inappropriate” (alterations in original) (quoting *Gonzales*, 550 U.S. at 166)).

60. *Id.* at 2309-10 (citation omitted).

61. *See id.* at 2310-18.

62. *See, e.g., id.* at 2310 (focusing only on “the relevant statute here”).

63. Brief for Petitioners at 49, *Whole Woman’s Health*, 136 S. Ct. 2292 (No. 15-274), 2015 WL 9592289.

64. *See, e.g., Whole Woman’s Health*, 136 S. Ct. at 2310-18; *see also* Brief for Petitioners, *supra* note 63, at 32-33; Brief for Respondents at 17-19, *Whole Woman’s Health*, 136 S. Ct. 2292 (No. 15-274), 2016 WL 344496.

65. *Whole Woman’s Health*, 136 S. Ct. at 2312.

stipulation that the ambulatory surgical center requirement would “reduce the number of abortion facilities available to seven or eight facilities” in the state.⁶⁶

Moreover, the Court and the parties assumed without question for the purpose of the litigation that the existing regulations before HB 2 did not impose an undue burden. For example, the Court balked at the fact that the “number of women of reproductive age living in a county . . . more than 150 miles from a provider increased from approximately 86,000 to 400,000 . . . and the number of women living in a county more than 200 miles from a provider from approximately 10,000 to 290,000.”⁶⁷ But in so doing, the Court tacitly assumed that the pre-HB 2 level of access—86,000 women living in a county more than 150 miles from a provider and 10,000 living more than 200 miles from a provider—was constitutionally adequate. In other words, by asking the Court to consider only the two provisions in isolation, litigants encouraged the Court to don blinders with regard to all restrictions except the two challenged provisions of HB 2. The Court thus considered only whether *those two regulations* individually imposed an undue burden, not whether women in Texas faced an undue burden from the combination of abortion regulations.

II. Critique of the Undue Burden Standard

The fundamental flaw of the undue burden standard as it is currently understood is that it views abortion regulations in isolation, which allows incremental encroachment on the right to access abortion. The standard has focused on the impact of a specific legal provision compared to what would otherwise be the status quo to determine whether that provision created an undue burden. Courts, in considering whether a law imposes an undue burden, have considered the burden the new law or provision imposes relative to the status quo before that law went into effect.⁶⁸ Indeed, even when litigants have attempted to challenge multiple regulations in the same lawsuit, they have challenged their unconstitutionality separately, and thus courts have considered their constitutionality separately.⁶⁹

66. *Id.* at 2316.

67. *See id.* at 2313 (alterations in original) (quoting the district court’s opinion).

68. *See, e.g., id.* at 2312.

69. *See, e.g.,* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 885-86 (1992) (opinion of O’Connor, Kennedy & Souter, JJ.) (assessing the constitutionality of a twenty-four-hour waiting period); *id.* at 900-01 (recordkeeping and reporting requirements); *id.* at 899-900 (parental consent provision); *id.* at 887-98 (majority opinion) (spousal notice requirement). This choice by advocates is entirely understandable. As discussed above, in *Casey*, the joint opinion held that “[a] finding of an undue burden is a shorthand for the conclusion that a state *regulation* has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.” *See id.* at 877

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Consider, for instance, the following hypothetical. In Year 0, a state has a regulatory regime under which abortion is regulated no differently than other medical procedures. Under that regime, women in the state face no undue burden. Then in Year 1, the state imposes a new, relatively minor restriction on abortion. Women in the state now face a slight barrier—say a 10% increase in the barriers they face. In Year 2, the state passes another, equally minor restriction—but now women face a barrier 20% greater than they did in Year 0. In Years 3, 4, and 5, the state continues to pass small, incremental regulations. Finally, when the burden increases to 50% relative to Year 0, a clinic or woman objects to the Year 5 regulation, claiming that it imposes an undue burden. Under the undue burden standard as it is currently articulated, the court would ask whether the Year 5 law imposes a burden compared to the previous status quo, comparing the regulation of Year 5 to the status quo of Year 4—not to the neutral state of affairs in Year 0. Because the regulation is incremental, that there is some additional burden imposed by the Year 5 regulation is not sufficient to declare the regulation unconstitutional. And even were the plaintiff to challenge the Year 4 regulation, too, it would be analyzed independently of the other restrictions. The court never compares any provision to the neutral Year 0; nor does it consider whether the combination of small restrictions in Years 1 through 5 might, in total, impose enough of a burden that the burden becomes undue even though each restriction, individually, does not. As a result, the state can continue to pass piecemeal restrictions on abortions, creating downward incremental pressure on abortion access, because none of the restrictions, standing alone, imposes an undue burden.

This precise problem occurred in *Whole Woman's Health*. There, the Court relied on the facts that “as of the time the admitting-privileges requirement began to be enforced, the number of facilities providing abortions dropped in half, from about 40 to about 20,” and “[e]ight abortion clinics closed in the months leading up to the requirement’s effective date.”⁷⁰ But this statistic ignored the web of statutory and regulatory restrictions already imposed on clinics and their patients.

(opinion of O’Connor, Kennedy & Souter, JJ.) (emphasis added). Advocates, then, are simply acting as the Court has indicated they ought to act. But emphasizing the specific statute or regulation ignores the broader picture and thus fails to truly determine whether women’s right to abortion access is burdened by the totality of the regulations.

70. See *Whole Woman's Health*, 136 S. Ct. at 2312.

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Prior to 2013, when the provisions at issue in *Whole Woman's Health* were enacted,⁷¹ Texas already had a complex scheme of abortion restrictions in place. Among other restrictions, Texas allows hospital staff to refuse to provide abortions,⁷² prevents any Medicaid funding from being used for an abortion,⁷³ mandates that abortion of a fetus at more than sixteen weeks' gestation occur in an ambulatory surgical center or hospital,⁷⁴ requires parental notice and consent or a judicial bypass for minors seeking an abortion,⁷⁵ requires doctors to present medically inaccurate information,⁷⁶ and mandates a twenty-four-hour waiting period between a patient's sonogram and her procedure.⁷⁷ Women across the country had experienced a rapid uptick in the number and severity of abortion restrictions.⁷⁸ In the late 1980s, there were 705 clinics nationwide; as a result of this trend, by 2011, the national number had dropped to 553.⁷⁹ Over the same timeframe, the population in Texas increased from approximately 17 million to approximately 26 million.⁸⁰

By the time the Supreme Court addressed the issue of abortion access in Texas, it was confronted not with the entire landscape of obstacles that stand between a Texan woman and her access to abortion, but rather with a narrow sliver of those obstacles. The Court was forced to determine whether women in Texas faced undue burdens on their right to an abortion without

71. Act of July 18, 2013, ch. 1, §§ 2, 4, 2013 Tex. Gen. Laws 5013, 5013-14, 5017 (codified as amended at TEX. HEALTH & SAFETY CODE ANN. §§ 171.0031, 245.010(a) (West 2017)), *invalidated in part by Whole Woman's Health*, 136 S. Ct. 2292; *see Whole Woman's Health*, 136 S. Ct. at 2300.

72. TEX. OCC. CODE ANN. § 103.001 (West 2017).

73. TEX. HEALTH & SAFETY CODE ANN. §§ 32.005, .015; *see Public Funding for Abortion*, ACLU, <https://perma.cc/T68V-DF6K> (archived Oct. 16, 2017).

74. TEX. HEALTH & SAFETY CODE ANN. § 171.004.

75. *See* TEX. FAM. CODE ANN. §§ 33.002, .003 (West 2017); TEX. OCC. CODE ANN. § 164.052(a)(19).

76. TEX. HEALTH & SAFETY CODE ANN. §§ 171.013-.014; *cf.* Travis M. Andrews, "Satirical" Texas Bill Turns Language of Antiabortion Laws on Men, WASH. POST (Mar. 13, 2017), <https://perma.cc/FW7C-AAZQ> (describing the booklet doctors must distribute to women seeking an abortion as "ideologically motivated and medically inaccurate" (quoting Jan Ross Piedad, *The Source Is the State's "Woman's Right to Know" Pamphlet a "Propaganda Piece?"*, TEX. PUB. RADIO (Jan. 9, 2017), <https://perma.cc/WGK4-XBXA>)). For more on the medically inaccurate nature of the required information, see notes 225-26 and accompanying text below.

77. TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4).

78. *See generally Last Five Years Account for More Than One-Quarter of All Abortion Restrictions Enacted Since Roe*, GUTTMACHER INST. (Jan. 13, 2016), <https://perma.cc/9PC7-VJKN>.

79. *See* Danielle Paquette, *Why Abortion Clinics in the U.S. Are Rapidly Closing*, WASH. POST: WONKBLOG (Feb. 25, 2016), <https://perma.cc/D6GQ-XLC5>.

80. *See United States and Texas Populations 1850-2015*, TEX. ST. LIBR. & ARCHIVES COMMISSION, <https://perma.cc/C9P3-PQVW> (last modified Feb. 8, 2017).

considering all the facts. By expressing concern about the reduction of clinics from forty to twenty, however, the Court seemingly accepted that forty clinics would have been adequate to provide abortion services for the more than 14 million women living in Texas at the time⁸¹ rather than artificially deflated by the pre-2013 landscape of regulations. Under that regime, every Texas clinic would be responsible for meeting the abortion services needs of 625,000 women—in addition to any other health services like birth control, pap smears, or cancer screenings the clinic might provide.

The impact of this approach is fourfold. First, it fails to position the right correctly, that is, it fails to center the woman's right. Second, due to methodological and quantitative challenges, changes in the abortion rate are difficult to measure. Third, and perhaps most significantly, even a 0% change in the abortion rate is not reliable evidence about whether women face an undue burden. Finally, looking at statutes in isolation allows states to incrementally chip away at the right to an abortion.

A. The Current Understanding of the Undue Burden Standard Fails to Position the Right from the Perspective of the Woman

The Supreme Court has consistently affirmed that “the Constitution protects a *woman's right* to terminate her pregnancy.”⁸² As the right belongs to the woman,⁸³ the burden should be analyzed from her perspective. From that view, whether a particular regulation alone, or the body of regulations as a whole, imposes a burden is immaterial—all that matters is that her right is unduly burdened by the laws that restrict the level of access she would otherwise enjoy. The Court has recognized “the right of the *individual* . . . to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.”⁸⁴ In other words, because the “Constitution protects individuals,”⁸⁵ the first prong of the analysis must be oriented to the individual.⁸⁶ But by emphasizing a specific

81. See *QuickFacts: Texas*, U.S. CENSUS BUREAU, <https://perma.cc/V3TP-TCW8> (archived Oct. 16, 2017) (reporting that as of July 2016, approximately 50.4% of the state's estimated population of 27,862,596 were women).

82. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 844 (1992) (emphasis added); see also *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2300, 2310-11 (2016) (reaffirming this principle).

83. See *Casey*, 505 U.S. at 851.

84. *Id.* (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)).

85. *Id.* at 896.

86. Cf. *Reynolds v. Sims*, 377 U.S. 533, 561 (1964) (holding that voting rights under the Fourteenth Amendment's Equal Protection Clause “are individual and personal in nature”); Pamela S. Karlan, *Turnout, Tenuousness, and Getting Results in Section 2 Vote* footnote continued on next page

regulation or statute, the undue burden standard as it is currently articulated by advocates and courts fails to adequately consider how the individual—and thus her right—is affected. In other words, by looking at the question from the perspective of the regulation or statute, not the woman, the undue burden standard misses the point of the individual right.

