

The Rhetoric of Choice: Restoring Healthcare to the Abortion Right

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In 1973 the Supreme Court in Roe v. Wade both identified a constitutional right of abortion and asserted that “the abortion decision in all its aspects is inherently, and primarily, a medical decision” to be made in consultation with a “responsible physician.” Since that time, the Court’s analysis has shifted away from the medical model, to identify abortion exclusively as a right of decisional autonomy. While scholarship has uniformly criticized the Roe analysis for subordinating women’s constitutional rights to the judgment of their doctors, it has left unanswered an important question: What, if anything, was lost when the Court turned from the medical model of reform toward identifying abortion as a right of decisional autonomy?

In this Article I argue that a previously unrecognized benefit of the Roe Court’s analysis was that it viewed abortion as a right that was inextricably linked to healthcare. Thus, while early cases compromised a woman’s right of choice, I argue that at the same time these cases better protected effective access to abortion via healthcare. By contrast, I demonstrate that the Court’s current analysis narrowly identifies abortion exclusively as a right of choice, uncoupled from access to healthcare. This analysis increasingly isolates pregnant women as rights holders and no longer acknowledges them as medical consumers. While nominally protecting the abortion right, it has severed the access necessary to exercise the right. As a result, the right of abortion is in danger of becoming a right without a remedy. I conclude that it is critical to reclaim healthcare as an integral aspect of the abortion right while rejecting the early analysis that deferred women’s decisionmaking to doctors. This reclaimed healthcare analysis will allow the right to better withstand challenges of legislation that seeks to restrict access to abortion-related healthcare and will create broader appeal for the right by casting it in a gender-neutral context.

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INTRODUCTION

In 1972 the abortion rights movement asserted that abortion was the “Woman’s Right to Choose.”¹ The slogan was in response to a competing “medical model” of abortion reform that sought to liberalize criminal abortion laws by granting doctors increased discretion to make the abortion decision on behalf of their patients.² Thus, while the feminist movement asserted abortion as an individual woman’s constitutional right of choice, the medical model sought to characterize abortion as an aspect of healthcare and thereby to vest the final decisionmaking authority with doctors.³ Indeed, the holding in *Roe v. Wade*⁴ reflects a compromise between these competing visions of abortion. In 1973, the Supreme Court in *Roe* both identified a constitutional right of abortion

1. See Jimmie Kimmey, *Right to Choose Memorandum*, in *BEFORE Roe v. Wade: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT’S RULING*, 33, 33–34 (Linda Greenhouse & Reva Siegel eds., 2010).

2. See KRISTIN LUKER, *ABORTION AND THE POLITICS OF MOTHERHOOD* 66 (1984); Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician’s Role in “Private” Reproductive Decisions*, 63 WASH. U. L.Q. 183, 197–201 (1985); Reva B. Siegel, *Roe’s Roots: The Women’s Rights Claims That Engendered Roe*, 90 B.U. L. REV. 1875, 1879 (2010) [hereinafter Siegel, *Roe’s Roots*]; discussion *infra* Part I.A.

3. LUKER, *supra* note 2, at 92–125; *Repeal*, in *BEFORE Roe v. Wade*, *supra* note 1, at 35, 35–67; Siegel, *Roe’s Roots*, *supra* note 2, at 1880–86.

4. 410 U.S. 113 (1973).

and asserted that “the abortion decision in all its aspects is inherently, and primarily, a medical decision”⁵ to be made in consultation with a “responsible physician.”⁶ The *Roe* Court’s accommodation of the medical model of abortion reform was widely criticized for subordinating women’s constitutional rights to the judgment of their healthcare providers.⁷ Instead, feminist scholarship argued for identifying abortion as a right of bodily autonomy and for expanding the constitutional basis of the abortion right, most frequently using the law of Equal Protection.⁸ Over time, the Supreme Court’s analysis gradually shifted from characterizing abortion within the context of healthcare to characterizing abortion exclusively as a right of decisional autonomy.

This Article argues that the rejection of the “medical model” combined with an exclusive focus on abortion as a right of choice has created a false conflict between these two aspects of the abortion right.⁹ I argue that in identifying abortion as a right of choice, the Court’s current

5. *Id.* at 166.

