

Medical Evidence and Expertise in Abortion Jurisprudence

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For another thing, the division of medical opinion about the matter at most means uncertainty, a factor that signals the presence of risk, not its absence. That division here involves highly qualified knowledgeable experts on both sides of the issue.—Stenberg v. Carhart, 2000¹

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.—Gonzales v. Carhart, 2007²

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¹ Stenberg v. Carhart, 530 U.S. 914, 937 (2000).

² Gonzales v. Carhart, 550 U.S. 124, 159 (2007).

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I. INTRODUCTION

Medical literature on abortion largely supports pro-choice legal claims. In turn, progressive lawyers often call for “evidence-based approaches” to lawmaking on the assumption that it will produce pro-choice legal and regulatory outcomes. This article argues that the evidence-based approach is no longer a reliable or stable strategy for pro-choice lawyering given transformations in judicial treatment of medical knowledge and a shifting evidentiary base.³

Drawing on landmark cases from 1973 to 2012, this article demonstrates how the Supreme Court and lower courts selectively utilize medical expertise and evidence to liberalize or constrain abortion access. With *Roe v. Wade*,⁴ the Supreme Court began its engagement with medical evidence and expertise intending to liberalize abortion. The Court relied on medical knowledge that lent credibility to progressive arguments, while dismissing evidence that supported conservative claims. In doing so, the court treated evidence supporting progressive claims as objective and neutral and discounted

³ I use the term progressive to describe lawyers and public health practitioners that support the liberalization laws. I use pro-choice and progressive interchangeably. I use conservative to describe lawyers and public health practitioners that support limiting access to abortion. I use pro-life and conservative interchangeably.

⁴ *Roe v. Wade*, 410 U.S. 113 (1973).

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claims that supported limiting access to abortion. This has now flipped—the Supreme Court and lower courts often treat medical evidence and expertise that supports conservative claims as objective and neutral. These newly-legitimated conservative ideas about abortion provide the foundation for the vast proliferation of informed consent laws that regulate provider-patient interaction at the most minute level—mandating that women seeking abortion look at sonograms and hear the fetal heartbeat, as well as scripting physician disclosures.⁵ This new reality is exemplified in *Texas Medical Providers Performing Abortion Services v. Lakey*, a Fifth Circuit case regarding the Texas 2011 Women’s Right to Know Act, in which the court heralds conservative expert and evidentiary claims as objective while discounting progressive assertions.⁶

Given the transformation in the development and use of medical evidence and expertise, I argue that progressive lawyering strategies on the issue of abortion should delink legal advocacy from its nearly absolute reliance on “evidence based approaches.” This is a novel, transformative, and controversial recommendation that challenges the nearly universally held position that abortion rights advocacy should rely on medical evidence and expertise. In keeping with reproductive rights advocacy, health law scholars support the idea that an evidence base, when developed with rigor and attention to methodology, lends itself to better judicial outcomes.⁷ In making this argument, progressive lawyers often overestimate the objectivity of scientific and medical expertise and under-theorize the role of politics in judicial decision-making.

The position of progressive lawyers implicitly runs against the argument made by constitutional legal theorists who argue that it is necessary to understand purportedly objective legal thinking in the context of politics and ideology.⁸ Similarly, STS scholars argue that science, evidence, and expertise emerge from society and that the court not only uses knowledge it also produces what we know.⁹ Drawing on insights

⁵ See GUTTMACHER INST., STATE POLICIES IN BRIEF: COUNSELING AND WAITING PERIODS FOR ABORTION (2015), http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf (discussing state laws requiring counseling and/or waiting periods prior to receipt of abortion services). For abortion clinic closures, in general, see Esme E. Deprez, *Abortion Clinics Close at Record Pace After States Tighten Rules*, BLOOMBERG BUS. (Sept. 3, 2013, 8:52 AM), <http://www.bloomberg.com/news/2013-09-03/abortion-clinics-close-at-record-pace-after-states-tighten-rules.html>; Stephanie Lucero, *Abortion Clinics Start Closing Across Texas*, CBS DFW (Nov. 1, 2013, 6:35 AM), <http://dfw.cbslocal.com/2013/11/01/abortion-clinics-start-closing-across-texas/>; Darrel Rowland & Alex Felser, *More Ohio Abortion Clinics Closing*, COLUMBUS DISPATCH (Oct. 16, 2013, 6:48 PM), <http://www.dispatch.com/content/stories/local/2013/10/16/1016-abortion-clinics-closing.html>.

⁶ *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012).

⁷ See, e.g., LESLIE J. REAGAN, *WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973* (1997).

⁸ See e.g., Duncan Kennedy, *Freedom and Constraint in Adjudication: A Critical Phenomenology*, 36 J. LEGAL EDUC. 518 (1986); Robert Post & Reva Siegel, *Originalism as a Political Practice: The Right’s Living Constitution*, 75 *FORDHAM L. REV.* 545 (2006); Reva B. Siegel, *The Right’s Reasons: Constitutional Conflict and the Spread of Woman-Protective Antiabortion Argument*, 57 *DUKE L.J.* 1641 (2008).

⁹ See SHEILA JASANOFF, *STATES OF KNOWLEDGE: THE CO-PRODUCTION OF SCIENCE AND SOCIAL ORDER* 2-3 (2007). Jasanoff defines co-production as:

[S]hortand for the proposition that the ways in which we know and represent the world (both nature and society) are inseparable from the ways in which we choose to live in it. Knowledge and its material embodiments are at once products of social work and constitutive of forms of social life; society cannot function without knowledge any more than knowledge can exist without appropriate social supports. Scientific knowledge, in particular, is not a transcendent mirror of reality. It both embeds and is embedded in social practices, identities, norms, conventions, discourses, instruments and institutions – in short, in all the building blocks of what we term the social. The same can be said even more

from constitutional legal theory, health law, feminist legal theory,¹⁰ and the field of science, technology, and society (STS),¹¹ this paper argues that the use of medical and scientific evidence and expertise, rather than produce determinate outcomes, as asserted by progressive health and reproductive rights advocates often proves indeterminate. For example, in the 2000 Supreme Court case *Stenberg v. Carhart*, the Court's examination of conflicting evidence and expertise on an abortion procedure resulted in a progressive outcome.¹² In the 2007 Supreme Court case *Gonzales v. Carhart*, nearly identical evidence and expertise resulted in a conservative outcome.¹³ Understanding the complicated role of medical evidence in adjudication requires an exploration of how courts and lawmakers use medical expertise and evidence to code the political projects of courts, how medical experts with conflicting opinions legitimate themselves through participating in adjudication, and how medical expertise and evidence constrains judicial decision-making. Importantly, rather than the Court simply consuming and adjudicating factual information about abortion, the Court itself becomes a site for production of new facts and knowledge about abortion.¹⁴

Given the indeterminacy of outcomes, how should progressive lawyers proceed? This analysis offers a series of strategic interventions designed to recalibrate progressive lawyering for reproductive health. These interventions are rooted in the feminist critique of science.¹⁵ In assessing the social and political context in which evidence emerges, this paper takes a critical view of the "objectivity" of knowledge about abortion.¹⁶ This approach revives an important piece of lawyering and advocacy

forcefully of technology.

Id.

¹⁰ For an example of feminist legal theory scholarship, see Martha Albertson Fineman, *The Vulnerable Subject: Anchoring Equality in the Human Condition*, 20 YALE J.L. & FEMINISM 1 (2008). Martha Fineman's work on vulnerability provides a particularly helpful lens by which to understand institutions as vulnerable. In this paper, the idea of institutional vulnerability allows us to see the clinic as a vulnerable institution. Fineman defines the institutional vulnerability:

Of course, societal institutions can ameliorate or complicate our vulnerability, but they should also be understood as vulnerable entities in and of themselves. We know that societal institutions are not foolproof shelters, even in the short term. They may fail in the wake of market fluctuations, changing international policies, institutional and political compromises, or human prejudices...Further this institutional vulnerability is almost always obscured, and those in control of institutions have a powerful interest in disclaiming the appearance of any vulnerability.

¹¹ For an example of STS scholarship, see Donna Haraway, *Situated Knowledges: The Science Question in Feminism and the Privilege of Partial Perspective*, 14 FEMINIST STUD. 575 (1988).

¹² See *Stenberg v. Carhart*, 530 U.S. 914 (2000).

¹³ See *Gonzales v. Carhart*, 550 U.S. 124 (2007).

¹⁴ See Post & Siegel, *supra* note 8, at 556.

¹⁵ For an example of the feminist critique of science, see Haraway, *supra* note 11.

¹⁶ The idea that science is socially constructed emerges from a long lineage of scholarship on the production of knowledge in society. In recent history, these ideas are traced back to the 1962 publication of Thomas Kuhn's *The Structure of Scientific Revolutions*. In his book, Kuhn argues, amongst other points, that the people who produce scientific knowledge (the scientists) should be understood contextually, allowing an interrogation of the production of scientific ideas. See generally THOMAS S. KUHN, *THE STRUCTURE OF SCIENTIFIC REVOLUTIONS* (1962). Kuhn's book helped to pave the way for sociologists and historians to begin to study the nature of science as well as the specific sociological study of science and technology. Since 1962, the critical study of science can be found in law, economics, sociology, gender studies, and public health, amongst other disciplines. In its contemporary form, this perspective often falls under the heading of "science, technology, and society" or "science and technology studies" (STS). For a history of STS, see, generally, Sheila Jasanoff, *A Field of Its Own: The Emergence of Science and Technology Studies*, in *THE OXFORD HANDBOOK OF INTERDISCIPLINARITY* 191-205 (Robert Frodeman & Julie Thompson Klein eds., 2012). For examples of work drawing on STS in law as well as economics, see, generally, Andrew Lang, *Governing 'As If': Global Subsidies Regulation and the Benchmark Problem*, in 67 CURRENT LEGAL

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for health: the critique of science, evidence, and expertise. It is a call to return to the skepticism offered to us by two of the most successful health movements in recent history—the feminist women’s health movement and the AIDS movement.¹⁷ For some, this is a frightening proposition that will lead to assertions unmoored from “truth” or “fact.” I argue instead that we need to revive this critique of evidence and expertise to maintain an analytic agility necessary to understanding the material consequences of a long-term transformation in the knowledge environment around abortion. Without sensitivity to the social construction of evidence and expertise, we will be unable to understand how the courts enable and legitimate shifts in the evidentiary base on abortion that result in a rapid decrease in abortion access.

This paper proceeds as follows. Part II analyzes four crucial Supreme Court decisions, *Roe v. Wade*, *Planned Parenthood v. Casey*,¹⁸ *Stenberg v. Carhart*, and *Gonzales v. Carhart*, to understand how the role of medical and scientific evidence in each decision changes from deferring to expertise and evidence supporting progressive views on abortion to eventually legitimizing conservative claims. This analysis facilitates an understanding of how the courts co-produce knowledge about abortion, and how some ideas about abortion become naturalized and taken as “fact” over time. Part III considers the impact of Supreme Court decisions on access to abortion services through the circulation of newly legitimized scientific, medical, and public health facts. I focus on *Lahey*, in which the claim that abortion has negative mental health consequences justified conservative demands for the imposition of heightened informed consent requirements for women seeking abortion against the wishes of progressive advocates.¹⁹ Given the transformation in Supreme Court and state court jurisprudence on abortion, Part IV draws on critiques offered by the feminist women’s health movement to reimagine reproductive justice advocacy. I argue that we should find regulatory interventions that seek both to reset the advocacy agenda for progressive lawyering on abortion and to reinvigorate the longstanding (but forgotten) critique of evidence and expertise in health law advocacy.

II. ROLE OF SCIENCE AND MEDICAL EXPERTISE IN THE ABORTION JURISPRUDENCE: RE-READING ROE, CASEY, STENBERG AND GONZALES

Both medical expertise and law are embedded in social, historical, and political environments.²⁰ In turn, we must view the actors in this current study—judges, lawyers, researchers, and physicians—as similarly embedded in these social, historical, and political environments.²¹

Understanding how medical evidence and expertise shaped abortion jurisprudence requires a close reading of four landmark decisions: *Roe v. Wade*, *Planned Parenthood v. Casey*, *Stenberg v. Carhart*, and *Gonzales v. Carhart*. To be clear, this is not simply

PROBLEMS 135 (Robert Chambers et al. eds., 2014); Haraway, *supra* note 11; Sally Engle Merry, *Measuring the World: Indicators, Human Rights, and Global Governance*, 52 CURRENT ANTHROPOLOGY S83 (2011).

¹⁷ See STEVEN EPSTEIN, INCLUSION: THE POLITICS OF DIFFERENCE IN MEDICAL RESEARCH 54-73 (2007) (discussing the role of the women’s health movement and the AIDS movement in the context of a broader politics of inclusion-and-difference in state policy making).