In this way, the current understanding of the undue burden standard operates in direct opposition to how constitutional rights protections often work in other areas. Frequently, “the trigger of unconstitutionality [is] retrogression.”⁸⁷ That is, protection operates as a one-way “ratchet”—allowing regulation of rights to become only more protective of those rights, not less.⁸⁸ The current interpretation of the undue burden standard turns this common principle on its head: States pass restrictions on abortion access, putting downward pressure on access to the right. Because courts never consider the overall scheme of restrictions on abortion, they not only allow for but also promote constitutional retrogression. Rather than ratcheting up protection of a right, this type of incrementalist regulation ratchets it down. By centering the analysis on a specific regulation or law, then, the Court applies the undue burden standard in a way that untethers it from its foundational moorings and theoretical center: the individual.

B. Because of Methodological and Quantitative Difficulties, Changes in the Abortion Rate Are Difficult to Measure

The current undue burden inquiry requires nearly impossible statistical gymnastics on the part of courts and advocates.⁸⁹ In making undue burden arguments, plaintiffs must present specific evidence that a *particular* law caused a decrease in access.⁹⁰ But having to prove that a specific law imposes burdens

Denial Claims, 77 OHIO ST. L.J. 763, 769-70 (2016) (discussing the individual nature of voting rights).

87. John C. Jeffries, Jr. & Daryl J. Levinson, *The Non-retrogression Principle in Constitutional Law*, 86 CALIF. L. REV. 1211, 1217 (1998).

88. *Id.* at 1212; *see also, e.g.*, *Romer v. Evans*, 517 U.S. 620, 623-24, 636 (1996) (holding that withdrawing existing legal protections for gay and lesbian individuals violated the Equal Protection Clause). *But see* Joan L. Larsen, *Importing Constitutional Norms from a “Wider Civilization”: Lawrence and the Rehnquist Court’s Use of Foreign and International Law in Domestic Constitutional Interpretation*, 65 OHIO ST. L.J. 1283, 1325-26 (2004) (exploring and critiquing the “one-way ratchet” approach to constitutional rights).

89. *See* Marshall H. Medoff, *The Response of Abortion Demand to Changes in Abortion Costs*, 87 SOC. INDICATORS RES. 329, 331-32 (2008) (noting that because of unavailability of data and differences in measurement, “causal year-to-year changes in abortion demand due to changes in state restrictive abortion laws are difficult to detect”).

90. *See, e.g.*, *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2318 (2016); *id.* at 2344 (Alito, J., dissenting); *Karlin v. Foust*, 188 F.3d 446, 487 (7th Cir. 1999); *Planned Parenthood Se., Inc. v. Strange*, 33 F. Supp. 3d 1330, 1356 (M.D. Ala. 2014); *Planned*

footnote continued on next page

is exceedingly difficult⁹¹—even if a law does itself impose enough of a burden that it, alone, unduly burdens the woman’s right, a court may not be able to find information that adequately demonstrates that burden.

This occurs for a number of reasons. First, accurate data on abortions is difficult to acquire.⁹² “It is well known that induced abortion is stigmatized and that women are reluctant to report having had one.”⁹³ Underreporting, even of legal procedures, is common.⁹⁴ Moreover, reporting rates are even lower among poor women, young women, and women of color—members of the demographics most likely to be affected by restrictions that make abortions more difficult to access.⁹⁵

In addition, there is no national reporting mechanism. Even the Centers for Disease Control and Prevention (CDC) relies on fifty-state surveys and self-reporting by clinics.⁹⁶ And it “concedes that its state abortion figures are incomplete and underreported—not all states provide figures to the CDC every year and not all abortion providers within a state report their abortion figures to their state health agencies every year.”⁹⁷ For abortions, “[u]nlike births, there is no reciprocal reporting system among state vital statistics departments.”⁹⁸ As

Parenthood of Wis., Inc. v. Van Hollen, 94 F. Supp. 3d 949, 992 (W.D. Wis. 2013), *aff’d sub nom.* Planned Parenthood of Wis., Inc. v. Schimel, 806 F.3d 908 (7th Cir. 2015); A Woman’s Choice-E. Side Women’s Clinic v. Newman, 904 F. Supp. 1434, 1458 (S.D. Ind. 1995), *certifying questions to* 671 N.E.2d 104 (Ind. 1996); Transcript of Oral Argument at 16, *Whole Woman’s Health*, 136 S. Ct. 2292 (No. 15-274).

91. Cf. Amelia Thomson-DeVeaux, *It’s Really Hard to Measure the Effects of Abortion Restrictions in Texas*, FIVETHIRTYEIGHT (Aug. 28, 2014, 8:08 AM), <https://perma.cc/6YRY-HG67>.

92. *See id.*

93. Elisabeth Ahman & Iqbal H. Shah, *Generating National Unsafe Abortion Estimates: Challenges and Choices*, in *METHODOLOGIES FOR ESTIMATING ABORTION INCIDENCE AND ABORTION-RELATED MORBIDITY: A REVIEW* 13, 13 (Susheela Singh et al. eds., 2010), <https://perma.cc/5W3K-BSQA>; accord Thomson-DeVeaux, *supra* note 91.

94. Ahman & Shah, *supra* note 93, at 13; accord Elise F. Jones & Jacqueline Darroch Forrest, *Underreporting of Abortion in Surveys of U.S. Women: 1976 to 1988*, 29 *DEMOGRAPHY* 113, 122 & tbl.5 (1992); J. Richard Udry et al., Research Note, *A Medical Record Linkage Analysis of Abortion Underreporting*, 28 *FAM. PLAN. PERSP.* 228, 230 (1996).

95. *See* Robert W. Brown et al., *Abortion Decisions Among Hispanic Women Along the Texas-Mexico Border*, 81 *SOC. SCI. Q.* 237, 250 (2000); Rachel K. Jones & Kathryn Kost, Report, *Underreporting of Induced and Spontaneous Abortion in the United States: An Analysis of the 2002 National Survey of Family Growth*, 38 *STUD. FAM. PLAN.* 187, 190-91 (2007); Udry et al., *supra* note 94, at 229.

96. *See* Karen Pazol et al., *Abortion Surveillance—United States, 2012*, *MORBIDITY & MORTALITY WKLY. REP.: SURVEILLANCE SUMMARIES*, Nov. 27, 2015, at 1, 2.

97. Medoff, *supra* note 89, at 331.

98. Silvie Colman & Ted Joyce, *Regulating Abortion: Impact on Patients and Providers in Texas*, 30 *J. POL’Y ANALYSIS & MGMT.* 775, 777 (2011).

a result, some researchers have estimated that abortion statistics actually account for as little as 35% of actual abortions.⁹⁹

More importantly for courts and litigants, changes in the data can be hard to attribute to a specific law or policy. A drop in abortion rates could mean that women are self-inducing abortions, having unlawful abortions, or seeking them out of state rather than forgoing them altogether.¹⁰⁰ Even when the abortion rate declines, it is difficult to know if that is in spite of women's need to access abortions rather than the product of other reasons—such as personal beliefs, better access to contraception, or economic changes.¹⁰¹

As a result of these methodological and quantitative challenges, changes in the abortion rate are difficult to measure.¹⁰² In particular, as restrictions make abortions more time-intensive or costly for women,¹⁰³ the disparate reporting rates between low- and higher-income women will exacerbate the inaccuracy of abortion data. Even if data could accurately capture how many medically induced abortions happen, those data would in all probability still fail to capture the total number of abortions. Research suggests that when women lack access to safe and legal abortion, they may seek to self-induce abortions.¹⁰⁴ Even where there is data, then, measurements of changes to the abortion rate are likely to be inaccurate in capturing the overall abortion rate.

99. Udry et al., *supra* note 94, at 228.

100. See Thomson-DeVeaux, *supra* note 91.

101. See *id.* (“Is it possible that some of those remaining women are self-inducing? Is it possible that they're continuing with their pregnancy? We don't know” (quoting Ted Joyce, Professor of Economics at the City University of New York)).

102. Medoff, *supra* note 89, at 331-32 (critiquing existing data that attempt to quantify changes in the abortion rate).

103. See, e.g., Caitlin Gerds et al., *Impact of Clinic Closures on Women Obtaining Abortion Services After Implementation of a Restrictive Law in Texas*, 106 AM. J. PUB. HEALTH 857, 863 (2016); see also Brown et al., *supra* note 95, at 239-40; Jones & Kost, *supra* note 95, at 191 & tbl.2 (comparing the rates of abortion procedures across different groups).

104. See D. Grossman et al., *Tex. Policy Evaluation Project, Univ. of Tex. at Austin, Knowledge, Opinion and Experience Related to Abortion Self-Induction in Texas 2* (2015), <https://perma.cc/VAQ2-GW8L> (finding that women who “had ever found it difficult to obtain reproductive health services” were more likely to attempt abortion self-induction); see also Seth Stephens-Davidowitz, *The Return of the D.I.Y. Abortion*, N.Y. TIMES (Mar. 5, 2016), <https://perma.cc/VY6S-AJ9E> (“Eight of the 10 states with the highest search rates for self-induced abortions are considered by the Guttmacher Institute to be hostile or very hostile to abortion.”).

C. Even When Changes in the Abortion Rate Can Be Measured, Such Changes Are Not Reliable Metrics for Whether Women Face an Undue Burden in Accessing Abortion Care

There is another fundamental problem with the abortion rate: Women who have and report abortions may simply have overcome barriers to access. This disconnect between the questions courts seek to address and the data they look to is not unique to abortion rights. For example, as Pamela Karlan has argued in the voting rights context, whether the right to vote has been burdened may not be determined based solely on aggregate turnout figures because the voter’s “right to vote may have been abridged if she gets [to the polls] only after overcoming new or different burdens.”¹⁰⁵ That is, if a voter struggled but was ultimately able to take time off from work and get to a polling place on voting day after a state closed down Sunday voting, the fact that the burden did not entirely prevent her from exercising her right to vote is not dispositive as to the question whether she was burdened.¹⁰⁶ So too with abortion rights: Evidence that women were ultimately able to obtain an abortion is not dispositive as to whether they had to overcome undue burdens to do so.

This statistical uncertainty affects not only how individuals’ decisions are assessed under the undue burden standard but also how the effects of a law on the operation of abortion clinics are considered. During oral argument for *Whole Woman’s Health*, Justice Alito repeatedly pressed the petitioners’ counsel for “direct” or “specific” evidence that “particular clinics” were forced to close because of the challenged law.¹⁰⁷ In response, Justice Kagan pointed to the fact that when preliminary injunctions were imposed, the clinics opened, and when the law was in effect, the clinics closed, concluding: “It’s almost like the perfect controlled experiment as to the effect of the law, isn’t it? It’s like you put the law into effect, 12 clinics closed.”¹⁰⁸ And clinic closures ultimately featured prominently in the Court’s reasoning that the law imposed an undue burden.¹⁰⁹

But *Whole Woman’s Health* was the exception, not the rule. Mimicking a “perfect controlled experiment” is nearly impossible when challenging an existing regulation—without a new law’s passage and the immediately observable follow-on effects, what individual effect any given provision may have had is difficult to measure.¹¹⁰ And when new restrictions are enacted

105. Karlan, *supra* note 86, at 774.

106. *See id.* at 773-74.

107. Transcript of Oral Argument, *supra* note 90, at 5, 12-13.

108. *See id.* at 14.

109. *See Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2312 (2016).

110. *Cf. Thomson-DeVeaux, supra* note 91.

together or in quick succession, disentangling which regulation was the final straw in a clinic closing or in a woman facing a substantial obstacle can be difficult or impossible. In any case, trying to identify which particular law caused a restriction in access entirely misses the point—if access is restricted and an undue burden is imposed, the Due Process Clause is violated, regardless whether that violation is the result of one particular law or of several laws in combination.