6. *Id.* at 153.

7. Reva Siegel, for example, has argued that the decision in *Roe v. Wade* straddled the women’s rights and the medical models of abortion rights, giving only “confused expression” to women as constitutional rights holders in the abortion decision and greater protection to doctors’ rights to make medical decisions than to women’s rights to control reproduction. Siegel, *Roe’s Roots*, *supra* note 2, at 1897. See, e.g., LAURENCE H. TRIBE, *ABORTION: THE CLASH OF ABSOLUTES* 45 (1990) (arguing that the medical model, which emphasized the role of doctors in the abortion decision, “reinforced the traditional role of the woman as dependent, without control over her future”); Appleton, *supra* note 2, at 197–201; Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199–200 (1992) (“The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision itself, which coupled with the rights of the pregnant woman the free exercise of her physician’s medical judgment. The *Roe* decision might have been less of a storm center had it . . . homed in more precisely on the women’s equality dimension of the issue . . .” (footnotes omitted)); Linda Greenhouse, *How the Supreme Court Talks About Abortion: The Implications of a Shifting Discourse*, 42 SUFFOLK U. L. REV. 41, 42 (2008); Reva B. Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273–80 (1992) [hereinafter Siegel, *Reasoning from the Body*]. But see Sylvia A. Law, *Abortion Compromise—Inevitable and Impossible*, 1992 U. ILL. L. REV. 921, 932–41 (1992) (offering a critique of Tribe’s *THE CLASH OF ABSOLUTES*).

8. See, e.g., LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW*, 1353–59 (2d ed. 1988); Appleton, *supra* note 2, at 197–201; Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375 (1985); Ginsburg, *supra* note 7, at 1200; Sylvia A. Law, *Rethinking Sex and the Constitution*, 132 U. PA. L. REV. 955 (1984) (arguing that abortion restrictions create unconstitutional gender-based discrimination); Catharine A. MacKinnon, *Reflections on Sex Equality Under Law*, 100 YALE L.J. 1281, 1308–24 (1991); Siegel, *Reasoning from the Body*, *supra* note 7, at 350–80; Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815 (2007); Cass R. Sunstein, *Neutrality in Constitutional Law (With Special Reference to Pornography, Abortion, and Surrogacy)*, 92 COLUM. L. REV. 1, 31–44 (1992).

9. For an excellent analysis of the “right to choose” slogan in the women’s movement, see ROSALIND POLLACK PETCHESKY, *ABORTION AND WOMAN’S CHOICE: THE STATE, SEXUALITY, AND REPRODUCTIVE FREEDOM* (rev. ed. 1990); Rosalind Pollack Petchesky, *Abortion in the 1980s: Feminist Morality and Women’s Health*, in *WOMEN, HEALTH, AND HEALING* (Ellen Lewin & Virginia Oleson eds., 1985).

analysis increasingly identifies pregnant women who seek abortion as “rights holders”—rather than medical consumers—and has severed the right to decide to terminate a pregnancy from access to healthcare necessary to exercise that decision. Accordingly, I argue that while the medical model of reform subordinated women’s right to *choose* abortion, paradoxically, the medical reform model resulted in greater acknowledgement that protection of access to abortion-related *healthcare* was an integral aspect of the right. By contrast, the Court’s current analysis leaves access to abortion vulnerable to erosion by courts and legislatures. I argue that under the Court’s evolving analysis, healthcare and choice have become a zero-sum trade-off: Rather than retaining the *Roe* Court’s original foundation of abortion as healthcare and also vesting in women the exclusive right to make reproductive choices, the Court’s current analysis instead identifies abortion exclusively as a right of choice that is uncoupled from healthcare access.¹⁰ Early feminist advocates called for a “right to choose” abortion that was intended as a broader demand for women’s equality. Meanwhile, the Court’s evolving analysis has come to restrict abortion exclusively to choice while denying access to abortion-related healthcare.¹¹ As a result, the right of abortion is in danger of becoming a right without a remedy as courts and legislatures restrict access to abortion healthcare services and regulate the consumer-provider relationship while nominally reaffirming the “right to choose.”