¹⁸ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

¹⁹ *Tex. Med. Providers Performing Abortion Servs. v. Lahey*, 667 F.3d 570, 576 (5th Cir. 2012).

²⁰ Legal realism thinks about law in social context. See generally OLIVER WENDELL HOLMES, THE COMMON LAW (1881). The social studies of science have also sought to understand science in social context. See, e.g., Kuhn, *supra* note 16. More recently, scholars have attempted to understand the role of expertise and experts on broader questions, including economics. See, e.g., JAMES R. HACKNEY, UNDER THE COVER OF SCIENCE: AMERICAN LEGAL-ECONOMIC THEORY AND THE QUEST FOR OBJECTIVITY (2007).

²¹ See Haraway, *supra* note 11, at 591.

an inquiry into when and in which context the Court cited to the “best evidence.” Instead this section seeks to, first, show how evidence codes political decisions in the technicality of expert knowledge. Second, the analysis shows how the invocation and deployment of medical evidence and expertise has indeterminate outcomes.²² Third, it shows how courts increasingly legitimize arguments based on evidence that supports limiting abortion access. Courts eventually place this research on par with the research that justifies liberalizing abortion. Finally, it is an examination of how courts mobilize expertise and evidence to establish new common sense “facts” about abortion: that life begins at viability, that women experience negative mental health consequences with their abortions, and that intact dilation and extraction is not a necessary procedure.

A. ROE V. WADE

1. Medical Authority and Expertise in the Roe Court

In 1973, *Roe* dramatically altered the legal landscape for abortion in the United States by instituting the trimester framework to evaluate laws impacting abortion access: the Court held that, prior to the end of the first trimester, states should not regulate abortion; after the end of the first trimester, states may reasonably regulate abortion; and after the moment of viability, the state may proscribe abortion altogether.²³

The *Roe* Court continued a tradition that was established in the nineteenth century of relying on medical evidence and expertise to shape the legal and regulatory environment on abortion.²⁴ However, in *Roe* and the many cases that followed, the Supreme Court had to address a major issue: medical experts often take contradictory positions with regard to abortion procedures and consequences. Crucially, rather than argue that medical experts and evidence might be influenced by politics, society, and culture,²⁵ the Court helped to paint a picture of medical experts detached from their social and political contexts. In doing so, the Court was able to defer to expertise understood to be objective, neutral, and apolitical on a highly contested issue.²⁶ The insulation of physicians and mere deference to their unbiased expertise enabled the political project of liberalizing abortion,²⁷ while fulfilling the promise made at the

²² Indeterminacy is a contested idea in scholarship on legal reasoning. In this paper, I utilize the idea of indeterminacy put forward in Karl Klare’s chapter, *Critical Perspectives on Social and Economic Rights, Democracy and Separation of Powers*. Klare suggests that indeterminacy emerges from legal realism. Indeterminacy allows an exploration of the embeddedness of knowledge and thus the limits of reason. However, indeterminacy “does not entail the death of reason” nor does it suggest that ideology trumps all else. Karl Klare, *Critical Perspectives on Social and Economic Rights, Democracy and Separation of Powers*, in *SOCIAL AND ECONOMIC RIGHTS IN THEORY AND PRACTICE: CRITICAL INQUIRIES* 3, 11-12 (Helena Alviar Garcia et al. eds., 2015).

²³ *Roe v. Wade*, 410 U.S. 113, 164-66 (1973).

²⁴ REAGAN, *supra* note 7.

²⁵ In *Roe*, the physician appears as several characters: a complainant in the case, a practicing doctor, and an expert that is part of a professional body governed by a code of ethics.

²⁶ See PAULA A. TREICHLER, HOW TO HAVE THEORY IN AN EPIDEMIC: CULTURAL CHRONICLES OF AIDS 15-39 (1999).

²⁷ “[Justice] Blackmun saw medicine not only as a source of authority and expertise, but also as a model of compassion, increasingly in a specifically political way. . . . He became an impatient critic of those who sought to undercut reproductive rights . . . chastising his fellow Justices for their blindness to ‘another world out there.’” Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 *BROOK. L. REV.* 147, 189 (2006) (quoting Justice Harry J. Blackmun, Third Draft of Planned Parenthood of Missouri v. Danforth 3 (June 6, 1976) (on file with The Library of Congress, Manuscript Division, The

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outset of the opinion: that the Court would consider the case of abortion “free of emotion and of predilection.”²⁸ In other words, through rationalizing the liberalization of abortion in terms of medical science and evidence, the Court insulated itself from accusations of acting politically. But first, the Court had to do the work to ensure that medical science was secure from scrutiny.

2. Setting the Stage: The American Medical Association as an Apolitical Institution

The *Roe* Court’s discussion of the American Medical Association’s (AMA’s) shifting stance on abortion between 1857 and 1970 exemplifies how courts establish medicine’s independent expert authority while acknowledging but minimizing the role of historical, political, and social context.

The *Roe* Court began its discussion by presenting the AMA’s 1857 position that abortion was a practice leading to the “destruction of human life.”²⁹ The Court then drew upon the 1871 Report on Criminal Abortion by the AMA’s Committee on Criminal Abortion, which has a similar tenor:

[A]mong other things, that it ‘be unlawful and unprofessional for any physician to induce abortion or premature labor, without the concurrent opinion of at least one respectable consulting physician, and then always with a view to the safety of the child-if that be possible,’ and calling ‘the attention of the clergy of all denominations to the perverted views of morality entertained by a large class of females-aye, and men also, on this important question.’³⁰

The decision jumps forward nearly 100 years to 1967 when the AMA softened its position with a “policy of opposition to induced abortion, except when there is ‘documented medical evidence’ of a threat to the health or life of the mother”³¹ The Court ended its assessment of the AMA with the organization’s 1970 Judicial Council opinion emphasizing that abortion is a medical procedure and the importance of the role of medical experts in performing the procedure.³²

According to the *Roe* Court, the AMA position did not change due to physicians’ political beliefs or shifting political, social, and cultural attitudes towards abortion. Rather, physicians were simply responding to new developments in medical knowledge:

When most criminal abortion laws were first enacted, the procedure was a hazardous one for the woman. This was particularly true prior to the development of antisepsis. . . . Thus, it has been argued that a State’s real concern in enacting a criminal abortion law was to protect the pregnant woman, that is, to restrain her from submitting to a procedure that placed her life in serious jeopardy.

Modern medical techniques have altered this situation. Appellants and various amici refer to medical data indicating that abortion in early pregnancy, that is, prior to the end of the first trimester, although not

Harry A. Blackmun Papers, Box 220, Folder 9))) (internal quotation marks omitted).

²⁸ See *Roe*, 410 U.S. at 116.

²⁹ See *id.* at 142.

³⁰ See *id.* (quoting 22 TRANSACTIONS AM. MED. ASS’N 38-39 (1871)).

³¹ See *id.* at 142-43 (citing *Therapeutic Abortion*, 116 PROC. AM. MED. ASS’N H.D. 40-51 (1967)).

³² See *id.* at 143-44 (citing William B. Steen et al., *Resolution 31: Reaffirmation of AMA Official Policy on Abortion*, 24 PROC. AM. MED. ASS’N H.D. 220 (1970)).

without its risk, is now relatively safe. . . . Consequently, any interest of the State in protecting the woman from an inherently hazardous procedure, except when it would be equally dangerous for her to forgo it, has largely disappeared.³³

By ascribing shifts in medical opinion to advances in medicine rather than evolving political and social beliefs, the Court left open the possibility that physicians have always simply acted on the best medical evidence of the day, uninfluenced by social forces.³⁴ Further, the decision ignored the possibility that the evidence itself may emerge from social norms including concerns for women's virtuousness or shifting demographics.³⁵

The AMA's treatment of changing opinion illustrates how the Court is able to discursively separate politics from science when interpreting medical expertise and evidence.³⁶ This allowed the Court to liberalize abortion laws—arguably the goal of the *Roe* Court—while insulating itself from scrutiny. As will be illustrated, in order to establish the rigor of scientific objectivity the Court had to proceed in two steps. First, it had to minimize, if not actively discredit, conservative physicians that filed a brief arguing that life begins at conception. Second, and relatedly, the Court had to downplay or ignore the oppositional nature of the medical amicus briefs.

3. Deference to Medical Expertise: Viability

Examining a key question of medical import in the decision exemplifies how the Court distinguished between medical authority that supported conservative or progressive arguments to eventually justify liberalizing abortion. In *Roe*, the Court's analysis of the key medical question, "when is the fetus viable?" demonstrates the Court's efforts to insulate progressive medical expertise and evidence from external scrutiny. The Court had before it both progressive and conservative claims about abortion. For example, the brief for the Planned Parenthood physicians argued that modern medical opinion regarded abortion as a procedure that should be available without state-imposed restrictions as to permissible reasons, pointing out that on June 25, 1970, the House of Delegates of the AMA recommended that licensed physicians be permitted to perform abortions in hospitals or approved clinics without restriction after consultation with two other physicians.³⁷

The brief of the American College of Obstetrics and Gynecologists (ACOG) similarly emphasizes the need for physicians to practice medicine without state regulation. ACOG argued that "[a] decision to perform an abortion should be regarded as strictly a medical decision and a medical responsibility. . . . [that] should be

³³ *Id.* at 148-49.

³⁴ See, e.g., D.A. O'Donnell & W.L. Atlee, Comm. on Criminal Abortion, Am. Med. Ass'n, *Report on Criminal Abortion*, 22 TRANSACTIONS AM. MED. ASS'N 239, 256 (1871).

³⁵ For example, the report highlights shifting demographics in America as well concern for the role of women as mothers. *Id.* at 243-244; see also Nicola Beisel & Tamara Kay, *Abortion, Race, and Gender in Nineteenth-Century America*, 69 AM. SOC. REV. 498 (2004) (Beisel and Kay argue that contestation around abortion in the nineteenth century was primarily about control over the reproductive capacity of Anglo-Saxan women.)

³⁶ Cf. LINDA GREENHOUSE, *BECOMING JUSTICE BLACKMUN: HARRY BLACKMUN'S SUPREME COURT JOURNEY* 90 (2005) (discussing Justice Blackmun's reliance on the medical history of abortion while writing his draft opinion).

³⁷ Supplemental Brief for Planned Parenthood Federation of America, Inc. and American Ass'n of Planned Parenthood Physicians as Amici Curiae Supporting Appellants, *Roe*, 410 U.S. 113 (1973) (Nos. 70-18, 70-40), 1972 WL 126043, at *10-11.

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removed entirely from the jurisdiction of criminal law.”³⁸

Pro-life physicians acting under the name “Certain Physicians, Professors, and Fellows of ACOG” also asserted their own medical authority. Their primary goal was to “urge [the] Court to consider the current medical and scientific evidence of the humanity of the unborn”³⁹ By keeping ACOG in its title, the group established itself within the larger medical community and in turn as a legitimate voice of the medical practitioner. Further, the group is careful to point out that many of their physician members are fellows of ACOG and practicing physicians.⁴⁰ These “Certain physicians of ACOG” disagree with ACOG’s push for the decriminalization of abortion in arguing that the fetus is an unborn child.

The Court, however, discounts the brief from these “certain” physicians in a sweeping move:

The latter [life starting at conception] is now, of course, the official belief of the Catholic Church. As one brief amicus discloses, this is a view strongly held by many non-Catholics as well, and by many physicians. Substantial problems for precise definition of this view are posed, however, by new embryological data that purport to indicate that conception is a ‘process’ over time, rather than an event, and by new medical techniques such as menstrual extraction, the ‘morning-after’ pill, implantation of embryos, artificial insemination, and even artificial wombs.⁴¹

The Court instead defers to physicians supporting the liberalization of abortion laws,⁴² delegitimizing physicians who expressed an opinion against abortion.⁴³

As we have noted, the common law found greater significance in quickening. Physicians and their scientific colleagues have regarded that event with less interest and have tended to focus either upon conception, upon live birth, or upon the interim point at which the fetus becomes ‘viable,’ that is, potentially able to live outside the mother’s womb,

³⁸ Brief of the American College of Obstetricians and Gynecologists et al., *Roe*, 410 U.S. 113 (1973) (No. 70-18), 1971 WL 128053, at *3.

³⁹ Motion and Brief Amicus Curiae for of Certain Physicians, Professors, and Fellows of the American College of Obstetrics and Gynecology Supporting Appellees, *Roe*, 410 U.S. 113 (1973), 1971 WL 128057, at *2 [hereinafter Brief of Certain Physicians].

⁴⁰ *Id.*

⁴¹ *Roe*, 410 U.S. at 161.