D. By Considering Each Restriction Individually, the Undue Burden Standard Allows States to Incrementally Decrease Abortion Access

Because the undue burden standard does not allow consideration of the totality of the regulatory scheme, the burden the whole system imposes is shielded from judicial review.¹¹¹ Under the current undue burden rubric, states can enact abortion restrictions piecemeal, safe in the knowledge that any challenges to their abortion regime will be made and reviewed individually, rather than by looking at the whole picture of abortion regulations. In other words, because courts never step back and take stock of the broader picture, states can do in pieces what they could not do in one fell swoop.

Many states now have extensive abortion regulations¹¹² that, when taken together, impose just the types of burdens that concerned the Court in cases like *Casey* and *Whole Woman's Health*. When a court looks to see if there is an undue burden on women, it looks to whether the particular challenged law unduly burdens women, not whether, cumulatively, the body of laws unduly burdens women.¹¹³ In other words, the court focuses on the burden each regulation creates, not the burden women actually experience. As a result, the approach takes for granted the constitutionality of the prior status quo—accepting the general landscape of a state's abortion regulations uncritically when asking whether a specific provision violates the Fourteenth Amendment.¹¹⁴ Thus, if a state can pass laws that *individually* do not burden the right to an abortion, that state can insulate from judicial scrutiny the burden its body

111. See *supra* notes 62-69 and accompanying text; see also Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1706 (2008) (arguing that the Supreme Court's abortion jurisprudence "uphold[s] incrementalist regulation enacted for fetal-protective purposes").

112. See, e.g., N.C. GEN. STAT. § 14-45.1 (2017); UTAH ADMIN. CODE r. 432-600 (2017). See generally *An Overview of Abortion Laws*, GUTTMACHER INST., <https://perma.cc/75ZW-F5FA> (last updated Oct. 1, 2017).

113. See *supra* notes 62-69 and accompanying text.

114. See, e.g., *Whole Woman's Health*, 136 S. Ct. at 2312-13; see also *supra* notes 70-81 and accompanying text (explaining the Court's approach to pre-2013 abortion access in Texas).

of laws *as a whole* might impose.¹¹⁵ And in allowing this, the current understanding of the undue burden standard undermines its entire purpose: to protect women’s right to abortion access.

III. An Alternative Approach to Evaluating Undue Burdens

Because of the serious flaw with the current articulation of the undue burden standard discussed in Part II above, the standard is not meeting its goal of protecting the “right recognized by *Roe* . . . ‘to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.’”¹¹⁶ But that is not necessarily a reason to condemn the undue burden standard entirely. It has the potential to live up to its constitutional intentions—so long as its application is modified.

In this Part, I propose such a modification. First, I describe my proposed alternative approach to the undue burden standard. Second, in order to elucidate how this approach would function, I explore how this approach would alter the analyses in *Casey* and *Whole Woman’s Health*. Third, I respond to the strongest potential counterarguments and explain how violations might be remedied under my approach.

A. Alternative Model

The undue burden standard should be reconceptualized in two ways. It should compare the abortion regulation regime against the fixed goalpost of regulations on comparable medical procedures to prevent incremental encroachment on women’s right to access abortion. Additionally, it should consider abortion regulations holistically, not individually. That is, in determining whether an abortion-regulating legal regime is constitutional, courts should compare it to the regime designed to regulate other medical procedures. If a court finds that the regime regulating abortion is significantly more burdensome than that regulating similar procedures that operate with similar goals, then the law is unduly burdensome and therefore unconstitutional.

115. This approach to the undue burden standard also has the potential to chill litigation. Pro-choice advocates might decide not to pursue challenges to abortion restrictions even in situations where there is strong evidence that the right is unduly burdened because they know that any one law in isolation is unlikely to have created that undue burden.

116. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 875 (1992) (opinion of O’Connor, Kennedy & Souter, JJ.) (quoting *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972)).

1. Comparing abortion regulatory regimes to analogous medical procedures

A comparative benchmark already lurks within the Supreme Court’s abortion jurisprudence: other medical procedures with analogous underlying state interests. In *Roe*, the Court held that “the abortion decision in all its aspects is inherently, and primarily, a medical decision.”¹¹⁷ In *Casey*, it repeatedly compared abortion to general medical procedures.¹¹⁸ In *Gonzales*, the Court compared restrictions on specific abortion procedures to the restrictions on abortions performed via hysterotomies.¹¹⁹ And in *Whole Woman’s Health*, it further “recognize[d] that the ‘State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient.’”¹²⁰ Thus, the natural analogy—and the baseline against which abortion restrictions ought be measured—is any other medical procedure with comparable underlying state interests in women’s health and the integrity of the medical profession.¹²¹

The Court gestured in the direction of this approach more explicitly in *Whole Woman’s Health*. There, the Court weighed the following facts:

The total number of deaths in Texas from abortions was five in the period from 2001 to 2012, or about one every two years . . . Nationwide, childbirth is 14 times more likely than abortion to result in death, but Texas law allows a midwife to oversee childbirth in the patient’s own home. Colonoscopy, a procedure that typically takes place outside a hospital (or surgical center) setting, has a mortality rate 10 times higher than an abortion. . . . [T]he mortality rate for liposuction, another outpatient procedure, is 28 times higher than the mortality rate for abortion[.]¹²²

If abortion truly is a “medical decision,” as the Court has repeatedly stressed, then determining whether it is being treated like one is a fair baseline for assessing whether the state is imposing an undue burden.

As explained in Part I above, there are three species of interests that states assert when regulating abortion: “the health of the woman,”¹²³ “the integrity

117. *Roe v. Wade*, 410 U.S. 113, 166 (1973).

118. See 505 U.S. at 884 (opinion of O’Connor, Kennedy & Souter, JJ.); *id.* at 917, 921 (Stevens, J., concurring in part and dissenting in part).

119. *Gonzales v. Carhart*, 550 U.S. 124, 147 (2007).

120. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016) (emphasis added) (quoting *Roe*, 410 U.S. at 150).

121. See *infra* Part III.B (demonstrating how to compare abortion regulations against these baseline medical procedures).

122. 136 S. Ct. at 2315 (citation omitted).

123. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992).

and ethics of the medical profession,”¹²⁴ and “the life of the fetus.”¹²⁵ For the first two interests, the state’s interest in regulating abortion is identical to its interest in regulating other procedures because nonabortive medical procedures may endanger women’s health and any dangerous or slipshod procedures may undermine the integrity of the medical profession. The third is discussed further below.

The interest in women’s health falls into one of two categories. First, the concern might be with the abortion procedures’ risks of morbidity and mortality.¹²⁶ Second, the state might worry about the psychological impacts of having an abortion; that is, that women will regret their decisions or that their decisions will change their lives in some deep and harmful way.¹²⁷ Neither of these concerns is specific to abortion, as most medical procedures come with some risk of complications that could lead to morbidity or mortality,¹²⁸ and many other procedures—like cosmetic surgery, vasectomies, and mastectomies—carry a risk that the patient will regret the procedure.¹²⁹

Because the state’s interest in women’s health really captures two types of interests—physical and psychological—I do not go so far as to propose an across-the-board benchmark procedure for all cases. But while abortion procedures vary depending on the stage of pregnancy and the needs of the woman,¹³⁰ abortion generally has a rate of decisional regret lower than or comparable to that of many other procedures: One study put the regret rate for abortions around 5%,¹³¹ whereas, for instance, 6-7% of people regret their

124. See *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (quoting *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)).

125. See *id.* at 158.

126. See, e.g., *Whole Woman’s Health*, 136 S. Ct. at 2315 (discussing the mortality rate associated with abortion).

127. See, e.g., *Gonzales*, 550 U.S. at 159 (“While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained.”). *But cf.* Siegel, *supra* note 111, at 1773-80 (arguing that women-protective rationales for restricting abortion access are paternalistic).

128. See generally *Death Rate from Complications of Medical and Surgical Care Among Adults Aged ≥ 45 Years, by Age Group—United States, 1999-2009*, 61 MORBIDITY & MORTALITY WKLY. REP. 750, 750 (2012) (showing ten years’ worth of data on death rates from “complications of medical and surgical care”).

129. See, e.g., Sandi Berwick & Áine Humble, *Older Women’s Negative Psychological and Physical Experiences with Injectable Cosmetic Treatments to the Face*, 29 J. WOMEN & AGING 51, 51 (2011); *infra* notes 132-34 and accompanying text.

130. See *In-Clinic Abortion*, PLANNED PARENTHOOD, <https://perma.cc/SU2U-W7PZ> (archived Oct. 18, 2017) (detailing several types of in-clinic abortion procedures and explaining that which is preferable “depend[s] on how far [the woman is] into [her] pregnancy”).

131. See, e.g., Corinne H. Rocca et al., *Decision Rightness and Emotional Responses to Abortion in the United States: A Longitudinal Study*, PLOS ONE 7 (July 8, 2015), <https://perma.cc>
footnote continued on next page

sterilizations,¹³² 19% regret prostate surgery,¹³³ and a whopping 42.5% of young breast cancer survivors regret some aspect of their treatment.¹³⁴ When a government justifies abortion regulations on the ground that all or some are intended to prevent women from regretting their decisions,¹³⁵ the burdens imposed on abortion ought be compared with those imposed on other procedures that also carry a risk of regret. So too when the government is primarily concerned with encouraging women to take the time to make an informed decision about what it considers to be a life-changing choice.¹³⁶ When the government asserts a concern that women will regret their decisions, the relevant benchmarks are other procedures with similar rates of regret and other life-changing choices a person can make, like marriage, career changes, or decisions about where or when to move.¹³⁷ The question should be what, if any, barriers a government places on the ability of individuals to make other life-changing decisions in comparison to those placed on abortion.¹³⁸ In

/LX2C-H5HA (“[A]pproximately 95% of women . . . reported that having the abortion was the right decision for them.”).

132. See D. Hollander, Digest, *Five Years After Their Own or Their Husband’s Sterilization, Few Women Regret the Decision*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 265, 265 (2002) (“Within five years after their husbands’ vasectomy, 6% of women indicated that it was not a good choice; essentially the same proportion of sterilized women (7%) expressed regret within five years after undergoing tubal occlusion.”).
133. See Tara Parker-Pope, *Regrets After Prostate Surgery*, N.Y. TIMES: WELL BLOG (Aug. 27, 2008, 9:26 AM), <https://perma.cc/PK5A-U3BA> (citing Florian R. Schroeck et al., *Satisfaction and Regret After Open Retropubic or Robot-Assisted Laparoscopic Prostatectomy*, 54 EUR. UROLOGY 785 (2008)).
134. See Sara Fernandes-Taylor & Joan R. Bloom, *Post-treatment Regret Among Young Breast Cancer Survivors*, 20 PSYCHO-ONCOLOGY 506, 511 tbl.3 (2011).
135. See, e.g., *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) (noting that the Partial-Birth Abortion Ban Act recognizes the “reality” that some women come to regret their abortions); Brief Amicus Curiae of the Family Research Council and Focus on the Family in Support of the Petitioner at 28, *Gonzales*, 550 U.S. 124 (No. 05-380), 2006 WL 1436686 (arguing that women who have abortions suffer “emotional and psychological trauma” and “regrets”).
136. See generally Siegel, *supra* note 111, at 1756-58 (discussing principles of informed consent in the abortion regulation context).
137. This is not to say that abortion has the same regret rate as moving, marriage, or career changes. Rather, I offer these examples of courses of conduct that may carry a risk of decisional regret.
138. For example, different states have enacted into law different judgments about the age after which, and the ease with which, men and women may get married with or without parental consent. Compare, e.g., ARK. CODE ANN. § 9-11-102 (2017) (setting a minimum age of seventeen for men and sixteen for women, with parental consent required for anyone under eighteen, and imposing a five-day waiting period on any pre-eighteen marriage license), with, e.g., MISS. CODE ANN. § 93-1-5 (2017) (setting a minimum age of seventeen for men and fifteen for women, with parental consent required for anyone under twenty-one).

the context of the government's asserted interest in preventing women from making decisions they will later regret, these types of decisions are comparable.