This Article proceeds in three Parts. Part I considers the historical origins and influence of recognizing abortion as healthcare in early case law. I highlight how the tension between healthcare and choice can be traced to competing claims of the medical reform and feminist movements in the early push for abortion rights. Next, I discuss how the Court’s early medical reform analysis subordinated women’s decisionmaking to the judgment of their providers. Finally, I argue that, paradoxically, because the medical model situated abortion in the context of healthcare, the Court was more willing to protect access to abortion services and articulated the abortion right as the decisional right to *obtain* abortion-related

10. This Article examines the Court’s characterization or recognition of abortion as healthcare. It is important to note that international human rights norms and the constitutions of most other countries create affirmative rights to health services. By contrast, in the United States, healthcare is not regarded as a positive right or a public good which citizens are entitled to receive, but as a negative right in which the individual has a right to access free of governmental interference. B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501 (2009); see discussion *infra* Part III.

11. Similarly, opponents of abortion have used the language of women’s rights to frame anti-abortion arguments in woman-protective anti-abortion legislation. See Judith Resnik, *The Production and Reproduction of Constitutional Norms*, 35 N.Y.U. REV. L. & SOC. CHANGE 226, 234 (2011); Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694 (2008); Reva B. Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991, 993 (2007) [hereinafter Siegel, *The New Politics*].

healthcare.¹² As a result, the Court viewed restrictions on access to abortion as restrictions of the right itself, recognized the importance and protected the privacy of the consumer-provider relationship against informed consent laws, and deferred to the expertise of providers instead of legislators in setting abortion policy.

Part II argues that none of the early recognition of abortion as healthcare appears in the most recent Supreme Court abortion cases, *Planned Parenthood of Southeastern Pennsylvania v. Casey*¹³ and *Gonzales v. Carhart*.¹⁴ To the contrary, the Court no longer discussed abortion within the context of women's health, and providers were referred to by derogatory terms such as "abortion doctors" and "abortionists."¹⁵ Further, the consumer-provider relationship was described as "nonexistent,"¹⁶ or worse, that women seeking abortions must be protected from providers who would seek to trick them into an abortion procedure that they would later come to regret.¹⁷ Instead, the Court articulated the right of abortion as a right to choose to terminate a pregnancy that was specifically separate from the ability to obtain abortion-related healthcare. The Court employed this rationale to uphold legislation restricting access to abortion through informed consent laws, waiting periods, reporting requirements, and an outright ban on an abortion procedure, while it nominally reaffirmed the "essential holding of *Roe*."¹⁸

I argue that this trend is not limited to the courts but is also reflected in legislation being passed in statehouses across the country. Woman-protective anti-abortion legislation narrowly identifies abortion as a right of choice and then fundamentally challenges women's *ability* to make the abortion decision, concluding that some women will, almost by nature, come to regret the abortion decision because it caused them to reject a relationship with their "child."¹⁹ Recent restrictions on coverage for abortion in private health insurance plans and controversies surrounding funding Planned Parenthood also reflect this trend: Laws that restrict healthcare funds, both public and private, from being used for abortion by their very terms identify abortion as unrelated to healthcare.²⁰ Thus case law, legislation, and policy in the area of abortion are all coalescing

12. See *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 438 (1983) (explaining that a hospitalization requirement unreasonably infringes upon "a woman's constitutional right to obtain an abortion"); discussion *infra* Part I.C.i.

13. 505 U.S. 833 (1992).

14. 550 U.S. 124 (2007).

15. See *infra* note 132 and accompanying text.

16. See *infra* note 83 and accompanying text.

17. *Gonzales*, 550 U.S. at 159–60.

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

19. *Gonzales*, 550 U.S. at 159. See generally Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, 16 DUKE J. GENDER L. & POL'Y 223 (2009) (exploring the law's failure to recognize pregnant women's abilities to choose whether to have an abortion).

20. See discussion *infra* Part II.C.

around the same idea that abortion is a right of choice but is not healthcare.