⁴² For a progressive physician viewpoint, see Motion for Leave to File a Brief and Brief as Amici Curiae for the American College of Obstetricians and Gynecologists et al., *Roe*, 410 U.S. 113 (1973) (No. 70-40) 1971 WL 126685. Many physician amici emphasized anti-abortion legislation’s restriction not only on patient choice, but also physician autonomy:

The rights of physicians to administer health care, and of patients to seek medical treatment, are fundamental personal interests recognized by national and international standards of medical practice, and protected by the First, Ninth, and Fourteenth Amendments. . . . In reviewing legislation affecting the medical profession, courts have particularly respected the knowledge and skill necessary for medical practice, the broad professional discretion necessary to apply it, and the concomitant state interest in guaranteeing the quality of medical practitioners.

Id. at *38.

⁴³ For a pro-life physician viewpoint, see Brief of Certain Physicians, *supra* note 39, at *8 (“From conception the child is a complex, dynamic, rapidly growing organism.”).

albeit with artificial aid.⁴⁴

In aligning themselves with progressive doctors the Court did not cite to the progressive physician briefs. The Court did, however, cite to *Williams Obstetrics*, the leading obstetrics textbook at the time. The authors of the textbook include Louis Hellman and Jack Pritchard, two physician signatories to the ACOG amicus brief.

The Court actively worked to establish the medical independence of physicians aligned with liberalizing abortion and then deferred to them. The Court portrayed the physician as a neutral arbiter, and medical authority as objective and independent from the courts. The decision ended on this note:

For the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician. . . . For the stage subsequent to approximately the end of the first trimester, the State, in promoting its interest in the health of the mother, may, if it chooses, regulate the abortion procedure in ways that are reasonably related to maternal health.⁴⁵

Medical science emerged as an objective authority on questions of viability, mental health, and abortion procedure. This enabled the Court's decisions to appear apolitical even in the context of competing claims.

4. Ignoring Conservative Claims: Abortion and Mental Health

Unlike the later cases on abortion, the *Roe* majority ignored arguments placed before it on the issue of negative mental health consequences of the procedure. The Court faced conflicting claims on mental health and abortion. The brief by the (pro-life) Certain Physicians of ACOG stated:

A World Health Organization scientific group concluded that "There is no doubt that the termination of pregnancy may precipitate a serious psychoneurotic or even psychotic reaction in a susceptible individual." Some investigators have indeed noted lasting psychiatric reactions. However, there has been much variation in the medical literature regarding the incidence of psychological sequelae to induced abortion.⁴⁶

Instead of heeding the assertion that abortion has negative mental health consequences, the *Roe* majority understood mental health concerns to be a factor *necessitating* an abortion rather than as an outcome of abortion:

Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent. Mental and physical health may be taxed by child care. There is also the distress, for all concerned, associated with the unwanted child, and there is the problem of bringing a child into a family already unable, psychologically and otherwise, to care for it. In other cases, as in this one, the additional difficulties and continuing stigma of unwed motherhood may be involved. All these are factors the woman and her

⁴⁴ *Roe*, 410 U.S. at 160.

⁴⁵ *Id.* at 164.

⁴⁶ Brief for Certain Physicians, *supra* note 39, at *55-56.

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responsible physician necessarily will consider in consultation.⁴⁷

The Court's unwillingness to give way to the argument that abortion causes psychological harm is a signal of the Court's desire to embolden the argument that abortion should be liberalized. In *Roe*, it was Blackmun who played an important role in ensuring that medical expertise was shielded from scrutiny in the course of the decision. We can see the complex boundary work performed by Blackmun as he isolated, insulated, and deferred to the medical authority that supported liberalizing abortion.⁴⁸ The Court analytically moved physicians and medical experts outside of the politics of the abortion debates. In *Roe*, the insulation of evidence, and in turn the Court, had strategic purpose: it allowed the Court to code its own political project in terms of expertise, and reified the idea that medical practitioners and experts are apolitical. In doing so, the Court was able to reach its own goal of rationalizing the decision in a manner "free of emotion and predilection."

Each of the abortion decisions that follow reveals how the Court manages the relationship between the Court and medical expertise to accomplish the broader political aim of increasing or decreasing access to abortion.

B. CASEY V. PLANNED PARENTHOOD

1. Medical Authority in the *Casey* Court

Twenty years later, the Court reconfigured the *Roe* rule in *Planned Parenthood v. Casey*. In *Casey*, the Court examined the constitutionality of five amendments to the Pennsylvania Abortion Control Act of 1982: an informed consent requirement; a twenty-four hour waiting period between the provision of certain information and the abortion; parental consent for minors; spousal notification; and reporting requirements for clinics.⁴⁹ Three of these requirements had a "medical emergency" exception.⁵⁰ The *Casey* Court was clear on its desire to maximize the ability of the state to regulate pregnancy.⁵¹ *Casey* discarded *Roe*'s trimester framework for regulating access to abortion and replaced it with the "undue burden" standard.⁵² In *Casey*, the Court made a slight move away from *Roe*'s protection of medical evidence that had shielded liberalizing abortion from scrutiny. The Court deferred to progressive medical authority on viability and medical emergencies, yet accepted conservative ideas on abortion and mental health.

Several issues necessitated medical inquiry in *Casey*: When is a fetus viable? What constitutes a medical emergency? Moreover, *Casey* became a pivot point for the

⁴⁷ *Roe*, 410 U.S. at 153 (emphasis added).

⁴⁸ Justice Blackmun asserts, "We need not resolve the difficult question of when life begins. When those trained in . . . medicine . . . are unable to arrive at any consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer." *Id.* at 159. "Nevertheless, the question simply reemerged in a different way. . . . Blackmun effectively had to decide when the life of the fetus 'began,' at least to the extent of deciding when the state's interest in protecting the fetus became compelling." Jack M. Balkin, *Roe v. Wade: An Engine of Controversy*, in *WHAT ROE SHOULD HAVE SAID* 3, 9 (Jack M. Balkin ed., 2005).

⁴⁹ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 833 (1992).

⁵⁰ *Id.* at 844.

⁵¹ *See id.* at 872 ("A [trimester] framework of this rigidity was unnecessary and in its later interpretation sometimes contradicted the State's permissible exercise of its powers.").

⁵² *Id.* at 837 ("An undue burden exists, and therefore a provision of law is invalid, if its purpose or effect is to place substantial obstacles in the path of a woman seeking an abortion before the fetus attains viability.").

Supreme Court on an important and controversial question: Are there negative mental health implications for abortion? The transition from *Roe* (abortion has no mental health consequences) to *Casey* and onwards (abortion has mental health consequences) was the outcome of the social and political organizing focused on mental health beginning in the 1980s—the period between *Roe* and *Casey*.

2. Deference to Medical Evidence and Expertise: Viability and Medical Emergencies

Viability remained a key consideration in *Casey*. The Court clearly articulated an unwillingness to renounce the central principle of *Roe*: a woman should be allowed to terminate her pregnancy before viability.⁵³ After viability, however, the state has a legitimate interest in the “life of the unborn” and thus the ability to restrict access to abortion.⁵⁴ In *Casey*, the Court acknowledged that viability is a shifting line determined by medical progress in the field of neonatology, marked, in part, by the ability of prematurely born fetuses to survive. In 1973, the date of the *Roe* decision, the earliest point of viability was twenty-eight weeks.⁵⁵ By the time of *Casey*, the point of viability was found to be twenty-three or twenty-four weeks.⁵⁶

We have seen how time has overtaken some of *Roe*'s factual assumptions: advances in maternal health care allow for abortions safe to the mother later in pregnancy than was true in 1973, and advances in neonatal care have advanced viability to a point somewhat earlier.⁵⁷

The Court saw shifting viability as an outcome of advances in medical practice. The Court therefore deferred fully to medical evidence and expertise on the question of viability, insulating itself from scrutiny on this question.

The Court treated “medical emergencies” similarly. In *Casey*, three of the provisions examined by the Court provide exceptions for medical emergencies: informed consent with a twenty-four hour waiting period; spousal consent for married women;⁵⁸ and parental consent for minors with the possibility of judicial bypass. A “medical emergency” is defined as a:

[A] condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as

⁵³ *Id.* at 871 (“The woman’s right to terminate her pregnancy before viability is the most central principle of *Roe v. Wade*. It is a rule of law and a component of liberty we cannot renounce.”).

⁵⁴ *Id.* at 869 (“The woman’s liberty is not so unlimited, however, that from the outset the State cannot show its concern for the life of the unborn, and at a later point in fetal development the State’s interest in life has sufficient force so that the right of the woman to terminate the pregnancy can be restricted.”).

⁵⁵ *Roe v. Wade*, 410 U.S. 113, 160 (citing LOUIS M. HELLMAN & JACK A. PRITCHARD, WILLIAMS’ OBSTETRICS 493 (14th ed. 1971)).

⁵⁶ *Casey*, 505 U.S. at 860 (discussing the progression of science).

⁵⁷ *Id.* (internal citations omitted).

⁵⁸ The Court discusses the informed consent requirement in detail:

Except in a medical emergency, the statute requires that at least 24 hours before performing an abortion a physician inform the woman of the nature of the procedure, the health risks of the abortion and of childbirth, and the “probable gestational age of the unborn child.” The physician or a qualified nonphysician must inform the woman of the availability of printed materials published by the State describing the fetus and providing information about medical assistance for childbirth, information about child support from the father, and a list of agencies which provide adoption and other services as alternatives to abortion. An abortion may not be performed unless the woman certifies in writing that she has been informed of the availability of these printed materials and has been provided them if she chooses to view them.

Id. at 881 (citing 18 PA. CONS. STAT. § 3205 (1990)).

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to necessitate the immediate abortion of her pregnancy to avert her death or for which a delay will create serious risk of substantial and irreversible impairment of a major bodily function.⁵⁹

In the context of the Pennsylvania act at issue, the Court stated that medical emergencies are contingent on a physician's good faith clinical judgment. However, just as in *Roe*, this reasoning ignores the possibility that clinical judgment is often variable—depending on the politics and beliefs of the individual physician.⁶⁰

3. Breaking From Progressive Medical Expertise and Evidence: Abortion and Mental Health

Casey is a pivotal moment in the Court's treatment of abortion and psychological harm. The *Casey* Court moved away from the *Roe* Court's assertion that psychological harm may be caused by unwanted pregnancy. According to the *Casey* Court, the abortion itself is what could psychologically harm a woman, if she is not adequately informed:

It cannot be questioned that psychological wellbeing is a facet of health. Nor can it be doubted that most women considering an abortion would deem the impact on the fetus relevant, if not dispositive, to the decision. In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed.⁶¹

This major shift represents a substantial victory for pro-life activism that had been building outside of the courtroom. Beginning in the 1980s, these anti-choice efforts

⁵⁹ *Id.* at 879 (quoting 18 PA. CONS. STAT. § 3203 (1990)) (emphasis added).

⁶⁰ Once again, the Court is faced with competing expert opinions about the questions at hand. As in *Roe*, this is explicitly acknowledged in the physician briefs. In arguing for a reversal of *Roe*, the American Association of Pro-life Obstetricians and Gynecologists (AAPLOG) write that the fetus should be "rightfully considered and treated as our second patient." Brief for the American Ass'n of Pro-life Obstetricians and Gynecologists (AAPLOG) and the American Ass'n of Pro-life Pediatricians (AAPLP) as Amici Curiae Supporting Respondents, *Casey*, 505 U.S. 833 (1992) (Nos. 91-744, 91-902), 1992 WL 12006428, at *6 [hereinafter Brief of AAPLOG] (quoting PRITCHARD & MACDONALD, WILLIAMS' OBSTETRICS vii (16th ed. 1980)). To justify this position on medical grounds, the brief argues that "fetal diagnosis and therapy" is a tool that obstetricians must possess. *Id.* The brief sets out to "provide the Court with a better understanding of the true nature and risks of pregnancy, childbirth and abortion as they are viewed in modern obstetrical practice. . . . [and] to correct many of the erroneous 'medical facts' set forth in petitioners' brief and that of ACOG." *Id.* at *2.

While acknowledging that doctors come from a variety of perspectives on abortion, ACOG argues that state laws "should not interfere" with medical judgment:

[W]hen a patient seeks medical care and treatment, such as abortion, state laws should not interfere with a health care provider's ability to exercise his or her best medical judgment in treating that patient. . . . [T]he Pennsylvania statute challenged here seriously interferes with a woman's ability, in consultation with her physician, to obtain an abortion . . .

Brief of the American College of Obstetricians and Gynecologists et al., *Casey*, 505 U.S. 833 (1992) (Nos. 91-744, 91-902), 1992 WL 12006402, at *1. In making this argument, ACOG relies on the validation of only progressive medicine in *Roe*. Interesting to note is that the pro-life expert groups attempt to gain legitimacy through their association with the larger entities from whom they break with ideologically. *See, e.g.*, Brief of AAPLOG, *supra* at *1. The physicians explicitly highlight that AAPLOG members are also members of ACOG and that the Pro-Life Pediatricians are also members of the American Academy of Pediatrics (AAP).