Likewise, when the state asserts an interest in preventing morbidity or mortality, the question should be whether the regulation treats abortion differently from procedures with similar rates of risk. This may vary depending on the type of abortion procedure at issue. Medication abortions have a major complication rate of 0.31%, whereas second-trimester or later procedures have a rate of 0.41%.¹³⁹ In cases challenging restrictions on medication abortion,¹⁴⁰ then, the correct medical procedure against which to compare the abortion restriction may be different than in cases involving surgical abortions.¹⁴¹

So too with regulations that aim to protect the integrity of the medical profession. From a safety perspective, abortion is just as safe as—if not safer than—many other medical procedures.¹⁴² As such, the state's interest in protecting patient health¹⁴³ is equally relevant to other medical procedures. Likewise, the state's interest in protecting “the physician's role as healer”¹⁴⁴ applies equally to abortion as to other medical procedures and services, so the degree of regulation that suffices to protect the interest in the latter is equivalent to that in the former.¹⁴⁵

By comparing abortion regulations to regulations of other procedures when the state asserts an interest in women's health and the integrity of the medical profession, only the fetal life interest remains. The interest in potential life¹⁴⁶ indeed applies differently in the abortion context than it does in the

139. See Ushma D. Upadhyay et al., *Incidence of Emergency Department Visits and Complications After Abortion*, 125 *OBSTETRICS & GYNECOLOGY* 175, 181 (2015).

140. See, e.g., *Planned Parenthood Ariz., Inc. v. Humble*, 753 F.3d 905, 909-10, 918 (9th Cir. 2014) (holding that the plaintiffs had demonstrated a likelihood of success on the merits of their claim that an Arizona law restricting access to certain abortifacient drugs imposed an undue burden on women's access to abortion).

141. See, e.g., *Gonzales v. Carhart*, 550 U.S. 124, 134-40 (2007).

142. See *Guttmacher Inst., Induced Abortion in the United States 2* (2017), <https://perma.cc/5QTJ-BFC7> (“A first-trimester abortion is one of the safest medical procedures and carries minimal risk . . .”).

143. See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016) (citing *Gonzales*, 550 U.S. at 149-50).

144. See *Gonzales v. Oregon*, 546 U.S. 243, 286 (2006) (Scalia, J., dissenting) (quoting *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997)).

145. One might object that a physician's “role as healer” is inadequately captured because of the physician's impact on the fetus. This appears to be the fetal life rationale in new wrappings: Insofar as it hinges on an interest in the fetus, the concern is better captured through the fetal life rationale, which is a separate rationale from the integrity-of-the-medical-profession rationale.

146. See *Gonzales*, 550 U.S. at 157 (“The government may use its voice and its regulatory authority to show its profound respect for the life within the woman.”).

context of other medical procedures. And insofar as the Court has held that the fetal life interest is legitimate,¹⁴⁷ there may be differences in how a state may regulate abortion compared to how it regulates other medical procedures under the undue burden standard. But because the state's interests in health and the integrity of the medical profession are the same for abortion as for other procedures, the analysis must be tethered to its treatment of those comparable procedures. The variation between how the state treats abortion and how it treats other medical procedures must be assessed from that baseline.¹⁴⁸

The benefit of taking this approach with regard to fetal life rationales specifically is twofold. First, states asserting an interest other than fetal life must be held accountable by comparison to other procedures implicating similar interests. In other words, this approach prevents states from cloaking fetal life concerns in the garb of concerns about women's health or the integrity of the medical profession. Historically, the antiabortion movement has been "fetal-focused,"¹⁴⁹ but as it "found itself unable to persuade a significant portion of the electorate" based on such rationales,¹⁵⁰ a new strategy developed:

147. *Id.* at 145 ("[T]he government has a legitimate and substantial interest in preserving and promoting fetal life . . ."). *But see* Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 359-63 (1992) (critiquing fetal life rationales from an equal protection perspective and arguing that "today, as in the nineteenth century, legislators enacting restrictions on abortion may act from judgments about the sexual and maternal conduct of the women they are regulating, and not merely from a concern about the welfare of the unborn").

148. The question of how much latitude the fetal life interest provides the state in abortion regulation is a difficult one and is beyond the scope of this Note. Some advocates have argued that the interest in fetal life is entirely illegitimate. *See, e.g.,* Seigel, *supra* note 147, at 335 ("[F]etal-protective regulation is rife with diverse forms of bias."). Others have argued that it should occupy a lesser position compared to the rights of women in conducting the undue burden analysis because "[t]he [undue burden] standard is less effective as a compromise when it purports to balance the interests of those who would protect (always already valuable) fetal 'life' against those who would not protect (always already valuable) fetal 'life.'" *See, e.g.,* Bridges, *supra* note 6, at 947-48; *see also* Sandra Rodgers, *Fetal Rights and Maternal Rights: Is There a Conflict?*, 1 CAN. J. WOMEN & L. 456, 459 (1986) (challenging the very idea of balancing between maternal and fetal interests and concluding that "maternal interests are entitled to precedence"). In any event, the challenge in the current standard of how to balance women's right to access abortion against the asserted interest in fetal health is no different under the understanding I propose and must be the subject of future scholarship.

149. *See* Siegel, *supra* note 111, at 1713 (describing a "fetal-focused and increasingly confrontational line of argument" as "the dominant voice of the antiabortion movement in the several decades after *Roe*"); Seigel, *supra* note 147, at 331-35 (discussing the centuries-long argumentative strategy of "present[ing] the fetus as an object of public interest scarcely connected physically or socially to the woman bearing it").

150. Siegel, *supra* note 111, at 1715.

Growing numbers of movement leaders came to appreciate that woman-focused antiabortion discourse might have strategic utility in persuading segments of the electorate the movement had heretofore been unable to reach: it might reassure those who hesitated to prohibit abortion because they were concerned about women's welfare that legal restrictions on abortion might instead be in women's interest.¹⁵¹

But insofar as these reasons are pretextual, my tethered approach prevents such pretext—as the Supreme Court held in *Stenberg v. Carhart*, one “cannot see” how the state’s “‘interest in the potentiality of human life’ . . . could make any difference to the question at hand, namely, the application of the ‘health’ requirement.”¹⁵² The state may not obfuscate its intent by claiming to protect women’s health or the integrity of the medical profession while actually trying to restrict or eliminate abortion access based on its concern for fetal life.

Second, tethering abortion to the fixed goalposts of other medical procedures prevents the type of downward incremental pressure permitted, and indeed encouraged, by the current approach to the undue burden standard. Analogous medical procedures thus function as a baseline against which abortion regulations can be better understood and analyzed. Under my proposed approach, courts can both retain the undue burden standard and be faithful to the fundamental right underlying the test—the right of a woman to access an abortion.¹⁵³

Critics might argue that comparing abortion to other procedures is a false analogy because it doesn’t adequately capture an important state interest in regulating abortion: the interest in fetal life. According to this critique, abortion is unlike other medical procedures because the state’s interest in protecting fetal life or fetal dignity gives it greater authority to regulate abortion.¹⁵⁴ This additional interest thus justifies disparate treatment.

Ultimately, this critique is not persuasive. The right belongs to the woman, not the fetus.¹⁵⁵ This critique fundamentally misunderstands the role of the competing interest. The state may have an interest in fetal life and promoting birth, but the fetus does not have any rights.¹⁵⁶ As a result, the inquiry must

151. *Id.*

152. 530 U.S. 914, 930-31 (2000) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992) (opinion of O’Connor, Kennedy & Souter, JJ.)).

153. *See Casey*, 505 U.S. at 844 (majority opinion).

154. *See id.* at 873 (opinion of O’Connor, Kennedy & Souter, JJ.) (rejecting the trimester framework because it “undervalues the State’s interest in potential life”); *Roe v. Wade*, 410 U.S. 113, 153-54 (1973) (“[A] State may properly assert important interests in . . . protecting potential life.”).

155. *See supra* notes 82-86 and accompanying text (discussing the identity of the rightholder).

156. *Cf. Roe*, 410 U.S. at 157-58 (“[T]he word ‘person’ . . . does not include the unborn.” (quoting U.S. CONST. amend. XIV, § 1)). *See generally* CYNTHIA R. DANIELS, *AT WOMEN’S*
footnote continued on next page

focus first and foremost on whether *the woman's* right is burdened and then on whether burdens on that right are justified compared to the state's interest in developing or promoting the "potentiality of human life."¹⁵⁷

Under the undue burden standard, whether a burden is undue is affected by how substantial the state's interest is. The two inquiries are assessed separately and then weighed against each other.¹⁵⁸ The undue burden test "requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer"; the Court has called this a "balancing."¹⁵⁹ In other words, while the burden on a woman and the state's interests are balanced, they are determined independently; the importance of the state's interest is irrelevant to the burden analysis, and vice versa.¹⁶⁰

This is consistent with how balancing tests are applied in other areas of constitutional law. In *Mathews v. Eldridge*, the Court held that procedural due process claims require courts to balance "the private interest that will be affected by the official action," "the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards," and "the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail."¹⁶¹ Similarly, *Pickering v. Board of Education* called on courts confronted with cases involving political speech by government employees to "balance . . . the interests of the

EXPENSE: STATE POWER AND THE POLITICS OF FETAL RIGHTS (1993) (critiquing the state's policing of women's bodies to protect fetuses); Dawn E. Johnsen, *The Creation of Fetal Rights: Conflicts with Women's Constitutional Rights to Liberty, Privacy, and Equal Protection*, 95 YALE L.J. 599 (1986) (arguing that any legal recognition of a fetus should be viewed critically so as not to infringe on women's rights).

157. *Stenberg*, 530 U.S. at 930; *see also supra* note 148 (discussing the ongoing debate about the interaction between women's rights and the fetal life interest).
158. *See Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016); *see also Isaacson v. Horne*, 716 F.3d 1213, 1223 (9th Cir. 2013) (discussing the "balance between a pregnant woman's right to control her body and the state's interest in preventing her from undergoing an abortion").
159. *Whole Woman's Health*, 136 S. Ct. at 2309. *But see id.* at 2324 (Thomas, J., dissenting) ("When assessing Pennsylvania's recordkeeping requirements for abortion providers, for instance, *Casey* did not weigh its benefits and burdens." (citing *Casey*, 505 U.S. at 901 (opinion of O'Connor, Kennedy & Souter, JJ))).
160. *See id.* at 2309 (majority opinion); *see also W. Ala. Women's Ctr. v. Miller*, 217 F. Supp. 3d 1313, 1346-47 (M.D. Ala. 2016) ("[T]o determine whether a law regulating abortion constitutes an undue burden on the right to terminate a pregnancy before viability, the court must balance the State's interests underlying a law against the obstacles imposed by the law to women's access to abortion."), *appeal dismissed as moot sub nom. W. Ala. Women's Ctr. v. Williamson*, 874 F.3d 1306 (11th Cir. 2017).
161. 424 U.S. 319, 335 (1976); *see also Hamdi v. Rumsfeld*, 542 U.S. 507, 528-29 (2004) (plurality opinion) (describing *Mathews* as the Court's preferred mechanism for "balancing . . . serious competing interests" in the procedural due process context).