Part III concludes that it is time to re-assert the initial recognition that healthcare is integral to the abortion right. The acknowledgment of abortion as a right of both healthcare and choice will bring the Court's abortion analysis full-circle and hearken back to the early characterization of abortion as a right of women's healthcare, while rejecting the medical reform analysis that casts women as passive objects in the healthcare system. Additionally, this recognition will allow the right of abortion to better withstand the challenges of legislation that seeks to restrict access to abortion-related healthcare, create broader appeal for the right by casting it in a gender-neutral context,²¹ and expose the fiction that is currently being perpetuated that women possess a constitutional right to abortion when, in actuality, they are denied access to abortion services necessary to effectuate that choice. Re-conceptualizing abortion as a right integrally related to women's healthcare will begin to reshape the political dialogue and cultural perception of abortion within the context of reproductive justice. Reclaiming abortion as an aspect of women's health will restore the right to one that is connected to a woman's experience of pregnancy by recognizing the need for access to affordable healthcare for birth control, abortion, and childbirth—rather than narrowly identifying abortion as a constitutional right of choice.²²

In 2009, opponents of abortion launched a comprehensive "Abortion Is Not Healthcare" campaign.²³ This Article suggests that this slogan and the "Woman's Right to Choose" slogan, more than thirty years apart and from widely divergent political viewpoints, encapsulate the characterization of pregnant women who seek abortion as rights holders and not medical consumers. Reclaiming abortion as a right of

21. B. Jessie Hill has highlighted this benefit of recognizing abortion as a healthcare right. Hill, *Reproductive Rights*, *supra* note 10, at 504–05.

22. While this Article addresses the rhetoric of rights as reflected in judicial decisions, much has been written about the impact of abortion cases on the lived reality of pregnant women. *See, e.g.*, Rhonda Copeland & Sylvia Law, *Nearly Allied to Her Right "To Be"—Medicaid Funding for Abortion: The Story of Harris v. McRae*, in *WOMEN AND THE LAW STORIES* 207, 208–51 (Elizabeth M. Schneider & Stephanie M. Wildman eds., 2011); Elizabeth M. Schneider & Stephanie M. Wildman, *Telling Stories to Courts: Women Claim Their Legal Rights*, in *WOMEN AND THE LAW STORIES*, *supra*, at 1, 1–19 (describing story-telling of women's experiences and the 1960's feminist method of consciousness raising as examples of women's lived reality); *see also* CATHARINE A. MACKINNON, *TOWARD A FEMINIST THEORY OF THE STATE* 86 (1989); Elizabeth M. Schneider, *The Dialectic of Rights and Politics: Perspectives from the Women's Movement*, 61 *N.Y.U. L. REV.* 589 (1986).

23. *See, e.g.*, John Boehner, *Taxpayer-Funded Abortion Is Not Healthcare Reform*, *NAT'L REV. ONLINE* (July 23, 2009, 4:00 AM), <http://www.nationalreview.com/critical-condition/48614/taxpayer-funded-abortion-not-health-care-reform/john-boehner>; *Abortion Is Not Healthcare Campaign Will Continue*, *OPERATION RESCUE* (Aug. 6, 2009, 9:54 AM), <http://www.operationrescue.org/archives/abortion-is-not-health-care-campaign-will-continue-sept-12-14>; *Abortion Is Not Healthcare*, *FACEBOOK*, <http://www.facebook.com/noabortion> (last visited Dec. 7, 2012); *"Abortion Is NOT Health Care" Signs*, *LOUISIANA RIGHT TO LIFE FEDERATION*, <http://www.prolifelouisiana.org/203.html> (last visited Dec. 7, 2012).

both healthcare and choice offers the potential for reclaiming the right within the larger framework of reproductive justice by granting all pregnant women, women who carry to term as well as women who choose to terminate their pregnancies, the right to exercise bodily autonomy and access healthcare in every aspect of their reproductive lives. It is because the rationale of rights has eclipsed recognition of abortion as healthcare that the relationship between a pregnant woman and her provider can be targeted to achieve political, but arguably not healthcare, ends. Therefore, it is critical to reassert the view, first articulated in early case law, that abortion is a right that is inextricably linked to healthcare and that laws seeking to restrict access to women's healthcare necessarily compromise the right itself.