⁶¹ *Casey*, 505 U.S. at 882.

sought to tie abortion to negative mental health outcomes. The oft-cited moment marking this tension was the 1987 directive from Ronald Reagan to his surgeon general Everett Koop asking for a comprehensive report on the psychological and medical impact of abortion on women.⁶² Betraying his reputation as a “pro-life” Surgeon General, Koop responded by stating that there was not enough rigorous evidence to make the case that abortion causes negative mental health outcomes.⁶³

Taking a stronger position against the argument that abortion has negative mental health outcomes, the American Psychological Association (APA) amicus brief to *Casey* stated that it is the informed consent requirements that may produce negative mental health effects.⁶⁴ Rejecting the APA’s proposition, and implicitly rejecting the Surgeon General’s analysis, the *Casey* Court chose to support the argument offered by pro-life briefs: it is a lack of information about the abortion procedures and its consequences that has negative mental health consequences post-abortion. This “protectionist” position⁶⁵ advocates that women require additional time in order to give well thought-out consent.⁶⁶ The Court’s deference to the pro-life advocates in *Casey* betrayed its normative project and legitimized the pro-life position that abortion can have mental health consequences.

Rather than bolstering the progressive legal and medical claims regarding abortion, the Court’s reliance on conservative claims justified a new standard: undue burden. The Court in *Casey* finds that the regulations did not constitute an undue

⁶² Nancy Adler et al., *Psychological Factors in Abortion: A Review*, 47 AM. PSYCHOLOGIST 1194, 1194 (1992).

⁶³ *Id.* at 1195.

⁶⁴ Brief for Amicus Curiae American Psychological Ass’n in Support of Petitioners, *Casey*, 505 U.S. 833 (1992) (Nos. 91-744, 91-902), 1992 WL 12006399, at *4. The APA argues in its brief that:

These provisions confuse the purpose and process of obtaining “informed consent” with that of pre-abortion counseling. . . . The inflexible “counseling” mandated by the Commonwealth is likely to be contrary to the best interests of many women. *First*, some of the state-mandated information is actually exaggerated and misleading. Contrary to the impression conveyed by the Commonwealth’s brochure, *empirical research does not support the contention that abortion is a significant risk factor for detrimental psychological effects*. Misrepresenting the psychological sequelae of abortion—particularly when the psychological effects of its alternatives are omitted—may actually compromise a woman’s recovery from an abortion. *Second*, requiring counselors to give the *same* litany of information to every pregnant woman, regardless of its relevance to or likely impact on her, is the antithesis of effective counseling. Indeed, it may result in unnecessary anxiety, stress and harm to many women. *Further*, the dictated information is biased—obviously designed more to discourage a woman from choosing to terminate her pregnancy than to inform her decision.

Id. Prompted by the increasing attention paid to the intersection of mental health and abortion by the courts and in political discourse about abortion, the APA first began filing amicus briefs in 1983, filing a brief for *Akron v. Akron Center for Reproductive Health*. *See id.* at *1.

⁶⁵ Siegel, *supra* note 8, at 1642-43 (arguing, while relying on dignity arguments, that the Supreme Court is shifting from fetal-protective arguments to woman-protective arguments. However, the Court’s current mobilization of women’s protective arguments based on a stereotypical idea of women’s roles do not forward a women’s rights agenda.) *Id.*

⁶⁶ The Court does not cite to physician briefs, but rather to pro-life advocates such as the Feminists for Life and Legal Action for Women. *See* Brief of Feminists for Life of America et al., as Amici Curiae in Support of Respondents & Cross Petitioners, *Casey*, 505 U.S. 833 (1992) (Nos. 91-744, 91-902), 1992 WL 12006409, at *8-9 (“In addition to the obvious physical complications, abortion has a profound psychological impact upon many women that can be found in the testimonies of women who have undergone abortion. Since the absolute safety of abortion, whether in the first trimester or thereafter, cannot be established, there is no justification for complete deregulation of the procedure. The Commonwealth of Pennsylvania must be allowed to protect the woman considering abortion by requiring that she be given an opportunity to give a meaningful consent.”).

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burden, and that they are justified by the state's interest in protecting the would-be mother.⁶⁷ In doing so, the Court set the stage for laws driven by conservative rationales to enter into the courtroom discussion on abortion.

C. STENBERG V. CARHART

1. Medical Authority in the *Stenberg* Court

In 2000, eight years after *Casey*, the Court heard *Stenberg v. Carhart*. *Stenberg* concerned a Nebraska statute banning “partial-birth abortion,” a procedure defined by the statute as:

[A]n abortion procedure in which the person performing the abortion partially delivers vaginally a living unborn child before killing the unborn child and completing the delivery.⁶⁸

The statute contained an exception for the life of the pregnant woman, but not for the health of the woman.⁶⁹ Leroy Carhart, a physician who performed clinical abortions, challenged the law.⁷⁰ The first contested medical question before the Court focused on the partial-birth abortion procedure itself, specifically comparing the intact Dilation and Extraction (“Intact D&X”) and the non-intact Dilation and Extraction (“D&X”).⁷¹ A D&X procedure may involve disarticulation of the fetus prior to its excavation.⁷² During an Intact D&X procedure, the physician does not disarticulate the fetus prior to removing it from the uterus, but rather collapses the skull either to bring the fetus feet first through the cervix or to bring the skull out first followed by the rest of the fetus intact.⁷³ The Court grappled with whether Intact D&X is ever necessary and, in turn, whether a health exception was required.⁷⁴ The Court declared the statute unconstitutional on two grounds: first, the law lacked an exception for the “preservation of the health of the mother”; and second, it imposed an undue burden on a woman's ability to choose the necessary abortion procedure, “thereby unduly burdening her right to choose abortion itself.”⁷⁵

2. Conflicting Expertise: Intact versus Non-Intact Dilation and Extraction

The *Stenberg* Court relied heavily on medical testimony and expertise to understand the procedures and risks they pose to women. Immediately, however, the Court had to find a way to adjudicate between numerous competing sources of opinion, each deemed to be medically and scientifically authoritative, but providing differing advice, guidance, and knowledge on the actual procedure. In the face of

⁶⁷ The only amendment found to constitute an undue burden by the *Casey* Court is the “husband notification” provision. *See Casey*, 505 U.S. at 837-38.

⁶⁸ *Stenberg v. Carhart*, 530 U.S. 914, 922 (2000) (quoting NEB. REV. STAT. § 28-326(9) (Supp. 1999)).

⁶⁹ NEB. REV. STAT. § 28-328(1) (Supp. 1999).

⁷⁰ *Stenberg*, 530 U.S. at 922.

⁷¹ Throughout this paper, I will use “Intact D&X” for a procedure in which the fetus is left largely intact through the abortion procedure. “D&X” will be used for an abortion procedure that requires disarticulation prior to removal of the fetus.

⁷² *Stenberg*, 530 U.S. at 927.

⁷³ *Id.*

⁷⁴ *See generally id.* at 931-37 (examining the medical evidence regarding the advantages and possible necessity of a D&X procedure).

⁷⁵ *Id.* at 930 (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874, 879 (1992)).

conflicting data, the Court became an arbiter of medical and health knowledge.⁷⁶

The Court had before it, for example, competing expert testimony and evidence from the district court as well as amicus briefs submitted by numerous organizations including the Association of American Physicians and Surgeons (AAPS) and the American College of Obstetrics and Gynecology (ACOG). The AAPS sought to prevent a health exception while ACOG supported a health exception. In each case, the physician claims filter through differing political and moral viewpoints of each organization. The AAPS submitted its brief alongside many pro-life physicians organizations. Each pro-life medical organization validated its own medical expertise through the claim that its physicians engaged in medical practice and by referencing a larger moral and ethical frame—Christianity or the Hippocratic Oath.⁷⁷ Together the amici argue that they represent “medical realities” of “partial-birth abortion.”⁷⁸ These amici do not recognize the intact D&X procedure, and proffer that it is not the standard or preferred method under any circumstance.⁷⁹

Unlike prior cases, the Court implicitly placed these two physician positions (those who seek to liberalize abortion versus those who seek to limit access) on par with one another by simply acknowledging the differing medical opinions as holding equal potential influence and legitimacy. Rather than insulating one set of ideas as medically factual and discounting the other with near silence, as the *Roe* Court did, the *Stenberg* Court’s equalization of divergent expert positions made it necessary for the Court to arbitrate medical expertise and experience.⁸⁰ In doing so, the Court legitimized the arguments of physicians who sought to limit access to abortion and placed them on par with physicians that sought to liberalize abortion. This had several outcomes: First, the Court recalibrated the field to include the range of scientific and medical argumentation produced by each group of physicians; and second, the Court legitimated the arguments put forward by the anti-choice physicians:

For another thing, the division of medical opinion about the matter at most means uncertainty, a factor that signals the presence of risk, not its absence. That division here involves highly qualified knowledgeable experts on both sides of the issue. Where a significant body of medical

⁷⁶ *Id.* at 935 (“We do not quarrel with Nebraska’s argument, for Nebraska is right. There are no general medical studies documenting comparative safety.”). *See also* Michael J. Perry, *Religion, Politics, and Abortion*, 79 U. DET. MERCY L. REV. 1 (2001) (discussing contestation between frames, particularly religious, mobilized in constitutional debates on abortion).

⁷⁷ In doing so, they authorize their own expertise and validate their membership as a group of experts. *See, e.g.*, Brief Amici Curiae of Ass’n of American Physicians and Surgeons et al. in Support of Petitioners, *Stenberg*, 530 U.S. 914 (2000) (No. 99-830), 2000 WL 228448, at *3 (“Amicus Curiae New Jersey Physicians Resource Council (“NJPRC”) is an association of 45 New Jersey physicians which provides insight on medical, ethical and social issues for policymakers, medical professionals and the public. NJPRC does not believe that partial birth abortion is ever medically indicated to save the life of the mother or to protect her future fertility.”)

⁷⁸ *Id.*

⁷⁹ *Id.*

⁸⁰ Further adding to the complexity of the Court’s role in utilizing medical expertise is the statement of the American Medical Association:

According to the scientific literature, there does not appear to be any identified situation in which intact D&X is the only appropriate procedure to induce abortion, and ethical concerns have been raised about intact D&X. The AMA recommends that the procedure not be used unless alternative procedures pose materially greater risk to the woman. The physician must, however, retain the discretion to make that judgment, acting within standards of good medical practice and in the best interest of the patient.

HEALTH & ETHICS POLICIES OF THE AMA H.D. § H-5.982(2).

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opinion believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view, we cannot say that the presence of a different view by itself proves the contrary. Rather, the uncertainty means a significant likelihood that those who believe that D & X is a safer abortion method in certain circumstances may turn out to be right. If so, then the absence of a health exception will place women at an unnecessary risk of tragic health consequences. If they are wrong, the exception will simply turn out to have been unnecessary.⁸¹

This explicit acknowledgement of a divided body of literature is important as we approach *Gonzales v. Carhart*, in which the Court cited to non-medical anecdotal evidence partly due to a perceived lack of clarity amongst medical experts.⁸²

3. Recalibrating the Stage: All Evidence is Objective Evidence

Because the majority opinion never fundamentally questioned the idea of medical objectivity on either side of the case, *Stenberg* Court laid the foundation for pro-life physicians to gain legitimacy in the eyes of the Court and the public.

The *Stenberg* majority saw the split in medical evidence as a signal to err on the side of caution:

But where substantial medical authority supports the proposition that banning a particular abortion procedure could endanger women's health, *Casey* requires the statute to include a health exception when the procedure is “necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.”⁸³

Despite the progressive outcome of the case, the Court made a radical shift that has changed the terrain of assertions of medical fact and evidence: the Court treated opposing physician perspectives on abortion as equally legitimate.⁸⁴ This has reset the discussion of medical expertise and evidence and evened the playing field for conservative and progressive voices. It has allowed for a complete transformation at the state level: now rather than insulating progressive medicine as apolitical and

⁸¹ *Stenberg*, 530 U.S. at 937.

⁸² See *infra* Part D.

⁸³ *Id.* at 938 (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992)).

⁸⁴ Language plays an important role in the decision. The use of particular words codes the political leaning of the Justices. In *Stenberg*, the language is chosen carefully, in line with what has been deemed medical standard language by the AMA and ACOG. In other words, the language itself betrays the political outcome of the decision. In *Stenberg*, the words “partial-birth abortion” appear only in the majority decision in quotes and the word “dismemberment,” signaling the tearing apart of a human, is replaced with “disarticulation,” a word that signals a medical procedure. The dissenting Justices from Kennedy to Scalia, however, code their decision in line with the language used by the conservative AAPS that uses the language of partial-birth abortion without quotations in turn signaling the dissent’s political positioning. For example, Kennedy states immediately in the context of his dissent that “[t]he Court's failure to accord any weight to Nebraska's interest in prohibiting partial-birth abortion is erroneous and undermines its discussion and holding.” This is remarkably apparent in his call for allowing laws that promote the life of the “unborn.” *Stenberg*, 530 U.S. 957 (“The political processes of the State are not to be foreclosed from enacting laws to promote the life of the unborn and to ensure respect for all human life and its potential.”).