[employee], as a citizen, in commenting upon matters of public concern and the interest of the State, as an employer, in promoting the efficiency of the public services it performs through its employees.”¹⁶² So too must courts evaluating voting restrictions “first consider the character and magnitude of the asserted injury to the rights protected by the First and Fourteenth Amendments” before considering “the extent to which [the government’s] interests make it necessary to burden the plaintiff’s rights.”¹⁶³

The interest in fetal life, insofar as it has constitutional relevance,¹⁶⁴ cannot strip the woman of her rights entirely. As Cass Sunstein argues, that the state and the woman have strong interests does not per se mean that those interests ought be given equal weight.¹⁶⁵ Rather, if “[t]hose desires have entirely different origins and consequences,” treating them “equally” disregards their context.¹⁶⁶ In the context of abortion access, the state interest in promoting birth is not equal, on balance, to the cataclysmic interest a woman has in preventing her body from being “coopt[ed] . . . for the protection of fetuses.”¹⁶⁷ At the first stage of the analysis, then, any interest in fetal life is irrelevant: Because the right belongs to the woman, the burden upon it must first be ascertained. Only then, when comparing the relative burdens on abortion and other medical procedures to determine whether the state’s interest justifies the difference in treatment, might the state’s interest in fetal life be relevant. In other words, any legitimate interest in fetal life is captured within the spectrum of differentiated treatment allowed by the undue burden standard. That standard does not require exact fealty to the standards imposed on other similar medical treatments; rather, it imposes limits on the permissible scope of variation.

Moreover, this concern would have no impact on many cases challenging abortion restrictions. As discussed above, many state regimes are defended not on the ground of promotion of potential life but rather on the basis of women’s health or the integrity of the medical profession—for which abortion is like

162. 391 U.S. 563, 568 (1968).

163. *See* *Anderson v. Celebrezze*, 460 U.S. 780, 789 (1983).

164. *But see* Caitlin E. Borgmann, *Judicial Evasion and Disingenuous Legislative Appeals to Science in the Abortion Controversy*, 17 J.L. & POL’Y 15, 32-33, 56 (2008) (critiquing the concept of a state interest in fetal life as a justification for abortion restrictions); Cass R. Sunstein, *Neutrality in Constitutional Law (with Special Reference to Pornography, Abortion, and Surrogacy)*, 92 COLUM. L. REV. 1, 33-34 (1992) (noting that aside from the abortion context, the “[g]overnment never imposes an obligation” to “allow one’s body to be devoted to the protection of another” and that arguments sounding in the fetal life interest “indicate[] that a discriminatory purpose is ultimately at work”).

165. *Cf.* Sunstein, *supra* note 164, at 33-34.

166. *See id.* at 5 (“The idea that neutrality demands that the desires be ‘equally’ respected disregards the historical context of inequality . . .”).

167. *See id.* at 31-34.

any other procedure.¹⁶⁸ Even where a state does assert its interest in the promotion of birth or fetal life as a justification for abortion restrictions, these restrictions may fail the undue burden standard because they are successful only in reducing the number of legal abortions; they do not actually restrict abortions in general.¹⁶⁹ Instead, women often turn to dangerous and illegal measures to end unwanted pregnancies.¹⁷⁰ So not only do restrictions serving this fetal life interest fail to actually promote that interest, but they also often have severe and negative impacts on women's health and safety and, insofar as medical professionals are involved in these "back alley" abortions, undermine the integrity of the medical profession. As a result, the state's interest in women's health may be undermined when abortion access is too restricted.

2. Considering abortion regulations holistically

Additionally, the comparison of regulations on abortion to regulations of analogous medical procedures should be done holistically. In other words, when assessing whether there is an undue burden, courts and advocates should consider the entire landscape of regulations on abortion rather than analyze each regulation on a piecemeal basis.

There are five major benefits to this approach. First, this alternative better centers the rightholder in the analysis. Rather than asking whether a particular law "imposes an undue burden on a woman's ability" to have an abortion,¹⁷¹ this approach asks whether women *experience* an undue burden. In other words, this version stands in the shoes of a woman seeking an abortion and asks, in totality, whether she experiences an undue burden. By contrast, the current understanding of the doctrine looks through the lens of the regulation itself and asks, myopically, whether that regulation alone imposes a burden. The holistic approach takes the perspective of a woman seeking an abortion and looks at the barriers she faces to accessing one. This difference in perspective better protects the right the undue burden standard is designed to preserve by preventing incremental encroachment on the right to access abortion and centering the analysis on the bearer of the right.¹⁷²

168. See, e.g., Brief for Respondents, *supra* note 64, at 16 ("The facially apparent and expressly stated purpose of the challenged provisions is to ensure patient safety and raise standards of care . . .").

169. See Sunstein, *supra* note 164, at 41 ("[A]nti-abortion restrictions serve their own purposes too poorly to be acceptable."); see also *supra* note 104.

170. See *supra* note 104 and accompanying text.

171. See, e.g., *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000) (emphasis added) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992) (opinion of O'Connor, Kennedy & Souter, JJ)).

172. See *supra* Part II.A.

Second, by demanding more holistic scrutiny, this approach serves a brush-clearing function. By tethering abortion regulation regimes to other healthcare regimes, the balance between women's rights and state interests required under the undue burden standard is more clearly articulated. Because courts must "consider the burdens a law imposes on abortion access together with the benefits those laws confer,"¹⁷³ requiring clarity and honesty about what the asserted state interests are allows courts to more readily determine this balance.

Third, this holistic approach is more administrable. It imposes more reasonable statistical burdens on advocates and courts. As discussed in Part II.B above, the current understanding of the undue burden model seems to mandate a "perfect controlled experiment as to the effect of the law"¹⁷⁴ because it requires that effects on clinic closures, women's access, and changes in the abortion rate be attributed to specific provisions of a law, even when such changes might be the result of a combination of barriers. My approach, by contrast, allows courts to consider whether abortion is being burdened holistically: If the right is burdened, it is irrelevant whether one subsection or another was the final straw.

This also creates greater judicial efficiency because courts could streamline the currently laborious process of attempting to make these difficult causal determinations.¹⁷⁵ This is even more true in challenges to longstanding, as opposed to newly adopted, regulations. In such cases, courts would no longer have to consider the hypothetical question of what access would look like in the absence of a single longstanding statute. That determination might prove challenging because of follow-on effects from the long-term restriction on access. Clinics are costly to open and operate.¹⁷⁶ Clinical staff may be difficult to find because many medical schools do not provide abortion training to students.¹⁷⁷ And abortion providers frequently experience threats, harassment,

173. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309 (2016).

174. See Transcript of Oral Argument, *supra* note 90, at 14.

175. See, e.g., *Whole Woman's Health*, 136 S. Ct. at 2310-21 (discussing at length whether the challenged law had a causal relationship with the effects alleged by the petitioners).

176. See, e.g., Meaghan Winter, *The Most Difficult Business You Could Run: Why It's So Hard to Run an Abortion Clinic—and Why So Many Are Closing*, BLOOMBERG BUSINESSWEEK (Feb. 24, 2016), <https://perma.cc/6DUG-YUQ5> (reporting that opening a new clinic could cost \$1 million).

177. See Mara Gordon, *The Scarcity of Abortion Training in America's Medical Schools*, ATLANTIC (June 9, 2015), <https://perma.cc/X6UF-BM5V> (noting that only 32% of U.S. medical schools offer formal lectures about abortion as part of their OB-GYN rotations (citing Eve Espey et al., *Abortion Education in Medical Schools: A National Survey*, 192 AM. J. OBSTETRICS & GYNECOLOGY 640, 641 tbl.I (2005))).

and even violence.¹⁷⁸ Asking whether, for example, in the absence of a particular provision of a regulation or code, a new clinic would immediately open—that is, whether that provision is the but-for cause of the undue burden—therefore imposes an unwieldy and unworkable empirical burden on courts and advocates. By contrast, under my alternative, once courts determine that women experience an undue burden in accessing abortion, questions about whether there is currently a provider willing to immediately open a new clinic, expand services into underserved areas, or otherwise expand access are irrelevant. The focus is on whether there is a burden, not which legal provision caused it.

Fourth, this approach would also serve the interests of regulators. A clearer marker of what is acceptable—the reasonable regulations on any medical procedure—would make it easier for legislatures and regulatory agencies to determine whether a regulation under consideration is constitutional. This proposal would provide a baseline from which regulators could work, even if it would also require them to consider how any proposed change to the regulatory structure might affect the overall scheme. Not only would this save time and expense for legislatures, but it would also prevent states from incurring unnecessary litigation costs in defending ultimately unconstitutional laws.¹⁷⁹

Furthermore, even when a court has determined that an abortion regulation regime is unconstitutional, the regulator retains some autonomy. When courts grant this type of relief in other contexts, the state is given the opportunity to propose a remedy that would bring it into compliance with the Constitution.¹⁸⁰ Thus, under this approach, states would be allowed to substantiate their regulatory priorities within constitutional limits.

178. *E.g.*, Nat'l Abortion Fed'n, 2016 Violence and Disruption Statistics: An Escalation in Hate Speech, Intimidation, and Obstruction as Well as a Decrease in Extreme Violence 1 (n.d.), <https://perma.cc/HCM2-GBT2>; *see* Nora Caplan-Bricker, 2015 Was the Most Violent Year in Recent Memory for Abortion Providers, SLATE (Apr. 6, 2016, 8:54 AM), <https://perma.cc/R2EY-Y5C6>; Mary Emily O'Hara, Abortion Clinics Report Threats of Violence on the Rise, NBC NEWS (Feb. 14, 2017, 6:53 PM ET), <https://perma.cc/LE3K-B52H>; *see also, e.g.*, Joe Stumpe & Monica Davey, Abortion Doctor Shot to Death in Kansas Church, N.Y. TIMES (June 1, 2009), <https://perma.cc/9LL9-5CRN>.

179. *See, e.g.*, Christine Sexton, Abortion Provider Gets \$50K in Legal Fees to Cover Defense Costs Against State Sanctions, POLITICO (Oct. 24, 2016, 3:16 PM EDT), <https://perma.cc/8DBJ-TWLB>; Alexa Ura, Texas May Owe Abortion Providers' Lawyers \$4.5 Million, TEX. TRIB. (Oct. 8, 2016, 11:36 AM), <https://perma.cc/6HJQ-UEAP>.

180. *See* Paul Gewirtz, Remedies and Resistance, 92 YALE L.J. 585, 596 (1983) ("Once actual ineffectiveness becomes apparent, of course, the judge can always enter a new decree designed to be more effective."); *see also infra* Part III.C (discussing remedies). For instance, in *Wyatt v. Stickney*, the district court held that involuntarily committed patients at a mental hospital were being denied constitutionally adequate individual treatment. *See* 344 F. Supp. 373, 374 (M.D. Ala. 1972), *aff'd in part and remanded in part sub nom.* *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974). Initially the district court

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Fifth and finally, a holistic approach to the undue burden standard—coupled with an assessment of the state’s abortion regulatory regime against the baseline of the regulatory regime for analogous medical procedures—grounds the right in an external, objective standard. This avoids the “frequent criticism of balancing . . . that the Court has no objective criteria for valuing or comparing the interests at stake.”¹⁸¹ Other healthcare services are not subject to the same pressures as abortion, where public opinion and strong ideological views may incentivize politicians to restrict access in order to garner political support.¹⁸² By tethering abortion restrictions to other healthcare regulations, then, the political incentives to cabin abortion access would be constrained because to do so legislatures would have to restrict access to analogous services. Healthcare consistently ranks as one of the most important issues to voters.¹⁸³ Restrictions in access to general healthcare, such as hospital closures, frequently generate intense and sustained public opposition.¹⁸⁴ Healthcare access, then, functions as a fixed benchmark: General healthcare access tends to

granted the hospital “six months in which to raise the level of care at [the mental hospital] to the constitutionally required minimum.” *See id.* (citing *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *abrogated in other part* by *Kansas v. Hendricks*, 521 U.S. 346 (1997)). After the hospital failed to come into compliance, the court ordered the implementation of more specific requirements. *See id.* at 375-76. These more specific requirements covered everything from the minimum day room area per patient to staffing ratios. *Id.* app. A at 379-83.