I. THE TENSION BETWEEN HEALTHCARE AND CHOICE IN EARLY ABORTION CASES

A. THE EARLY ABORTION RIGHTS MOVEMENTS

In many ways, the current tension in the law between viewing pregnant women as either rights holders or as healthcare consumers can be traced to the early abortion rights movement. In the 1960s there were two movements working simultaneously to alternatively reform and legalize abortion: the doctor-led abortion reform movement and the women's rights movement.²⁴ Within the doctor-led medical abortion reform movement, doctors, lawyers, and public health officials appealed to legislators to reform therapeutic abortion laws²⁵ by giving doctors clearer guidelines and greater discretion in deciding when abortion was lawful.²⁶ The American Medical Association Policy Statement of 1970 reads:

WHEREAS, Abortion, like any other medical procedure, should not be performed when contrary to the best interests of the patient since good medical practice requires due consideration for the patient's welfare and not mere acquiescence to the patient's demand

RESOLVED, That abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only after consultation with two other

24. See LUKER, *supra* note 2, at 66–125; *Introduction*, in *BEFORE Roe v. Wade*, *supra* note 1, at 3, 3–5; Siegel, *Roe's Roots*, *supra* note 2, at 1879–86.

25. The term “therapeutic abortion” refers to “justifiable” abortions designed to preserve a woman's life. LUKER, *supra* note 2, at 73; Susan Brownmiller, *Everywoman's Abortions: “The Oppressor Is Man”* (March 27, 1969), in *BEFORE Roe v. Wade*, *supra* note 1, at 127, 127.

26. LUKER, *supra* note 2, at 66; Siegel, *Roe's Roots*, *supra* note 2, at 1879. MODEL PENAL CODE § 230.3(2) (Proposed Official Draft 1962) provided:

A licensed physician is justified in terminating a pregnancy if he believes there is substantial risk that continuance of the pregnancy would gravely impair the physical or mental health of the mother or that the child would be born with grave physical or mental defect, or that the pregnancy resulted from rape, incest, or other felonious intercourse.

physicians chosen because of their professional competency and in conformance with standards of good medical practice.²⁷

As this policy statement illustrates, the medical reform model sought to vest the discretion to decide when abortion was permissible solely in the hands of the physician, rather than giving pregnant women the right to abortion “on demand.”²⁸ The doctor-led reform movement was based on a nineteenth century paternalistic model that viewed abortion as a medical issue and posited that doctors, rather than pregnant women, should make the decision about abortion based on their professional judgment.²⁹

At the same time that doctors sought reform of abortion laws, the women’s rights movement sought the outright repeal of criminal abortion laws based on the argument that access to safe and legal abortion was a constitutional right.³⁰ While the medical abortion reform movement chose to approach abortion reform through the legislative process,³¹ the women’s movement took to the streets and sought to achieve its goals through grass-roots organizing and consciousness-raising groups.³² The women’s rights movement explicitly challenged the fundamental presumption of the medical reform model that doctors should be vested with the discretion to make decisions about abortion.³³ Rather, they called for repeal of abortion laws and argued that the abortion decision should rest solely with the woman.³⁴ The women’s rights movement cast abortion rights as essential to the “full human dignity and personhood” of women.³⁵ Thus, a woman’s ability to control her reproduction was identified by the women’s rights movement as an aspect of equal citizenship.³⁶ The conflicting viewpoints of the medical reform model and the women’s rights model of abortion were summed up in Betty Friedan’s 1969 speech *Abortion: A Woman’s Civil Right*:

27. *American Medical Association Policy Statement, June 1970*, in *BEFORE Roe v. Wade*, *supra* note 1, at 28, 28–29. Justice Harry A. Blackmun had a copy of this document in his file when he was writing his opinion in *Roe v. Wade*. *Id.* at 26. The document contained check marks indicating that he had read them. *Id.*

28. *See id.* at 28.

29. Jimmie Kimmey, *Abortion Law Reform in the United States*, in *BEFORE Roe v. Wade*, *supra* note 1, at 31, 31.

30. *See id.* at 31–33.

31. *See* GENE BURNS, *THE MORAL VETO* 168 (2005); LUKER, *supra* note 2, at 66–73.