The actual language of the decision and the words to describe the procedure change as each Justice makes his or her statement on abortion. These politics encoded in the language used in the decision and the dissent signal the political positions taken by the justices in *Stenberg* as the language of the AAPS and anti-choice groups find its way into the majority decision.

rigorous, the door has been opened for a full normative debate coded in credible scientific expertise on both sides.

D. GONZALES V. CARHART

1. Medical Authority in the *Gonzales* Court

Gonzales v. Carhart examined the constitutionality of the federal Partial-Birth Abortion Ban Act of 2003 (“PABA”) and revisited the issues initially presented in *Stenberg*.⁸⁵ Amongst the key issues in the case was whether the late-term abortion procedure ban was unconstitutional because it lacked a health exception for the mother.⁸⁶ The Court ruled that the ban was not unconstitutional because the legislation should be read narrowly as only barring Intact D&X, and thus did not place any woman at immediate health risk because other late-term abortion procedures could be performed instead.⁸⁷ Further, the Court rationalized that the scienter requirement for physicians allowed performance of the procedure where absolutely necessary if the physician had not begun the procedure with the intent to perform Intact D&X.⁸⁸

The *Gonzales* decision reflected the new post-*Stenberg* terrain of medical expertise. Even though the *Stenberg* opinion produced a progressive outcome from the standpoint of pro-choice activists and advocates, it also rewrote the boundaries of “reliable” and “objective” medical evidence by legitimizing conservative medical expertise and evidence *Stenberg* reset the terms of the conversation: pro-life and pro-choice medical testimony and expertise could legitimately be treated as equal. This was a dramatic shift from the early abortion jurisprudence that discounted pro-life medical assertions almost entirely. Now, all evidence and expertise was equal, and all was subject to interrogations of ideological bias and all were equally capable of being deemed objective.

2. Conflicting Expertise: Intact versus Non-Intact Dilation and Extraction

There are several key questions requiring scientific and medical expertise in the *Gonzales* decision that recall the deliberations in *Stenberg*. First, the Court grappled with the procedure itself, raising questions about the safety and efficacy of the Intact D&X procedure.⁸⁹ If the Court found the Intact D&X to be safer and more efficacious, the Court could consider granting a health exception that would allow Intact D&X to be performed when necessary.⁹⁰

Justice Kennedy began his opinion in *Gonzales* by citing testimony from Congressional hearings, including that of a nurse testifying before the Senate Judiciary Committee. The nurse attended a late term procedure and described what she observed:

The baby’s little fingers were clasping and unclasping, and his little feet were kicking. Then the doctor stuck the scissors in the back of his head,

⁸⁵ *Gonzales v. Carhart*, 550 U.S. 124, 133 (2007).

⁸⁶ *See id.* at 161-63 (discussing the contradictory opinions concerning the medical necessity of a D&X procedure).

⁸⁷ *Id.* at 165.

⁸⁸ *See id.* at 155.

⁸⁹ *Id.* at 136.

⁹⁰ *Id.*

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and the baby's arms jerked out, like a startle reaction, like a flinch, like a baby does when he thinks he is going to fall.⁹¹

The Court treated the testimony as a description of the methodology of the medical procedure. After describing the nurse's testimony, Kennedy's language shifted from a discussion on Intact D&X to a discussion on the various methods of "killing the fetus."⁹²

The Court, however, still had to distinguish *Gonzales* from *Stenberg* in order to find the PABA constitutional. After all, the *Stenberg* Court erred on the side of a cautionary exception for women's health in the face of what it considered to be conflicting medical evidence.⁹³ As in *Stenberg*, the parties in *Gonzales* made competing factual claims about the safety, efficacy, and necessity of the Intact D&X. The Court once again acknowledged these contradictions when the *Gonzales* majority stated that "there is documented medical disagreement whether the Act's prohibition would ever impose significant health risks on women."⁹⁴

The Court's discussion of conflicting medical opinions stemmed partly from the physicians who filed opposing briefs. For example, ACOG stated:

The medical advantages of [Intact D&Xs] are now widely acknowledged. As reflected by hearings before Congress and in the courts, the safety advantages of the intact variant are recognized by an array of skilled physicians with impeccable credentials and vast clinical experience. These safety advantages are confirmed by leading medical texts and peer-reviewed studies; the curricula of leading medical schools; and even some of the Act's supporters—including the Government's own witnesses. Indeed, as medical practice has evolved in the nine years since ACOG first formulated its policy on [Intact D&X], and in the six years since this Court decided *Stenberg*, the medical consensus about these safety advantages has grown. Against this backdrop, the consequences of the Act's failure to include an exception for procedures necessary to protect a woman's health are clear.⁹⁵

ACOG depoliticizes its argument for a health exception by highlighting the expertise of the individuals reviewing the medical facts and literature on the Intact D&X procedure.

A task force convened by the Executive Board reviewed the medical facts surrounding the issue and drafted a proposed policy statement. The task force consisted of practicing obstetrician-gynecologists, who were "carefully select[ed] . . . based on their expertise and viewpoint" — ACOG "chose task force members from diverse backgrounds." Members included, among others, specialists in treating high-risk pregnancies and physicians who regularly performed or oversaw abortions, including [Intact D&Xs]. The task force also included at least

⁹¹ *Id.* at 138-39.

⁹² *Id.* at 139.

⁹³ *Id.* at 144 ("The Court of Appeals for the Ninth Circuit agreed. Like the Court of Appeals for the Eighth Circuit, it concluded that the absence of a health exception rendered the act unconstitutional. The Court interpreted *Stenberg* to require a health exception unless 'there is consensus in the medical community that the banned procedure is never medically necessary to preserve the health of the woman.'").

⁹⁴ *Id.* at 162.

⁹⁵ Brief of the American College of Obstetricians and Gynecologists as Amicus Curiae Supporting Respondents, *Gonzales*, 550 U.S. 124 (2007) (No. 05-380), 2006 WL 2867888, at *2-3.

one physician who opposed abortion.

. . . [T]he task force concluded that [Intact D&X] could be the safest or most appropriate procedure for a given patient, and that the decision whether to choose such a procedure should be left to a woman and her physician. The task force presented this conclusion to ACOG's Executive Board in a draft Statement of Policy.

The Executive Board includes, among others, nationally elected officers, and elected representatives from each of ACOG's nine geographic districts and one district made up of members of the Armed Forces. . . .⁹⁶

The expert group compiled by ACOG produced the following statement:

A select panel convened by ACOG could identify no circumstances under which [Intact D&X] . . . would be the only option to save the life or preserve the health of the woman. An intact D&X, however, may be the best or most appropriate procedure in a particular circumstance to save the life or preserve the health of a woman, and only the doctor, in consultation with the patient, based on the woman's particular circumstances can make this decision. The potential exists that legislation prohibiting specific medical practices, such as intact D&X, may outlaw techniques that are critical to the lives and health of American women.⁹⁷

A similar display of expert knowledge legitimized pro-life physician organizations. In a move that mimicked progressive strategies for discounting conservative science, conservative physicians suggested that ACOG relied on physician's subjective experiences rather than going through a proper peer-review process. For example, in arguing that the Intact D&X is never required, the American Association of Pro-Life Obstetricians and Gynecologists (AAPLOG) and congressmen who support the "partial birth abortion ban" stated the following:

The absence of empirical evidence to support the safety of D&X is reflected in the three papers on which Respondents rely for all their "data" to support D&X: Haskell's (not peer-reviewed), McMahon's (not peer-reviewed), and Chasen's. Haskell's 1992 paper was neither peer-reviewed nor controlled; it was simply a compiled series of his own personal experience.⁹⁸

The pro-life argument that physicians favoring a women's health exception fail to proffer objective empirical evidence spurred a reaction from other amici. For example, the amicus brief of the Women's Medical Association and Medical Students for Choice attempts demonstrate why and how peer-reviewed studies are not always possible in the surgical context:

Surgery, by its nature, does not fit the randomized control trial ("RCT") paradigm. When a new technique is first developed, there is simply no way to create a sufficient number of "trials" to conduct a controlled study. Even after a new surgical technique has reached a level of

⁹⁶ *Id.* at *8-9.

⁹⁷ *Id.* at *10.

⁹⁸ Brief for American Association of Pro Life Obstetricians and Gynecologists (AAPLOG) et al. as Amici Curiae Supporting Petitioner, *Gonzales*, 550 U.S. 124 (2007) (No. 05-380), 2006 WL 1436688, at *21-22.

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acceptance in the surgical community, circumstances often continue to preclude such evaluation. However, despite substantial impediments to controlled studies, the level of knowledge and skill in the surgical profession has exploded in the past century because the surgical community has developed a field-specific approach: it engages in widespread communication regarding common problems, theoretical approaches and ultimately practical solutions. When a surgeon finds a technique that represents an improvement over prior techniques, he or she records the results and shares them with others, who then begin to perform the new technique and share their experience.

This is the way numerous now familiar procedures were introduced and evaluated when they were new and untested. The safety and health benefits of [Intact D&X] have been demonstrated in the same manner. Accordingly, as each of the lower courts to have addressed Congress's findings has concluded, "credible medical evidence" does, in fact, exist to show that [Intact D&X] is not only safe and effective, but it is often safer than alternative methods of terminating pregnancy in the second trimester.⁹⁹

Two aspects of the debate in the briefs are worth noting. First, the arguments by amici are familiar in public health literature, and they signal a sophisticated engagement of conservative physicians and activists in scientific and medical discourse. In other words, in a debate about a contentious public health issue, one group will typically argue that there is one form of evidence, more likely than not the randomized control trial, that is the only rigorous, objective, and generalizable form of data—the gold standard for public health evidence on the contested issue. The responding side, unable to produce this evidence for a variety of reasons, argues that it is impossible to collect data in the requested form.¹⁰⁰ For example, in the late-term abortion context randomized control trials are not the standard utilized by surgeons to assess the efficacy of new procedures.¹⁰¹

This back-and-forth frames how we understand some forms of medical evidence as more legitimate than others in the law and policy making process. Typically, it is progressives demanding more rigorous evidence, undermining the research upon which conservative claims are made. Interestingly, in the abortion context, however, this familiar debate puts progressives on the defensive, arguing that it is impossible to produce the evidence demanded of them. This defensive posture is the opposite of how progressive advocates on health imagine themselves. In other words, progressives tend to imagine themselves as having the good, rigorous evidence on their side and conservatives as manufacturing ideologically oriented data.¹⁰² The debate in the late-term abortion context, however, reveals that, at least in some cases, it is conservatives who successfully make accusations of weak evidence against progressives. Second, a careful study of evidence put forward by both sides reveals that both pro-life and pro-

⁹⁹ Brief for American Medical Women's Ass'n et al. as Amici Curiae Supporting Respondents at *3, *Gonzales*, 550 U.S. 124 (2007) (No. 05-1382).

¹⁰⁰ *Compare, e.g., id.* at *22 (arguing that the procedure does not fit into standard randomized control trials, but that there is still evidence from clinicians regarding its safety), *with* Brief for AAPLOG, *supra* note 98, at *22-23 (arguing that there is a lack of empirical data to support the procedure's safety and necessity).

¹⁰¹ Brief for American Medical Women's Ass'n et al., *supra* note 99, at *22.

¹⁰² *See, e.g.,* Brief of AAPLOG, *supra* note 98.

choice advocates betray their own demands for “rigorous data” by consistently invoking “lower standards” of evidence as legitimate.

The Court shows deference to congressional fact-finding surrounding PABA.¹⁰³ Congress asserted the following facts in the PABA: first, partial birth abortions pose serious risks to women undergoing the procedure; second, there is no credible evidence that partial birth abortions are safer than other procedures; third, a “prominent medical organization” has found that partial birth abortions are not a medically accepted procedure; fourth, partial birth abortion is never necessary to preserve the health of a woman; fifth, partial birth abortion is never medically necessary according to the doctor who developed the medical procedure; and sixth, banning the procedure is good for a woman’s health.¹⁰⁴ These factual findings led Congress to conclude that:

[P]artial-birth abortion is never medically indicated to preserve the health of the mother; is in fact unrecognized as a valid abortion procedure by the mainstream medical community; poses additional health risks to the mother; blurs the line between abortion and infanticide in the killing of a partially-born child just inches from birth; and confuses the role of the physician in childbirth and should, therefore, be banned.¹⁰⁵

Further, Congress weighed in on the quality of the evidence available:

There is no credible medical evidence that partial-birth abortions are safe or are safer than other abortion procedures. No controlled studies of partial-birth abortions have been conducted nor have any comparative studies been conducted to demonstrate its safety and efficacy compared to other abortion methods. Furthermore, there have been no articles published in peer-reviewed journals that establish that partial-birth abortions are superior in any way to established abortion procedures. Indeed, unlike other more commonly used abortion procedures, there are currently no medical schools that provide instruction on abortions that include the instruction in partial-birth abortions in their curriculum.¹⁰⁶

The Court validated these congressional assertions. Unlike in *Stenberg*, where the Court and Congress took the conflicting evidence as a sign to err on the side of a woman’s health exception, in *Gonzales*, the Court deferred to Congress’ ability to legislate in the face of medical uncertainty.