181. *See* T. Alexander Aleinikoff, *Constitutional Law in the Age of Balancing*, 96 YALE L.J. 943, 972 (1987) (discussing frequent criticisms of balancing).
182. *See* Gerald N. Rosenberg, *The Surprising Resilience of State Opposition to Abortion: The Supreme Court, Federalism, and the Role of Intense Minorities in the U.S. Politics System*, 34 ST. LOUIS U. PUB. L. REV. 241, 247 (2015). Rosenberg argues that “the federal system’s disproportionate rewarding of intense minorities” and “the coalition between the Republican Party and religious social conservatives” have helped sustain political opposition to abortion. *Id.* at 242.
183. *See, e.g., Healthcare System*, GALLUP NEWS, <https://perma.cc/7CFA-99KK> (archived Oct. 20, 2017) (demonstrating that a majority of respondents polled from 2001 to 2017 consistently expressed that they worried a “great deal” about “the availability and affordability of healthcare” (capitalization altered)); *see also, e.g., PEW RESEARCH CTR., 2016 CAMPAIGN: STRONG INTEREST, WIDESPREAD DISSATISFACTION 31* (2016) <https://perma.cc/FS8K-EZR8>; Wendy W. Simmons, *Health Care an Important Issue This Year*, GALLUP NEWS (Sept. 28, 2000), <https://perma.cc/W854-Z5K9>.
184. *See, e.g., Battle over East Bay Hospital Closure Draws Hundreds to Town Hall Meeting*, KTVU.COM (updated Sept. 22, 2016, 12:35 AM PDT), <https://perma.cc/R3UF-LHPD>; *Dozens Fight New Orleans Hospital Closure*, USA TODAY (Mar. 26, 2006, 12:13 PM), <https://perma.cc/KV76-2N2F>; Andrea K. McDaniels, *Chestertown Residents Fighting Hospital Closure Get Support of State Officials*, BALT. SUN (Feb. 19, 2016, 9:49 PM), <https://perma.cc/5EMC-LAZS>; *Richmond Unites to Fight Hospital Closure by Filing Federal Lawsuit Against Responsible County Officials*, S.F. BAY VIEW (Aug. 18, 2014), <https://perma.cc/XG8U-QJ7V>; Jim Vasil, *Two Years After North Adams Regional Hospital Closure, Supporters Continue Fight*, SPECTRUM NEWS (Mar. 28, 2016, 8:41 PM EDT), <https://perma.cc/3V2J-YM2N>.

be relatively constant over time.¹⁸⁵ By tying abortion restrictions to other healthcare services, the same political forces that resist restrictions of other services would extend to abortion services, lessening the political advantage that could be gained by enacting unconstitutional regulations.

Moreover, for the reasons discussed above, this holistic approach adequately captures the state's interest in fetal life; it simply requires that states using this rationale be candid about it.¹⁸⁶ If courts continue to accept the state's interest in fetal life as legitimate, that interest will remain relevant to a state's ability to regulate abortion. However, states may not obscure or obfuscate their interest in fetal life under the guise of women's health or the integrity of the medical profession. And the baseline against which differentiated treatment of abortion is compared is the regulation of analogous procedures.

B. Applications of the Alternative

To illustrate how my holistic alternative approach to the undue burden standard would work in practice, consider how it might have altered the analysis in *Casey* and *Whole Woman's Health*.

In *Casey*, the Court upheld provisions of Pennsylvania law that imposed a parental consent requirement, a mandatory twenty-four-hour waiting period, and reporting and recordkeeping requirements;¹⁸⁷ the Court struck down only the state's spousal notification requirement.¹⁸⁸ The Court started to compare the waiting period requirement to the regulations imposed on other medical procedures by asking whether it would be "constitutional for the State to require that in order for there to be informed consent to a kidney transplant operation the recipient must be supplied with information about risks to the donor as well as risks to himself or herself."¹⁸⁹

Under my approach, the Court's analysis would have differed in three ways. First, because the choice of kidney transplants as a comparison alludes to the state's interest in women's health, the Court would have determined whether that comparison was accurate. Here, if the state's concern was with morbidity and mortality, the kidney transplant comparison is inaccurate.

185. See BRIAN W. WARD ET AL., NAT'L CTR. FOR HEALTH STATISTICS, U.S. DEP'T OF HEALTH & HUMAN SERVS., EARLY RELEASE OF SELECTED ESTIMATES BASED ON DATA FROM THE 2015 NATIONAL HEALTH INTERVIEW SURVEY 13 fig.2.1 (2016), <https://perma.cc/E8PV-SDDW> (demonstrating that in all years from 1997 to 2015, 85-90% of people had a "usual place to go for medical care").

186. See *supra* notes 146-53 and accompanying text.

187. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 881-87, 899-901 (1992) (opinion of O'Connor, Kennedy & Souter, JJ.).

188. *Id.* at 887-98 (majority opinion).

189. *Id.* at 883 (opinion of O'Connor, Kennedy & Souter, JJ.).

Kidney transplants have mortality rates up to 5% and complication rates up to 44%.¹⁹⁰ By contrast, the abortion complication rate is 2.1%,¹⁹¹ and the mortality rate is 0.0006%.¹⁹² As the procedures are therefore not comparable, the regulations imposed on a kidney transplant are not an appropriate benchmark when analyzing the state's asserted interest in women's health.

Second, even if a kidney transplant were a comparable medical procedure in terms of morbidity and mortality, the Court would have asked a different question. Rather than asking whether Pennsylvania actually required that kidney transplant patients undergo a twenty-four-hour waiting period before receiving the procedure, it merely asked whether such a waiting period would be constitutional.¹⁹³ This is problematic because it does not actually tether the challenged abortion restriction to actual restrictions placed on other medical procedures. Put simply, kidney transplants have not been determined to be constitutionally protected. So what regulations a state might or might not impose are irrelevant; a state has almost plenary authority to regulate kidney transplants, but lacks comparable authority to regulate abortions.¹⁹⁴ The Court therefore did not measure whether abortion was really restricted relative to other medical procedures. The value of comparing the abortion regulation regime against the regime regulating other medical procedures with comparable underlying state interests in patient health¹⁹⁵ and protecting the integrity of the medical profession¹⁹⁶ is that it crystalizes the state's interests. If abortion is regulated more stringently, then the restrictions must be based on the state's interest in fetal life because the other two species of state interests are fully captured in other types of medical regulations. And the burden the

190. See John R. Silkensen, *Long-Term Complications in Renal Transplantation*, 11 J. AM. SOC'Y NEPHROLOGY 582, 582 (2000).

191. See Upadhyay et al., *supra* note 139, at 181.

192. See Elizabeth G. Raymond & David A. Grimes, *The Comparative Safety of Legal Induced Abortion and Childbirth in the United States*, 119 OBSTETRICS & GYNECOLOGY 215, 216 tbl.1 (2012) (showing 0.6 deaths per 100,000 pregnancies).

193. See *Casey*, 505 U.S. at 882-83 (opinion of O'Connor, Kennedy & Souter, JJ.) ("We also see no reason why the State may not require doctors to inform a woman seeking an abortion of the availability of materials relating to the consequences to the fetus, even when those consequences have no direct relation to her health. An example illustrates the point. We would think it constitutional for the State to require that in order for there to be informed consent to a kidney transplant operation the recipient must be supplied with information about risks to the donor as well as risks to himself or herself.").

194. See *supra* Part I (detailing the development of the Court's recognition that women have a constitutional right to abortion).

195. See, e.g., *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2310 (2016) (reaffirming that the state has a legitimate interest in patient health).

196. See, e.g., *Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (reaffirming that the state has a legitimate interest in the integrity of the medical profession).

regulations impose on abortion must be assessed against how the state treats analogous procedures. The Court's discussion of hypothetically permissible restrictions that could be imposed on kidney transplants,¹⁹⁷ then, is beside the point. What matters is how the state in fact regulates analogous procedures.

The third and most important way the Court's analysis would have changed is that it would have considered the abortion regulations together, not separately. In *Casey*, the Court was presented with each provision independently¹⁹⁸ and so considered each provision in isolation.¹⁹⁹ But taking the regulations separately prevented the Court from considering the real burden women in Pennsylvania experienced. For example, the potential burden of a waiting period would be very different if there were a clinic in every city and town in the state than if there were one clinic for the entire state.²⁰⁰ And the number of clinics in operation might hinge on a variety of types of regulations some states have adopted, including facility requirements,²⁰¹ physician-only laws,²⁰² telemedicine bans,²⁰³ admitting privileges requirements,²⁰⁴ and location restrictions.²⁰⁵ Moreover, a woman's access to abortion may be

197. Cf. *Casey*, 505 U.S. at 882-83 (opinion of O'Connor, Kennedy & Souter, JJ.).

198. See Brief for Respondents at i, *Casey*, 505 U.S. 833 (Nos. 91-744 & 91-902), 1992 WL 12006423 (stating the questions presented in provision-by-provision terms).

199. See *Casey*, 505 U.S. at 879-80 (medical emergency provision); *id.* at 881-87 (opinion of O'Connor, Kennedy & Souter, JJ.) (informed consent); *id.* at 887-98 (majority opinion) (spousal notice requirement); *id.* at 899-900 (opinion of O'Connor, Kennedy & Souter, JJ.) (parental consent); *id.* at 900-01 (recordkeeping and reporting requirements).

200. The Court did not discuss how many clinics were operating in Pennsylvania at the time of its decision. There were at least five, as the petitioners were five clinics and one physician. See *id.* at 845 (majority opinion). As of this writing, there are at least thirteen operational clinics providing abortion services in Pennsylvania. See *Find a Health Center: Pennsylvania*, PLANNED PARENTHOOD, <https://perma.cc/WVB7-YZ4X> (archived Oct. 20, 2017) (listing ten Pennsylvania locations that "offer[] abortion services"); *Pennsylvania Abortion Clinics*, ABORTION.COM, <https://perma.cc/24BK-98MS> (archived Oct. 20, 2017) (listing three more).

201. See, e.g., *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2314-15 (2016).

202. See, e.g., ALA. CODE § 26-23A-7 (2017) ("Only a physician may perform an abortion."); ARIZ. REV. STAT. ANN. § 36-2155(A) (2017) ("An individual who is not a physician shall not perform a surgical abortion."); ARK. CODE ANN. § 20-16-603(b)(1) (2017) ("When . . . [a] drug or chemical regimen is used to induce an abortion, the initial administration of the drug or chemical shall occur in the same room and in the physical presence of the physician . . ."). See generally *An Overview of Abortion Laws*, *supra* note 112 ("41 states require an abortion to be performed by a licensed physician.").

203. See, e.g., ALA. CODE § 26-23E-7.

204. See, e.g., *Whole Woman's Health*, 136 S. Ct. at 2310.

205. See, e.g., ALA. CODE § 22-21-35(b) (banning abortion clinics from operating within 2000 feet of a "K-8 public school"), *invalidated by* *W. Ala. Women's Ctr. v. Miller*, No. 2:15cv497-MHT (WO), 2017 WL 4843230 (M.D. Ala. Oct. 26, 2017), *appeal docketed*, No. 17-15208 (11th Cir. Nov. 22, 2017).

affected by bans on certain types of procedures,²⁰⁶ waiting periods,²⁰⁷ and parental consent provisions.²⁰⁸ By failing to consider the totality of the burdens a woman seeking an abortion might face, the Court could not have truly considered whether she faced an undue burden.