32. LUKER, *supra* note 2, at 95–108 (describing women’s rights tactics of leafleting, abortion teach-ins, consciousness-raising groups, and petitioning to push for abortion rights); Brownmiller, *supra* note 25, at 127–30 (describing a protest during an abortion reform hearing by the New York legislature where the Redstockings, a women’s liberation group, objected to the slate of witnesses who had been called to testify as they consisted of fourteen men and one woman, a nun).

33. LINDA GORDON, *THE MORAL PROPERTY OF WOMEN: A HISTORY OF BIRTH CONTROL POLITICS IN AMERICA* 295–97 (4th ed. 2002); Siegel, *Roe’s Roots*, *supra* note 2, at 1880.

34. LUKER, *supra* note 2, at 92–125; *Repeal*, in *BEFORE Roe v. Wade*, *supra* note 1, at 35, 35–67; Siegel, *Roe’s Roots*, *supra* note 2, at 1880–86.

35. Betty Friedan, *Abortion: A Woman’s Civil Right*, in *BEFORE Roe v. Wade*, *supra* note 1, at 38, 39; Siegel, *Roe’s Roots*, *supra* note 2, at 1881.

36. Siegel, *Roe’s Roots*, *supra* note 2, at 1881–85.

There is only one voice that needs to be heard on the question of the final decision as to whether a woman will or will not bear a child, and that is the voice of the woman herself. Her own conscience, her own conscious choice.

....

... Reform, don't talk to me about reform—reform is still the same—women, passive object. Reform is something dreamed up by men, abortion reform. Maybe good ordered men, good ordered men, but they can only think from their point of view of men. Women are the passive objects that somehow must be regulated . . . What right have they to say? What right has any man to say to any woman: you must bear this child?³⁷

Thus, the reform model argued for abortion reform to protect women's health, while the women's rights movement sought to legalize abortion to promote women's rights.³⁸

B. THE SUBORDINATION OF WOMEN'S RIGHTS TO DOCTORS

The medical reform model was, at least initially, the model favored by courts.³⁹ In *Roe v. Wade*⁴⁰ the Court framed the right of abortion as the right of *doctors* to practice medicine according to their professional judgment rather than recognizing abortion as a right of *women's* health that necessarily included access to abortion services.⁴¹ In describing the abortion right, the *Roe* Court stated:

37. Friedan, *supra* note 35, at 39.

38. See, e.g., *National Organization for Women Bill of Rights*, in *BEFORE Roe v. Wade*, *supra* note 1, at 36, 37–38 (“We Demand: . . . The right of women to control their own reproductive lives by removing from penal codes the laws limiting access to contraceptive information and devices and laws governing abortion.”); *National Association for Repeal of Abortion Laws, NARAL Policy Statement*, in *BEFORE Roe v. Wade*, *supra* note 1, at 40, 40–41 (“1. Safe abortions performed by physicians should be readily available to all women on a voluntary basis, regardless of economic status and without legal encumbrance. 2. As a medical procedure, abortion should be subject only to the general laws regulating medical licensure and practice.”).

39. See *TRIBE*, *supra* note 7, at 33 (arguing that the medical model, which emphasized the role of doctors in the abortion decision, reinforced the traditional role of women as dependent and not in control of their destiny); Appleton, *supra* note 2, at 197–201 (discussing the role of doctors as decisionmakers in early case law of abortion); Ginsburg, *Speaking in a Judicial Voice*, *supra* note 7, at 1199–200; Siegel, *Reasoning from the Body*, *supra* note 7, at 273–79 (describing how *Roe's* medical framework deferred to doctors' judgments and failed to acknowledge how the social organization of motherhood affected women's decisionmaking); Siegel, *Roe's Roots*, *supra* note 2, at 1897 (arguing that the *Roe* decision straddled the medical and women's rights models and gave only “confused expression” to women as constitutional rights holders).

40. 410 U.S. 113 (1973). The Court held that a Texas criminal abortion statute violated women's right of privacy encompassed by the Fourteenth Amendment's concept of personal liberty. *Id.* at 153–54.