The reality, that no body of evidence on late-term abortion meets the rigorous evidentiary standards of the randomized control trial, opens the door to a greater range of evidence. In *Roe* and *Casey*, where the Court portrayed the medical establishment as objective and neutral, the Justices were able to defer to medical expertise and evidence. In the post-*Stenberg* context, however, because the Court leveled the playing field, judges must now arbitrate medical evidence and expertise. Courts pick and choose which facts are relevant, continuing to draw and redraw the boundaries of what is rigorous medical evidence and what is not.¹⁰⁷

¹⁰³ See *Gonzales*, 550 U.S. at 165-66 (discussing how to consider congressional findings).

¹⁰⁴ Partial-Birth Abortion Ban Act of 2003, Pub. L. No. 108-105, § 2, 117 Stat. 1201, 1201-06 (2003).

¹⁰⁵ § 2, 117 Stat. at 1206.

¹⁰⁶ *Id.*

¹⁰⁷ This is exemplified by reading Ginsberg’s dissent:

During the District Court trials, “numerous” “extraordinarily accomplished” and

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3. The Psychological Impact of Abortion

Once again in *Gonzales* the psychological impact of abortion was on the table. In the post-*Stenberg* environment, divergent expertise provided an opportunity to make new findings of fact and legitimate new truths about abortion. In *Gonzales*, the court promulgated the idea that women experience negative mental health consequences because of their abortions. In making this assertion, the Court cited to the Sandra Cano Brief. The Cano Brief began by elucidating the expertise the amici bring—expertise largely driven by personal experience:

Amici Sandra Cano is the “Doe” of *Doe v. Bolton*. It was *Doe v. Bolton* which provided for the health exception and led to partial-birth abortion and abortion on demand. While it is unusual for a successful litigant to file an amicus brief opposing the health exception which was the heart of her case, Mrs. Cano in fact never wanted an abortion in *Doe v. Bolton* and fraud was perpetrated on the Court. Her Affidavit is Appendix A. . .

Other amici are 180 post-abortive women who have suffered the adverse emotional and psychological effects of abortion. Congress in its findings only discussed the physical health consequences of abortion. However, other health consequences not stated in Congress' findings would be helpful to the Supreme Court in making its decision. The women attest to the fact that there are adverse emotional and psychological health effects that have affected their lives. All of the women have used their full name in the original Affidavits, but some have requested that only their initials be used publicly to protect their confidentiality.

Although the Supreme Court only made non-evidence based assumptions in *Roe v. Wade* and *Doe v. Bolton* because abortion was generally not legal or widespread, the post-abortive women amici provide this Court with their real life experiences and attest that abortion in practice hurts women's health. Post-abortive women were asked, “How has abortion affected you?” . . .¹⁰⁸

Importantly, the Cano brief stated, amongst other points, that abortion is a cause of negative mental health experiences.¹⁰⁹ Kennedy cited to the brief to make a new

“very experienced” medical experts explained that, in certain circumstances and for certain women, intact D & E [intact D&X] is safer than alternative procedures and necessary to protect women's health. The District Courts' findings merit this Court's respect. Today's opinion supplies no reason to reject those findings. Nevertheless, despite the District Courts' appraisal of the weight of the evidence, and in undisguised conflict with *Stenberg*, the Court asserts that the Partial-Birth Abortion Ban Act can survive “when . . . medical uncertainty persists.” This assertion is bewildering. Not only does it defy the Court's longstanding precedent affirming the necessity of a health exception, with no carve-out for circumstances of medical uncertainty; it gives short shrift to the records before us, carefully canvassed by the District Courts. Those records indicate that “the majority of highly-qualified experts on the subject believe intact D & E [intact D&X] to be the safest, most appropriate procedure under certain circumstances.”

Gonzales, 550 U.S. at 179-80 (Ginsburg, J., dissenting) (citations omitted).

¹⁰⁸ Brief of Cano et al. as Amici Curiae Supporting Petitioner at 1, *Gonzales*, 550 U.S. 124 (2007) (No. 05-308).

¹⁰⁹ For a discussion of competing narratives about women's experiences with abortion See Linda McClain, *Equality, Oppression, and Abortion: Women Who Oppose Abortion Rights in the Name of Feminism*, in *FEMINIST NIGHTMARES: WOMEN AT ODDS* 159, 160-61 (Susan Ostrow Weisser & Jennifer Fleischner eds., 1994).

finding of fact in the abortion context:

Respect for human life finds an ultimate expression in the bond of love the mother has for her child. The Act recognizes this reality as well. Whether to have an abortion requires a difficult and painful moral decision. 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. Severe depression and loss of esteem can follow.¹¹⁰

Kennedy's citation to the Cano Brief is particularly interesting for scholars attempting to understand the Court's use of medical expertise. Rather than grapple with conflicting evidence, Kennedy detoured around the literature and cited to a brief filled with first person anecdotes about women's health. The briefs were collected in part by the Justice Foundation, an organization that collects testimonies of women about their experiences with abortion through its "Operation Outcry" ministry. The ministry's explicit goal is to end "the pain of abortion by expositing the truth about its devastating impact on women, men, and families."¹¹¹

In her dissent, Justice Ginsberg reacted strongly to Kennedy's assertion:

Revealing in this regard, the Court invokes an antiabortion shibboleth for which it concededly has no reliable evidence: Women who have abortions come to regret their choices, and consequently suffer from "[s]evere depression and loss of esteem." Because of women's fragile emotional state and because of the "bond of love the mother has for her child," the Court worries, doctors may withhold information about the nature of the [Intact D&X] procedure.¹¹²

Ginsberg's dissent acknowledged that the academic literature actively contests the growing data on abortion and negative mental health consequences. The dissent cited numerous studies demonstrating that a vast majority of the literature did not support Kennedy's conclusions about abortion's negative mental health consequences. Interestingly, however, the dissent's citation contains a "but see" citation to academic work claiming that abortions can have negative mental health consequences.¹¹³ Although it is found in Ginsberg's dissent, we can read this "but see" citation as a validation of a literature on abortion and negative mental health consequences. It is a signal that this literature can no longer be ignored despite an enormous amount of criticism with regard to methodology.

The debates on abortion and mental health are contentious—with both sides drawing on evidence that is often, but not always, published in mainstream medical and public health journals. The pushback featured in the *Gonzales* dissent took the classic form of debates in public health law research --- accusations of infidelity towards rigorous research against a claim based on anecdotes. Although these critiques are often successful when progressives levy them, in *Gonzales* it was the anti-choice advocates who successfully put pro-choice advocates on the defensive by mobilizing first person narratives to generate widespread support and create an opening for the

¹¹⁰ *Gonzales*, 550 U.S. at 159.

¹¹¹ *About*, OPERATION OUTCRY, <http://www.operationoutcrystories.org/about/who-we-are/> (last visited Feb. 18, 2015).

¹¹² *Gonzales*, 550 U.S. at 183 (Ginsburg, J., dissenting).

¹¹³ *Id.* at 184 n.7 (Ginsburg, J., dissenting).

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literature on mental health and abortion to enter.¹¹⁴ The Court's treatment of conservative advocacy, emanating from both physicians and activists, as on par with that evidence supporting liberalizing abortion, contributes to the legitimization of conservative ideas about abortion. In other words, the Court plays a central role in resetting the playing field on expertise and evidence in the abortion debates.

III. FROM THE SUPREME COURT TO THE STATE: TEXAS MEDICAL PROVIDERS PERFORMING ABORTION SERVICES V. LAKEY

With the Court shaping and producing ideas about abortion, and legitimating conservative claims, we see an increase in regulations that limit abortion access.¹¹⁵ In other words, this new "knowledge" about abortion, legitimized by the Court, now structures access to abortion services.¹¹⁶ The litigation surrounding the 2011 Texas Women's Right to Know Act (WRKA) is an example of how newly minted facts impact the regulatory environment and impede access to abortion services. While informed consent pertaining to public health has a long history in U.S. common law, the discussion on informed consent in the abortion context largely emerged from attempts to prevent access to abortion.

In 2011 Texas passed House Bill 15, which requires:

the physician "who is to perform an abortion" to [perform and] display a sonogram of the fetus, make audible the heart auscultation of the fetus for the woman to hear, and explain to her the results of each procedure and to wait 24 hours, in most cases, between these disclosures and performing the abortion.¹¹⁷

A woman may choose not to receive verbal explanation of the results of the sonogram if she falls into one of three exceptions: (1) if the woman is pregnant as a result of rape or incest that "has been reported or not reported because the woman fears retaliation resulting in serious bodily injury"; (2) if she is a minor utilizing judicial bypass procedures "to avoid parental notification"; or (3) if she has a fetus with an "irreversible medical condition or abnormality."¹¹⁸

In *Lakey*, the Court of Appeals for the Fifth Circuit overturned the lower court's decision enjoining enforcement of WRKA, acting on *Gonzales's* assertion that abortion's negative mental health consequences justify heightened informed consent

¹¹⁴ In the *Gonzales* decision it is relevant to note that the language Kennedy uses actively signals the politics of the opinion: to uphold restrictions on abortion procedures. For example, the "some doctors" may "kill the fetus"; in another instance Kennedy expresses that "[i]t is, however, precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State." *Gonzales*, 550 U.S. at 159. Kennedy also often utilizes the language of "dismemberment" rather than "disarticulation." The latter was utilized by the *Stenberg* majority and the former by its dissent. Thus the very language of the decision betrays the political outcome, signaling to the lawyers and advocates the political persuasion of the decision.

¹¹⁵ See GUTTMACHER INST., *supra* note 4 (discussing state laws requiring counseling and/or waiting periods prior to receipt of abortion services).

¹¹⁶ For a discussion of a similar phenomenon in the area of gay rights, see Libby Adler, *Just The Facts: The Perils of Expert Testimony and Findings of Fact in Gay Rights Litigation*, 7 UNBOUND: HARV. J. LEGAL LEFT 1 (2011); Janet E. Halley, *Sexual Orientation and the Politics of Biology: A Critique of the Argument from Immutability*, 46 STAN. L. REV. 503 (1994).

¹¹⁷ *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 573 (5th Cir. 2012). See also TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4)(B)-(D) (2011).

¹¹⁸ *Lakey*, 667 F.3d at 578 n.6. "A woman may decline to view the images or hear the heartbeat, but she may decline to receive an explanation of the sonogram images only on certification that her pregnancy falls into one of three statutory exceptions." *Id.* at 573 (citing TEX. HEALTH & SAFETY CODE § 171.0122(b)-(d) (2011)).

standards. The *Lakey* court reproduced the entirety of the *Gonzales* passage on abortion having negative mental health effects, making these negative health effects a “fact” that has traveled from conservative assertions outside the judiciary in the 1980s, to the Supreme Court’s holdings in both *Casey* and *Gonzales*, and finally into state laws on abortion.¹¹⁹ This new “fact” helped the circuit court justify the increased informed consent requirement because it could prevent, amongst other harms, psychological risks to the mother. The Fifth Circuit also found that the actual information conveyed to the patient did not constitute an undue burden given that it is the conveyance of medical knowledge from the provider to the patient.¹²⁰

The Fifth Circuit was not naïve to the political projects that undergird the production of evidence. In fact, the court sought to distinguish between the “medical” and the “ideological”:

H.B. 15 requires the taking and displaying of a sonogram, the heart auscultation of the pregnant woman’s fetus, and a description by the doctor of the exams’ results. That these medically accurate depictions are inherently truthful and non-misleading is not disputed by Appellees, nor by any reasoned analysis by the district court.¹²¹

The Fifth Circuit cited to the Merriam-Webster definition of “ideological” in order to defend what it saw as medically factual (and thus non-ideological) information:

At times, the district court characterizes these disclosures as “ideological,” but the court misunderstands the term. Speech is ideological when it is “relating to or concerned with ideas” or “of, relating to, or based on ideology.” . . . The distinction the court there sought to employ was between factual information and moral positions or arguments. Though there may be questions at the margins, surely a photograph and description of its features constitute the purest conceivable expression of “factual information.” If the sonogram changes a woman’s mind about whether to have an abortion – a possibility which *Gonzales* says may be the effect of permissible conveyance of knowledge – that is a function of the combination of her new knowledge and her own “ideology” (“values” is a better term), not of any “ideology” inherent in the information she has learned about the fetus.¹²²

The court’s reliance on “truthful” medical information resonates with the early medical cases on abortion, albeit with a different outcome. By isolating medical knowledge, the *Lakey* court drew a boundary between fact and ideology. This time, however, the conservatives benefit from the fact/ideology distinction while the progressive position is dismissed.