Under my approach to the undue burden standard, the Court would have considered what restrictions Pennsylvania law actually imposed on other medical procedures comparable to abortion. At the time of *Casey*, in addition to overcoming the hurdles actually at issue in the case, a woman seeking an abortion in Pennsylvania had to convince a physician that her abortion was “necessary.”²⁰⁹ And she could not have sought an abortion after viability unless her life or health were at risk.²¹⁰ The Court would have had to analyze the extent to which other medical procedures in Pennsylvania were subject to similar limitations.²¹¹

Given the differences in how abortion was regulated compared to other procedures, the Court would then have turned to whether women faced a “substantial obstacle in [their] path,”²¹² compared to other procedures, in accessing abortions. Further, because the state’s interests in women’s health and the integrity of the medical profession are adequately captured in the foregoing analysis, this inquiry would then have asked whether the burden imposed on abortion, now justified only by a potential interest in fetal life, was undue. As the Court held in *Casey*, “A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”²¹³ Here, the analysis would have tracked how the Court currently evaluates purpose and effect—asking what the asserted state interest is, whether the interest is accomplished by the restriction, and whether the

206. See, e.g., *Stenberg v. Carhart*, 530 U.S. 914, 920-22 (2000); cf. *Gonzales v. Carhart*, 550 U.S. 124, 150-56 (2007).

207. See generally *Counseling and Waiting Periods for Abortion*, GUTTMACHER INST. (Oct. 1, 2017), <https://perma.cc/8G7T-WPWM>.

208. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 899-900 (1992) (opinion of O’Connor, Kennedy & Souter, JJ.).

209. See Act of Nov. 17, 1989, No. 1989-64, § 2, 1989 Pa. Laws 592, 593 (codified at 18 PA. CONS. STAT. § 3204 (2017)).

210. See *id.* § 4, at 597-99 (codified at 18 PA. CONS. STAT. §§ 3210-3211) (restricting abortions performed “when the gestational age of the unborn child is 24 or more weeks”).

211. This inquiry would ultimately have turned on the actual burdens women faced at the time of the lawsuit. But because the Court in fact only considered the implications of each provision in isolation, an assessment of the cumulative burdens faced by women in Pennsylvania is unavailable in retrospect.

212. *Casey*, 505 U.S. at 877 (opinion of O’Connor, Kennedy & Souter, JJ.).

213. *Id.*

interest justifies the imposed obstacles.²¹⁴ The Court would have considered the state's entire regulatory regime, rather than specific provisions in isolation. Given the different degrees of restriction between the regime regulating other medical procedures and that regulating abortion, the Court would likely have found that the Pennsylvania abortion regime, even if grounded in legitimate interests, imposed a substantial obstacle and thus was an unconstitutional burden.

By contrast, applying my approach would likely change only the reasoning, but not the outcome, in *Whole Woman's Health*. First, the Court would have compared Texas's abortion restrictions with those imposed on other medical procedures. Before *Whole Woman's Health* was decided, Texas permitted only physicians who had admitting privileges at a hospital within thirty miles to perform abortions.²¹⁵ Additionally, clinics were required to comply with extensive reporting²¹⁶ and staffing²¹⁷ requirements, pay a two-year renewal fee of \$5000,²¹⁸ undergo frequent inspection,²¹⁹ meet the facility requirements of ambulatory surgical centers,²²⁰ and meet "[d]ozens" of "additional requirements."²²¹

Moreover, Texas required that women seeking abortions generally wait at least twenty-four hours between appointments.²²² If the person seeking an abortion were a minor, her parent or legal guardian must generally have been given forty-eight hours' notice of her intent to have an abortion.²²³ The performing physician must also have performed a sonogram, displaying and

214. See *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2309-10 (2016).

215. See TEX. HEALTH & SAFETY CODE ANN. § 171.0031(a)(1) (West 2017), *invalidated by Whole Woman's Health*, 136 S. Ct. 2292; see also *id.* § 171.003; 25 TEX. ADMIN CODE § 139.53(c)(1) (2017), *invalidated by Whole Woman's Health*, 136 S. Ct. 2292.

216. See 25 TEX. ADMIN. CODE §§ 139.4, .5.

217. See *id.* §§ 139.43-.47.

218. See *id.* § 139.22(a).

219. See *id.* § 139.31.

220. See TEX. HEALTH & SAFETY CODE ANN. § 245.010(1) (providing for promulgation of minimum standards for abortion facilities and requiring that the standards be equivalent to those for ambulatory surgical centers), *invalidated by Whole Woman's Health*, 136 S. Ct. 2292; 25 TEX. ADMIN CODE § 139.40 (adopting minimum standards for abortion facilities by reference to those for ambulatory surgical centers), *invalidated by Whole Woman's Health*, 136 S. Ct. 2292; see also TEX. HEALTH & SAFETY CODE ANN. §§ 243.009-.010 (providing for promulgation of minimum standards for ambulatory surgical centers).

221. See *Whole Woman's Health*, 136 S. Ct. at 2315 (citing 25 TEX. ADMIN. CODE §§ 135.1-.56).

222. TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4).

223. See TEX. FAM. CODE ANN. § 33.002(a) (West 2017) (providing the general forty-eight-hour notice rule). *But see id.* § 33.002(b)-(c) (providing limited exceptions).

orally describing the image to the woman seeking an abortion.²²⁴ The physician must also have provided her with state-produced information,²²⁵ including medically inaccurate information regarding “the potential danger to a subsequent pregnancy and of infertility” and “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.”²²⁶ These materials must also have included “the probable anatomical and physiological characteristics” and “color pictures” of fetuses at two-week intervals of fetal development.²²⁷ And after the “post-fertilization age of the unborn child,” as determined by the physician, reached twenty weeks, the woman would not have been able to receive an abortion at all,²²⁸ unless she faced “death or a serious risk of substantial and irreversible physical impairment of a major bodily function, other than a psychological condition.”²²⁹

No analogous medical procedure in Texas was so heavily regulated. All other medical procedures that carry physical risks required simple informed consent without the imposition of a waiting period or state-written materials containing false information.²³⁰ Indeed, for many procedures Texas did not even require the disclosure of risks.²³¹ Nor were any other facilities so heavily regulated. Ambulatory surgical centers generally provide services involving much more invasive and risky procedures, including colonoscopies, endoscopies, cataract removal, and laser eye surgery.²³² Yet the same facility

224. TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4).

225. *See id.* §§ 171.012(a)(1)-(3), 171.013-.016.

226. *See id.* § 171.012(a)(1)(B)(ii)-(iii); *see also* Peter Frank et al., *The Effect of Induced Abortion on Subsequent Fertility*, 100 BRIT. J. OBSTETRICS & GYNAECOLOGY 575, 580 (1993) (“[I]nduced abortion does not appear to have an important effect on future fertility.”); *Abortion, Miscarriage, and Breast Cancer Risk: 2003 Workshop*, NAT’L CANCER INST., <https://perma.cc/E8E9-HJCH> (last updated Jan. 12, 2010) (“[N]ewer studies consistently showed no association between induced and spontaneous abortions and breast cancer risk.”).

227. TEX. HEALTH & SAFETY CODE ANN. § 171.016(a)-(b).

228. *Id.* §§ 171.043-.044.

229. *Id.* § 171.046(a).

230. *See* 25 TEX. ADMIN. CODE § 601.2 (2017) (listing “procedures requiring full disclosure of specific risks and hazards” (capitalization altered)). The only other procedures singled out from the general provision are radiation therapy, electroconvulsive therapy, hysterectomies, and anesthesia or analgesia. *See id.* §§ 601.5, 601.7-.9.

231. *See id.* § 601.3 (listing “procedures requiring no disclosure of specific risks and hazards” (capitalization altered)).

232. *See* U.S. DEP’T OF HEALTH & HUMAN SERVS., REPORT TO CONGRESS: MEDICARE AMBULATORY SURGICAL CENTER VALUE-BASED PURCHASING IMPLEMENTATION PLAN 2-3, 3 exhibit 1 (n.d.), <https://perma.cc/38F4-595X>; *see also* Karen A. Cullen et al., *Ambulatory Surgery in the United States, 2006*, NAT’L HEALTH STAT. REP., Jan. 28, 2009, at 1, 6-7.

requirements were imposed on facilities providing abortion services.²³³ Overall, patients at ambulatory surgical centers experienced serious complications or deaths in about one in 1000 cases.²³⁴ But “[t]he total number of deaths in Texas from abortions was five in the period from 2001 to 2012, or about one every two years (that is to say, one out of about 120,000 to 144,000 abortions).”²³⁵

Even birth centers, one of the few other procedure-specific categories within Texas health and safety regulations,²³⁶ were required to comply with much less extensive facility requirements—for example, they need not have had a pre-operation holding suite, recovery room, or paved roads and walkways.²³⁷ Nor did Texas’s physician-only rule²³⁸ apply to birth centers; certified nurse-midwives and midwives could also have served as birth attendants.²³⁹ And despite the fact that “[n]ationwide, childbirth is 14 times more likely than abortion to result in death,”²⁴⁰ birth centers in Texas did not need to maintain admitting privileges with local hospitals—they only needed to “be located within . . . 30 minutes['] normal driving time of a referral hospital.”²⁴¹ And this disparate treatment between abortion regulations and regulations on other medical procedures is borne out in real-world access: As of October 2017, there were 649 hospitals,²⁴² 484 ambulatory surgical centers,²⁴³

233. See TEX. HEALTH & SAFETY CODE ANN. § 245.010(a), *invalidated by* *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

234. See Sandra G. Boodman, *Popularity of Outpatient Surgery Centers Leads to Questions About Safety*, KAISER HEALTH NEWS (Dec. 16, 2014), <https://perma.cc/CM27-ED22>.

235. *Whole Woman’s Health*, 136 S. Ct. at 2315. Data that more precisely compare the rates of morbidity are unavailable.

236. See generally 25 TEX. ADMIN. CODE ch. 137 (establishing Texas’s regulatory regime for birthing centers).

237. Compare *id.* § 135.52 (setting forth plant and construction requirements for ambulatory surgical centers), with *id.* § 137.36 (providing for minimal physical requirements for birthing centers).

238. TEX. HEALTH & SAFETY CODE ANN. § 171.003 (“An abortion may be performed only by a physician licensed to practice medicine in this state.”).

239. 25 TEX. ADMIN. CODE § 137.2(7) (defining “[b]irth attendant” to include “[a] physician, certified nurse-midwife . . . , or a licensed midwife”); *id.* § 137.34(a)(3)(A).

240. See *Whole Woman’s Health*, 136 S. Ct. at 2315.

241. 25 TEX. ADMIN. CODE § 137.36; see also *id.* § 137.42(a)(2) (requiring disclosure of “collaborative arrangements,” rather than full admitting privileges, that centers may have with referral hospitals).

242. Tex. Health & Human Servs., Profession Roster Report: Hospitals 48 (2017), <https://perma.cc/9KN8-E8HW>.

243. Tex. Health & Human Servs., Profession Roster Report: Ambulatory Surgical Center 37 (2017), <https://perma.cc/84CK-9VHG>.

and 76 birth centers²⁴⁴ in Texas. By contrast, the district court found that under the challenged regime and the surgical center requirement in particular, at most eight abortion clinics would have remained in operation.²⁴⁵ This stark contrast would have led to greater burdens on women seeking abortions than on women seeking other medical services, including increased travel time,²⁴⁶ fewer clinics at higher costs,²⁴⁷ increased delay,²⁴⁸ and even the complete loss of access for some women.²⁴⁹ If the Court had taken this whole landscape of access into account, it would have concluded that abortion access is treated differently from the fixed goalposts of other medical procedures.