This decision exemplifies how after *Gonzales*, and given today’s political climate surrounding abortion, we must read Blackmun’s defense of medicine differently in *Roe*. Over thirty years later, the insulation of medicine does not support the progressive cause, but the conservative one. Rather than insulate medical knowledge for the sake of increasing access to abortion, we are now insulating medical knowledge to limit access to abortion and forward a conservative political project.

¹¹⁹ See *id.* at 576 (quoting *Gonzales*, 550 U.S. at 157-59).

¹²⁰ See *id.*

¹²¹ *Id.* at 577.

¹²² *Id.* at 577 n.4.

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PART IV: A RETURN TO FEMINIST SKEPTICISM

Can the reproductive justice movement, emerging from the history of the feminist women's health movement, return to critique of medical evidence and expertise? In the face of an increasingly destabilized medical evidence and evidentiary base, I argue that this change is necessary to recalibrate reproductive justice lawyering and activism. In this section I offer a background to the feminist women's health movement and offer suggestions for a new style of regulatory engagement.

A. THE WOMEN'S HEALTH MOVEMENT: SKEPTICS, BELIEVERS, AND EXPERTS

The current political environment demands rethinking the feminist reproductive rights mantra that a woman's health is "between the woman and her doctor." In this contemporary feminist imaginary about the physician-patient space, the physician is equipped with objective, neutral, apolitical medical and scientific evidence about the woman's body.¹²³ The doctor conveys this knowledge to the woman in an unbiased manner at which point she makes a decision about her care.¹²⁴ This framing assumes the neutrality of medical practitioners and the evidence they draw on.¹²⁵ The current posture of the reproductive justice movement betrays the critical feminist impulse towards evidence and expertise that began the feminist women's health movement.¹²⁶ Conservative organizations, including anti-choice groups, however, have long seen through this ideation of the physician-patient relationship. In fact, some of the most effective means to prevent access to abortion are not based on an assumption that the physician-patient space is unregulated, but rather on a recognition that it is highly regulated. In the informed consent context alone, the state regulates a wide range of interactions between providers and patients. For example, the state mandates reading scripts about abortion and the fetus to patients, waiting periods between patient counseling and abortion services, displaying ultrasounds to the pregnant woman, discussing negative psychological consequences of abortion, and performing transvaginal ultrasounds.¹²⁷ In some jurisdictions regulations also require that the physician display ultrasounds and sonograms and that the woman must look at the image unless there is a "look-away" exception in effect.¹²⁸ In other words, these laws seek to regulate the physical movement of the woman and her physician in the clinic. In acknowledging this high level of regulation, anti-choice activists have effectively worked to shift the clinical environment by shaping the information physicians give to their patients. Progressives should mobilize regulatory interventions to further liberalize access to abortions. This counter strategy will not be based on a belief that evidence-based approaches will lead to determinate outcomes, but rather will find its foundation in feminist skepticism towards knowledge production.

A return to feminist skepticism necessitates a consideration of how feminist

¹²³ See generally Maya J. Goldenberg, *On Evidence and Evidence-Based Medicine: Lessons from the Philosophy of Science*, 62 SOC. SCI. & MED. 2621 (2006).

¹²⁴ See *id.*

¹²⁵ *But cf.* Fineman, *supra* note 10 (articulating the problem of viewing institutions as objective and argues that we must instead see institutions as vulnerable).

¹²⁶ See generally WENDY KLINE, *BODIES OF KNOWLEDGE: SEXUALITY, REPRODUCTION, AND WOMEN'S HEALTH IN THE SECOND WAVE* (2010).

¹²⁷ This list is simply illustrative and not comprehensive. For a comprehensive list of state regulations, see GUTTMACHER INST., *supra* note 5.

¹²⁸ See GUTTMACHER INST., *STATE POLICIES IN BRIEF: REQUIREMENTS FOR ULTRASOUND* (2015), http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf.

organizing related historically to ideas of medical expertise and evidence.

The feminist women's health movement began in the 1960s and 1970s, and was premised on second-wave feminist ideas.¹²⁹ In short, and at the risk of understating the movement's complexity, feminist women's health activists saw scientific knowledge as knowledge by and about men.¹³⁰ The feminist women's health movement was pivotal in generating expert knowledge of women's bodies and women's health. Women's health activists historically mobilized two simultaneous and contradictory positions in the context of advocating for greater attention to women's health issues. First, there was the position that the establishments that produce knowledge about health are not objective. Instead, these knowledge producers—scientists, doctors, and epidemiologists—exist in patriarchal structures that conceptualize health through the male body.¹³¹ The activists promoted a politics of “difference and inclusion,” and women sought to be included in medical research and knowledge.¹³² Second, paradoxically, women's health activists appeared to support the idea that knowledge could be objective, as long as it was inclusive of women.¹³³ In other words, at its root, the women's health movement did not seek to undermine entirely the institutions against which they fought. The activists primarily sought to make medical and scientific knowledge more complete, more thorough, and more accurate. The women's health movement sought to do so as it engaged with the various disciplinary streams of science, medicine, and epidemiology.¹³⁴ In arguing for the inclusion of women's bodies in scientific and medical research as a means to get accurate information about women's health, feminist health activists reaffirmed the idea that scientific evidence can be produced in an objective, neutral manner. This was so even while the very act of challenging the public health, medical, and scientific establishments through legal and broader activism signaled an underlying distrust in the ability of these institutions to produce objective and determinate knowledge.

There are several oft-cited victories of the women's health movement, including the liberalization of abortion law. First, there was *Roe v. Wade*. While the women's health movement advocated for abortion, *Roe* marked an important moment in which the broader feminist sex-equality movement took up the women's health agenda.¹³⁵ Other major victories came in the realm of HIV and at the National Institutes for Health (NIH) in the 1990s. In 1993 Congress passed the NIH revitalization act, which required the inclusion of women and minorities in all NIH-funded research.¹³⁶ In the 1990s feminist lawyers also demanded the inclusion of female-specific identifiers

¹²⁹ See KLINE, *supra* note 126, at 12-14.

¹³⁰ See *id.*; MICHELLE MURPHY, SEIZING THE MEANS OF REPRODUCTION (2012).

¹³¹ See KLINE, *supra* note 126, at 12-14.

¹³² See EPSTEIN, *supra* note 17, at 56-57.

¹³³ See *id.* The founding of the Our Bodies Our Selves collective and 1973 publication of the Our Bodies Our Selves played an important role in generating information about women's bodies. KLINE, *supra* note 126, at 1-5. This was the start of a new line of thinking about women's health: that alongside the male scientific medical establishment, it was women who could speak to their own bodies. *Id.*

¹³⁴ For a description of “feminist epidemiology,” see Marcia Inhorn & K. Lisa Whittle, *Feminism Meets the “New” Epidemiologies: Toward an Appraisal of Antifeminist Biases in Epidemiological Research on Women's Health*, 53 SOC. SCI. & MED 553, 563-64 (2001).

¹³⁵ Linda Greenhouse & Reva Siegel, *Before (and After) Roe v. Wade: New Questions About Backdash*, 120 YALE L.J. 2028, 2042 (2011) (arguing that mainstream feminist mobilization of abortion issues began with Betty Friedan moving the National Organization of Women (NOW) to take on abortion as a sex-equality issue).

¹³⁶ Steven Epstein, *Bodily Differences and Collective Identities: The Politics of Gender and Race in Biomedical Research in the United States*, 10 BODY & SOC'Y 183, 183-84 (2004).

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amongst the list of AIDS defining illnesses.¹³⁷ This became another feminist victory when the Centers for Disease Control amended its list to include female-specific AIDS defining illnesses.¹³⁸

A deeper critique of evidence and expertise began as post-modernist strains of feminist engagement took hold amongst feminist activists and scholars. The post-modern turn inside of the women's rights movement questioned the objectivity and determinacy of science itself. Would the inclusion of women's bodies result in a more rigorous knowledge of women's bodies? Or, must the production of knowledge itself be deconstructed? Feminist philosopher of science Donna Haraway famously critiqued the idea that there is a privileged view on "the inside" of science. Haraway argued that all scientific knowledge is contingent on the social construction of science, coining the term "the god trick" to identify the opposing belief that there is vantage point from which scientists could be fully objective.¹³⁹ This move in feminist understandings of science, the move toward seeing the knowledge produced from studies as "situated"¹⁴⁰ and subject to critique, would subject even the most inclusive studies to interrogation.¹⁴¹ Although the internal feminist debates continue, two key lessons can be extracted from the posture of feminist health activists towards knowledge production that can continue to shape the contemporary women's health movement. First, the production of knowledge itself is situated. We cannot treat medical evidence and expertise as inherently objective and neutral. Second, we should interrogate the institutions that engage in the production of knowledge about women's health including courts and clinics. Revisiting these feminist critiques provides a new way forward for the reproductive justice movement and for rethinking abortion advocacy.

B. RETHINKING THE STRATEGY FOR REPRODUCTIVE JUSTICE: REGULATORY REFORM PROPOSALS

Contemporary feminist health activists seem reticent to accept the thesis that feminists historically championed in the context of feminist health advocacy: that evidence is the product of the social and political environment from which it emerges—and law plays a role in shaping this evidence. Similarly, rather than view institutions—for example, hospitals—as products of legal regulations informed by the political evidentiary landscape and thus central to the attainment of reproductive justice, feminists today view institutions and the individuals that comprise them as

¹³⁷ Aziza Ahmed, "Rugged Vaginas" and "Vulnerable Rectums": *The Sexual Identity, Epidemiology, and Law of the Global HIV Epidemic*, 26 COLUM. J. GENDER & L. 1, 28-29 (2013).

¹³⁸ *Id.* at 29.

¹³⁹ See Haraway, *supra* note 11, at 581; Ellen Kuhlmann & Birgit Babitsch, *Bodies, Health, Gender: Bridging Feminist Theories and Women's Health*, 25 WOMEN'S STUD. INT'L F. 433, 434-35 (2002) (arguing that Judith Butler and Donna Haraway, amongst other scholars, pushed the limits of feminist understandings of the body, moving beyond binary frames).

¹⁴⁰ Haraway coined the term "situated knowledge" to refer to the importance of context in the creation of scientific knowledge. See Haraway, *supra* note 11.

¹⁴¹ Post-modern feminist legal theorists also posited that the law has a role in producing the woman's body. For instance, Mary Jo Frug argued that sex differences are semiotic—"constituted by a system of signs that we produce and interpret" as "anatomically determined and psychologically predictable." Mary Jo Frug, *A Postmodern Feminist Legal Manifesto (An Unfinished Draft)*, HARV. L. REV. 1045, 1046 (1992). For feminist critique in the context of health activism See Gillian Einstein & Margrit Shildrick, *The Postconventional Body: Rethorising Women's Health*, 69 SOC. SCI. & MED. 293, 294 (2009) (arguing that post-modernism has something to offer women's health practitioners, despite its "unalign[ment] with current women's health practice" in its present state).

capable of functioning apolitically and neutrally. I argue that a new vision of reproductive justice must recognize the clinical space as highly regulated and work to shape it for progressive purposes.¹⁴² We must take into account how knowledge, when created and deployed, orders access to abortion.¹⁴³

Unlike feminists, anti-choice activists have become incredibly effective at regulating the doctor-patient relationship in the abortion context. Coded in the language of safety and risk, the informed consent regulations and the shifting evidentiary base on mental health and abortion show a deep understanding operationalized by the anti-choice movement—that institutions, expertise, and evidence can be influenced from the inside out. The resistance of feminist legal activists to truly deconstruct the political formations that comprise institutions has undermined the reproductive justice movement.

Understanding that institutions, such as clinics, are shaped by regulations provides the necessary foundation for a new reproductive justice framework. This understanding moves us beyond thinking that a clinic in any way can be a regulation-free zone. Further, it requires us to pay attention to how regulations of institutions are justified through the invocation of medical and scientific expertise and knowledge. Perhaps most demanding, it requires us to see how the law is not necessarily driven by evidentiary claims, but rather helps produce them.

By viewing the sites of abortion and other pregnancy-related services as structured by the regulatory environment, we can rethink the reproductive justice strategy with regard to regulation. This view challenges the feminist refrain: “between a woman and her doctor.” That refrain seeks to establish a zone of privacy in the medical clinic or hospital setting in which women can get information about abortion free from politics.¹⁴⁴ Abortion rights activists, for example, critique abortion “scripts” on the ground that they interfere with the sanctity of the space between women and their physicians. It is necessary to dismantle the idea of public/private divide that is built into this conception of the physician-patient relationship. Dismantling this dichotomy is crucial because it animates political projects and underpins legal strategy while

¹⁴² While calling for the regulation of patient-physician interaction in abortion critiques mainstream activism on reproductive justice, it is not uncommon in other areas of health activism. For example, HIV activists long called for the regulation of patient-physician interaction in the context of HIV testing and counseling. See, e.g., KITTY GRANT & ANNEKE MEERKOTTER, S. AFRICAN LITIGATION CTR., PROTECTING RIGHTS: LITIGATING CASES OF HIV TESTING AND CONFIDENTIALITY OF STATUS (Priti Patel ed., 2012), available at <http://www.southernafricalitigationcentre.org/1/wp-content/uploads/2012/11/Litigating-Cases-of-HIV-Testing-and-Confidentiality-of-Status-Final.pdf>.

¹⁴³ See generally MICHEL FOUCAULT, THE ORDER OF THINGS: AN ARCHEOLOGY OF THE HUMAN SCIENCES 345 (1971) (“It was indeed necessary, given these conditions, that the knowledge of man should appear, in its scientific aims, as contemporaneous and of the same origin as biology, economics, and philosophy”); Karl Klare, *The Public/Private Distinction in Labor Law*, 130 U. PA. L. REV. 1358 (1982); Frances E. Olsen, *The Family and the Market: A Study of Ideology and Legal Reform*, 96 HARV. L. REV. 1497, 1498 (1983) (“The vision of the market and the family as a dichotomy - the perception that social life comprises two separate though interdependent spheres - can be described as a structure of consciousness. By structure of consciousness, I mean a shared vision of the social universe that underlies a society's culture and also shapes the society's view of what social relationships are “natural” and, therefore, what social reforms are possible.”).

¹⁴⁴ Cf. *20 Week Ban*, PLANNED PARENTHOOD, <http://www.plannedparenthoodaction.org/issues/abortion-access/20-week-ban> (last visited Feb. 18, 2015) (advocating the traditional feminist view); *Abortion Opponents Put Politics Between a Woman and Her Doctor*, QUAD-CITY TIMES (Oct. 9, 2013, 1:13 AM), http://qctimes.com/news/opinion/editorial/abortion-opponents-put-politics-between-a-woman-and-her-doctor/article_dbd21b70-7eff-5c0e-b5d8-0a99dcc57ead.html.

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foreclosing the possibility of social and regulatory reforms that will enable access to abortion services.

Instead, advocates can derive legal reform strategies by viewing the clinic as a highly regulated space. New strategies for reproductive justice could not only counter pro-life regulations but could also make the clinical environment safer for women seeking abortion. Conceptualizing the clinic as a space that can be regulated generates a range of legal strategies that are otherwise foreclosed by the current ironic feminist faith in institutions as neutral, objective, and apolitical.

New regulatory interventions designed to improve abortion access could build out of the current political, regulatory, and evidentiary climate. These suggestions are not foolproof. These suggestions may even fail given our current political environment, in which courts are arguably more conservative, medical evidence and expertise supporting a progressive perspective has been destabilized by counter literature, and anti-choice groups wield enormous amounts of financial and political power. They are worth considering, however, because these suggestions move the reproductive justice movement head on into the regulation debates.

I propose three suggestions for regulatory intervention. First, states could mandate disclosure by all pregnancy-related providers of the types of services that are available—including whether abortions are available and accessible at the given facility. This mandate will target non-abortion providers, such as Crisis Pregnancy Centers (CPCs), who misleadingly suggest that abortions are provided in order to draw women in and then dissuade them from getting an abortion. Second, progressive activists could offer modified scripts for providers given the contested domain of “facts” regarding abortion. Third, states could mobilize their health care licensing regulations to regulate all abortion counselors (borrowing from a successful strategy to improve HIV counseling and care). These recommendations move the focus of abortion legal advocacy away from privacy, towards regulation as a new way of addressing access to abortion services. This new focus on regulation avoids wading into the newly controversial territory of medical evidence and informed consent. Given the political and social context in which abortion lawmaking occurs, one cannot guarantee that these strategies would necessarily withstand the scrutiny of a court or public ideologically opposed to abortion. The strategies do, however, take into account the concerns raised by this paper about the Court’s treatment of medical evidence and expertise.

1. Mandatory Disclosure of Services for All Pregnancy-Related Service Providers—Including Those That Do Not Provide Abortions

The first proposal is to make mandatory the disclosure of available (and non-available) services at all facilities providing pregnancy-related services.¹⁴⁵ This

¹⁴⁵ This proposal raises First Amendment concerns. Attempts to regulate CPCs have been met with mixed success. *See e.g.*, *Evergreen Ass’n v. City of New York*, 740 F.3d 233 (2nd Cir. 2014) (holding that requiring CPCs to disclose whether they have a licensed medical provider on staff does not violate the First Amendment, whereas requirements that CPCs disclose: (1) whether or not they provide referrals for abortion, emergency contraception, or prenatal care; and (2) that the city encouraged pregnant women to consult with a licensed medical practitioner, violates the First Amendment); *Greater Baltimore Ctr. for Pregnancy Concerns, Inc. v. Mayor & City Council of Baltimore*, 721 F.3d 264 (4th Cir. 2013) (reversing summary judgment in favor of CPC challenging requirement to disclose whether or not they provide or make referrals for abortion or contraception services); *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570 (5th Cir. 2012).

proposal builds on ongoing advocacy.

Women seek abortion-related services in clinics or in abortion specific servicing centers. These can include a hospital or a stand-alone abortion clinic. CPCs are pregnancy service providers that do not provide abortion despite the misleading nomenclature of “crisis pregnancy center.” CPCs are designed to look like abortion clinics but have the goal of deterring women from abortion through “pro-life” counseling.¹⁴⁶ In this manner, the CPCs are actually roadblocks for women attempting to access abortion services.

The existence of clinics that provide services and are forced to disclose state-mandated information about abortion, alongside CPCs, creates a confusing environment, where it may be difficult for women seeking to end pregnancies to navigate their options. Reproductive health and justice organizations are reticent to join the battle over regulating provider speech fearing that it would backfire. This concern is now outdated—regulations, including informed consent standards, largely operate to block abortion access. To counter this, progressive health lawyers should propose regulations that mandate physicians and service providers to disclose services provided to enable access to quality abortion care. For actual abortion providers, this would mean stating to women that an abortion can be obtained at the facility. For CPCs, this requirement would mandate clarifying that abortions will not be provided.

This proposal addresses the concerns raised by this paper by sidestepping the debate on medical “facts” that has produced conservative victories, and instead focusing on making clinical and provider environments transparent to the women accessing services.

2. Offer Moderated Language on Abortion Consequences

Aware of the politics of the “facts” in the abortion context, a second strategy is to offer a moderated statement of abortion’s potential consequences rather than the current script that is meant to scare or dissuade women from abortions. For example, in accordance with the Texas WRKA, a woman is offered the following information in a booklet:

You should know that women experience different emotions after an abortion. Some women may feel guilty, sad, or empty, while others may feel relief that the procedure is over. Some women have reported serious psychological effects after their abortion, including depression, grief, anxiety, lowered self-esteem, regret, suicidal thoughts and behavior, sexual dysfunction, avoidance of emotional attachment, flashbacks, and substance abuse. These emotions may appear immediately after an abortion, or gradually over a longer period of time. These feelings may recur or be felt stronger at the time of another abortion, or a normal

For further discussion of First Amendment concerns raised by this proposal and related litigation, see Aziza Ahmed, *Informed Decision Making and Abortion: Crisis Pregnancy Centers, Informed Consent, and the First Amendment*, 43 J.L. & MED. ETHICS 51 (2015). Jennifer M. Keighley, *Can You Handle the Truth? Compelled Commercial Speech and the First Amendment*, 15 J. CONST. L. 539 (2012).

¹⁴⁶ STAFF OF H. COMM. ON GOV’T REFORM, 109TH CONG., FALSE AND MISLEADING HEALTH INFORMATION PROVIDED BY FEDERALLY FUNDED PREGNANCY RESOURCE CENTERS 1-2 (2006), available at <http://www.chsourcebook.com/articles/waxman2.pdf>; NAT’L ABORTION REPROD. RIGHTS ACTION LEAGUE [NARAL], THE TRUTH ABOUT CRISIS PREGNANCY CENTERS (2015), <http://www.prochoiceamerica.org/media/fact-sheets/abortion-cpcs.pdf>.

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birth, or on the anniversary of the abortion.¹⁴⁷

In contrast, guidelines from the United Kingdom Royal College of Obstetrics and Gynecologists (RCOG), provide that “[w]omen with an unintended pregnancy should be informed that the evidence suggests that they are no more likely to suffer adverse psychological sequelae whether they have an abortion or continue and have the baby.”¹⁴⁸ Further, the guidelines instruct, “[w]omen with an unintended pregnancy and a past history of mental health problems should be advised that they may experience further problems whether they choose to have an abortion or to continue with pregnancy.”¹⁴⁹

While equivocal, the RCOG deemphasizes the shock value of the litany of consequences required by the Texas law. Further, given the current political environment, the RCOG moderates the pro-life assertions of gross harm post-abortion. Most importantly, the RCOG reports the current state of information on mental health without embellishment. A moderated script might also state clearly the politically contentious environment in which that abortion evidence is produced.

3. Regulate All Abortion Service Providers—Including Pregnancy Counselors

A final proposal would be to regulate all abortion counseling under health care or other licensing and regulation statutes. Currently, many individuals who provide private abortion-related counseling services are not deemed to be health care providers.¹⁵⁰ Thus a vast amount of abortion counseling is not regulated and the individuals providing counseling are not licensed. Licensing, even when largely regulated by the profession, could have the effect of moderating extreme statements in the context of pregnancy services.

This is not a novel approach. HIV counseling guidelines, for example, may advise or require particular counseling and testing protocols.¹⁵¹ By defining “provider” broadly in the context of HIV testing, states have brought a range of actors under regulatory oversight.¹⁵² Similarly, broadening regulation of abortion counseling would bring CPCs into the purview of state control and oversight by public health agencies. This regulatory oversight may moderate the statements made by CPCs.

V. CONCLUSION

In order to see how the evidentiary terrain of abortion is legitimized, validated,

¹⁴⁷ TEX. DEP’T OF HEALTH, A WOMAN’S RIGHT TO KNOW 16 (2003). *See also* Carolyn Jones, “*We Have No Choice*”: *One Woman’s Ordeal with Texas’ New Sonogram Law*, TEX. OBSERVER (Mar. 15, 2012, 8:03 AM) <http://www.texasobserver.org/we-have-no-choice-one-womans-ordeal-with-texas-new-sonogram-law/>, (detailing a story of one woman’s experience receiving a second term abortion in Texas).

¹⁴⁸ ROYAL COLL. OF OBSTETRICIANS AND GYNECOLOGISTS, THE CARE OF WOMEN REQUESTING INDUCED ABORTION: EVIDENCE-BASED CLINICAL GUIDELINE NO. 7 § 5.13 (2011).

¹⁴⁹ *Id.* § 5.14.

¹⁵⁰ *See* MD. NARAL EDUC. FUND & NARAL FOUND., CRISIS PREGNANCY CENTER INVESTIGATION SUMMARY 5 (2002).

¹⁵¹ Rhode Island Rules and Regulations Pertaining to HIV Counseling, Testing, Reporting, and Confidentiality, R23-6.3-HIV, § 2.0 (2012).

¹⁵² *See e.g.*, DEL. CODE ANN. tit. 16, § 714(18) (2010 & Supp. 9 2014) (defining “provider” as any nurse, physician, dentist or other dental worker, optometrist, podiatrist, chiropractor, laboratory or blood bank technologist or technician, phlebotomist, dialysis personnel, emergency healthcare provider (including any paramedic, emergency medical technician, law-enforcement personnel or firefighter), others whose activities involve contact with patients, their blood or corpses, and other public or private providers as defined by the Division.”).

and co-produced by the courts, we must analyze the political, economic, and social forces that structure courts and clinics. Reproductive justice and rights advocates must re-assess the reliability of public health, scientific and medical expertise as the basis for a determinate strategy for progressive abortion reform. In other words, progressive lawyers cannot presuppose the stability of public health, scientific, and medical expertise and evidence as a foundation for pro-choice activism.

Rethinking how our current knowledge environment shapes regulations in the abortion context requires us to look beyond clinics as a private space and towards the idea that the clinic is a vulnerable institution. Rather than decry the regulation of clinics, progressives should take up the regulation of provider-patient interaction with consideration of the current political and evidentiary climate. Progressive lawyers must think beyond “between a woman and her doctor” to reveal new strategies for improving abortion access.

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