Based on that conclusion, the Court would then have inquired whether, in comparison to that baseline of the treatment of other procedures, the body of law “ha[d] the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion.”²⁵⁰ The arguments Texas made in *Whole Woman’s Health* regarding the safety of the woman²⁵¹ would fall by the wayside because health concerns are captured in the comparison to other medical procedures with similar risks and complication rates. So too would arguments based on the state’s interest in promoting the integrity of the medical profession and the reputation of doctors as healers.²⁵² Thus, the deviation must be explained by the other possible state interest: fetal life.²⁵³ At this stage, the Court’s analysis would have followed the familiar track: The “Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.”²⁵⁴ The only difference between what the Court’s analysis would have looked like under my approach and what the Court actually did is as follows: Rather than focusing on the number of clinic closures *as a result of that particular law*, it would have focused on whether access is restricted *overall* compared to other outpatient procedures. Unless Texas could have

244. Tex. Health & Human Servs., Profession Roster Report: Birthing Center 6 (2017), <https://perma.cc/H8NQ-XQ7P>.

245. See *Whole Woman’s Health*, 136 S. Ct. at 2301.

246. *Id.* at 2318.

247. See *id.* at 2317-18.

248. See *id.* at 2317.

249. *Id.* at 2316-17 (“[T]he proposition that these ‘seven or eight providers could meet the demand of the entire State stretches credulity.’” (quoting the district court’s opinion)).

250. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (opinion of O’Connor, Kennedy & Souter, JJ.).

251. See Brief for Respondents, *supra* note 64, at 32-40.

252. *Cf. Gonzales v. Carhart*, 550 U.S. 124, 157 (2007) (discussing a controversial procedure’s “effects on the medical community and on its reputation”).

253. See *Casey*, 505 U.S. at 872 (opinion of O’Connor, Kennedy & Souter, JJ.).

254. *Whole Woman’s Health*, 136 S. Ct. at 2310 (emphasis omitted) (quoting *Gonzales*, 550 U.S. at 165).

demonstrated that the disparate access between abortion and other similar medical procedures did not have the “purpose or effect”²⁵⁵ of creating an undue burden, the Court would have found the Texas abortion regime unconstitutional.

C. Remedies Under the Holistic Approach

My approach also raises a natural pragmatic question: How would advocates seeking this type of holistic review proceed? First, litigants would challenge the overall system of abortion restrictions. Courts would then ask whether other medical procedures that have similar physical and psychological risk factors have similar restrictions and regulations to those imposed on abortions. If abortion is subject to restrictions that go beyond those imposed on analogous procedures, the Court would ask whether, cumulatively, the body of law “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion.”²⁵⁶ If the answer is yes, then the Court should find in favor of the plaintiffs. Injunctive relief, where appropriate, would not only likely result in striking down a single provision of one law—as it does under the current interpretation of the undue burden standard—but also possibly in injunctions aimed at targeting general noncompliance with the Due Process Clause. In other words, plaintiffs should craft complaints that challenge the whole regime of burdens imposed on abortion rather than bring piecemeal attacks.

This type of suit is hardly novel. The most famous example of such broad injunctive relief for a constitutional violation is *Brown v. Board of Education II*, in which the Court ordered the district courts on remand “to take such proceedings and enter such orders and decrees . . . as are necessary and proper to admit to public schools on a racially nondiscriminatory basis with all deliberate speed the parties to these cases.”²⁵⁷ But *Brown* is not the only case to grant this type of broad constitutional injunctive relief rather than simply strike down a solitary provision. For example, in *Brown v. Plata*, the Supreme Court affirmed the findings of a three-judge district court that California prison conditions violated the Eighth Amendment and upheld an injunctive regime to eliminate the violation by reducing overcrowding.²⁵⁸ The plaintiffs

255. *Id.* at 2309 (quoting *Casey*, 505 U.S. at 878 (opinion of O’Connor, Kennedy & Souter, JJ)).

256. *Casey*, 505 U.S. at 877 (opinion of O’Connor, Kennedy & Souter, JJ).

257. 349 U.S. 294, 301 (1955). See generally Karl A. Cole-Frieman, Note, *The Ghosts of Segregation Still Haunt Topeka, Kansas: A Case Study on the Role of the Federal Courts in School Desegregation*, KAN. J.L. & PUB. POL’Y, Fall 1996, at 23, 31 (using Topeka, Kansas to explore how lower courts implemented the *Brown* decision).

258. 563 U.S. 493, 545 (2011) (affirming the “relief ordered by the three-judge court” and ordering the state to “implement the order without further delay”).

had alleged that California “had failed to provide constitutionally adequate medical care in California’s prisons in violation of the Eighth Amendment prohibition against cruel and unusual punishment.”²⁵⁹ The State ultimately conceded that the prison conditions violated the Eighth Amendment and agreed to an injunction to remedy the constitutional violation, but because the State failed to comply with that injunction, the court then imposed further judicial oversight.²⁶⁰ The Supreme Court, affirming that oversight regime, held: “If government fails to fulfill [its] obligation, the courts have a responsibility to remedy the resulting Eighth Amendment violation.”²⁶¹ The Court further reasoned: “Courts faced with the sensitive task of remedying unconstitutional prison conditions must consider a range of available options, including appointment of special masters or receivers and the possibility of consent decrees.”²⁶²

In other Eighth Amendment prison condition cases, too, some Justices have taken a holistic approach, reasoning:

It is important to recognize that various deficiencies in prison conditions “must be considered together.” The individual conditions “exist in combination; each affects the other; and taken together they [may] have a cumulative impact on the inmates.” Thus, a court considering an Eighth Amendment challenge to conditions of confinement must examine the totality of the circumstances. Even if no single condition of confinement would be unconstitutional in itself, “exposure to the cumulative effect of prison conditions may subject inmates to cruel and unusual punishment.”²⁶³

In the prison conditions context, then, the determination that the regime is not in compliance with the constitutional minimum then requires the court to bring the violating state into compliance, often through a consent decree.²⁶⁴

259. See Brief of *Plata* Appellees at 10, *Plata*, 563 U.S. 493 (No. 09-1233), 2010 WL 4641625.

260. See *Plata*, 563 U.S. at 507 (explaining that after the state failed to comply with the remedial injunction to which it had stipulated, “the court appointed a Receiver to oversee remedial efforts”).

261. *Id.* at 511 (citing *Hutto v. Finney*, 437 U.S. 678, 687 n.9 (1978)).

262. *Id.*; see also, e.g., *Wilbur v. City of Mount Vernon*, 989 F. Supp. 2d 1122, 1133-34 (W.D. Wash. 2013) (entering a continuing injunction against a city for violations of the Sixth Amendment and remarking that “the Court will ‘not shrink from [its] obligation to enforce the constitutional rights of all persons’” (alteration in original) (quoting *Plata*, 563 U.S. at 511)); *Sanders v. City of Houston*, 543 F. Supp. 694, 696 (S.D. Tex. 1982) (entering a permanent injunction against the defendants), *aff’d mem.*, 741 F.2d 1379 (5th Cir. 1984).

263. *Rhodes v. Chapman*, 452 U.S. 337, 362-63 (1981) (Brennan, J., concurring in the judgment) (alteration in original) (footnote omitted) (citations omitted) (first quoting *Holt v. Sarver*, 309 F. Supp. 362, 373 (E.D. Ark. 1970), *aff’d*, 442 F.2d 304 (8th Cir. 1971); then quoting *Laaman v. Helgemoe*, 437 F. Supp. 269, 322-23 (D.N.H. 1977)) (writing for three Justices).

264. See *id.* at 353 n.1 (discussing prison condition litigations “in which prisons or prison systems have been placed under court order” and referring to relevant consent decrees).

This means that, usually, the state will be given an opportunity to come into compliance once its regime has been found unconstitutional.²⁶⁵ And if a court is concerned that a general injunction will not effectively resolve the problem, it may require specific actions on the part of the state.²⁶⁶

The same general principles ought to apply to abortion restrictions. If a court finds an undue burden, “the scope of injunctive relief [would be] dictated by the extent of the violation established.”²⁶⁷ Once a court determines that a state’s abortion regulation regime imposes an undue burden, the court should, as in other contexts, craft a remedy to address the violations.²⁶⁸ Because the undue burden challenge is, on this view, a holistic endeavor, remedies should likewise be holistic.

Critics might argue that even under my understanding of the undue burden standard, states could “game” the test by asserting in litigation that all of their restrictions exist to protect fetal life, rather than women’s health or the integrity of the medical profession, or that the legislative regime exists to protect all rationales at once. Such gaming would be unsuccessful. First, as discussed in Part III.A.1 above, the anti-abortion rights movement has, over recent decades, realized that serious strategic disadvantages flow from framing abortion restrictions as protective of fetal life.²⁶⁹ These strategic and political considerations may place some external limitations on anti-abortion rights legislators’ willingness to simply frame every restrictive law as fetal life-protective. In addition, even if states did begin to frame every restriction in terms of fetal life, that strategy would be in vain. Because under my understanding of the undue burden standard abortion rights are tethered to fixed goalposts of other comparable procedures, the scope of the burdens states could impose is inflexible. So even if states passed a barrage of fetal life-related laws, the allowable variation for abortion restrictions would mean that an overzealous state’s regime would likely impose an undue burden and thus violate the Fourteenth Amendment. In other words, simply shifting their asserted rationale would not change the severity of regulation on abortion that

265. Cf. Shima Baradaran-Robison, Comment, *Kaleidoscopic Consent Decrees: School Desegregation and Prison Reform Consent Decrees After the Prison Litigation Reform Act and Freeman-Dowell*, 2003 BYU L. REV. 1333, 1345-46 (explaining the process by which school districts could come into compliance with constitutional mandates as implemented by district courts).

266. See Gewirtz, *supra* note 180, at 596-97.

267. *Califano v. Yamasaki*, 442 U.S. 682, 702 (1979) (citing *Dayton Bd. of Educ. v. Brinkman*, 433 U.S. 406, 414-20 (1977)); accord *Lewis v. Casey*, 518 U.S. 343, 359-60 (1996) (discussing the proper scope of an injunctive order).

268. See *Cobell v. Norton*, 283 F. Supp. 2d 66, 86 (D.D.C. 2003) (discussing the use and scope of structural injunctions), *vacated in part and remanded*, 392 F.3d 461 (D.C. Cir. 2004).

269. See *supra* notes 149-51 and accompanying text.

states are allowed to impose. Furthermore, if states asserted in litigation that their regimes existed to simultaneously promote multiple state interests, courts could simply approach such claims as they approach any claim about the purposes of a law: by critically analyzing it through normal principles of statutory interpretation.

Conclusion

The Supreme Court has repeatedly affirmed the right of a woman to terminate her pregnancy. But the standard currently used to evaluate abortion restrictions allows incremental restrictions on abortion access. By asking whether any particular law creates an undue burden, the undue burden standard ignores the burdens that laws can impose in conjunction, and in so doing incorrectly positions the right to an abortion as emphasizing a particular law rather than the woman who has the right. Further, the undue burden standard imposes serious evidentiary and statistical burdens on advocates and courts and, as a result, creates downward incremental pressure on abortion access.

If women's Fourteenth Amendment rights to terminate their pregnancies are to be taken seriously, the undue burden standard should be reevaluated. Instead of assessing whether one particular statute or regulation imposes a burden, the test should assess whether, overall, women seeking abortions experience the same burdens as do patients seeking analogous medical procedures. If women facing abortions face greater obstacles and burdens, then the test should assess, against that baseline, whether women seeking abortion face an undue burden. This approach ties abortion to the relative constant of other medical care and therefore prevents the downward incrementalism in abortion access that plagues the current model.