41. Elizabeth Reilly, *The “Jurisprudence of Doubt”: How the Premises of the Supreme Court's Abortion Jurisprudence Undermine Procreative Liberty*, 14 J.L. & POL. 757, 774–77 (1998). A Supreme Court clerk to Justice Lewis F. Powell, Jr., wrote a notation on an early draft of the *Roe* opinion that read:

HAB has placed considerable emphasis on the role of the physician and the free exercise of his professional judgment Indeed, on page 49, he states, “The abortion decision inherently is a medical one, and the responsibility for that decision must rest with the

The decision vindicates the right of the physician to administer medical treatment according to his professional judgment up to the points where important state interests provide compelling justifications for intervention. Up to those points, the abortion decision in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician.⁴²

In response to the State's interest in protecting health and maternal life, the *Roe* Court stated that, "neither interest justified broad limitations on the reasons for which *a physician and his pregnant patient might decide* that she should have an abortion in the early stages of pregnancy."⁴³ And again, "prior to this 'compelling' point, *the attending physician, in consultation with his patient*, is free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."⁴⁴

The Court echoed this doctor-centered view in *Planned Parenthood of Central Missouri v. Danforth*.⁴⁵ There, the Court set forth the role of the physician as central to the abortion decision: "[T]he abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician."⁴⁶ Thus, under the Court's analysis, women's constitutional right of choice was subordinated to the discretion and judgment of their medical providers. In fact, early abortion rights cases were brought by doctors challenging abortion legislation as void for vagueness. These claims were set forth as infringing the constitutional rights of doctors,⁴⁷ rather than those of pregnant women.⁴⁸

physician." Doesn't it seem that this language overstates the doctor's role and undercuts the woman's personal interest in the decision? All medical decisions are the product of an agreement between patient and doctor. I see no reason, therefore, not to add a clause to this sentence indicating that the abortion decision must rest "with the physician *and his patient*."

Greenhouse, *supra* note 7, at 41 (citing Memorandum from Larry A. Hammond to Justice Lewis F. Powell, Jr., Supreme Court of the United States (Nov. 27, 1972) (on file with Lewis F. Powell, Jr., Collection, Box 5, Washington & Lee University Law School Library)).

42. *Roe*, 410 U.S. at 165-66.

43. *Id.* at 156 (emphasis added).

44. *Id.* at 163 (emphasis added).

45. 428 U.S. 52 (1976).

46. *Id.* at 61 (citing *Roe*, 410 U.S. at 164). The Court summarized the *Roe* decision by stating, "The participation by the attending physician in the abortion decision, and his responsibility in that decision, thus, were emphasized." *Id.*

47. In fact, in its first draft of the *Roe* decision, the Court considered striking down the Texas abortion statute solely on the ground that it was void for vagueness, and thereby would have only met doctors' needs of having firmer rules to follow as to the health exception for the mother. This result would have met the goals of the medical model of reform by clarifying doctors' decisionmaking power and control over the abortion decision. Justice Blackmun's first draft of the *Roe* opinion rested on vagueness grounds, arguing that the Texas law gave too little guidance and clarity to enable physicians to exercise their medical judgment. Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 172 (2006) (citing Justice Harry A. Blackmun, Draft Opinion of *Roe v. Wade* (May 18, 1972) (Blackmun Papers, Box 141, Folder 4)); see LINDA GREENHOUSE, *BECOMING JUSTICE BLACKMUN: HARRY BLACKMUN'S SUPREME COURT JOURNEY* 87-88 (2005); see also Siegel, *Roe's Roots*, *supra* note 2, at 1894-97.

Early abortion cases cast doctors as not only giving medical advice but also as assuming a larger interpersonal role of assessing both the medical and emotional aspects of the abortion decision.⁴⁹ For example, the Court in *Doe v. Bolton*,⁵⁰ decided the same day as *Roe v. Wade*, stressed that “medical judgment may be exercised in light of all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient.”⁵¹ In overturning sections of a Georgia criminal abortion statute, the Court described:

the conscientious physician . . . whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients. He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so-called ‘error,’ and needs. The good physician . . . will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling.⁵²

This characterization of the male obstetrician caring for his “frail” female patient, explicitly cast women as passive objects in the medical system. Doctors, by contrast, were described as active decisionmakers, looking after the interests of their female patients. This model also implied that doctors exercised veto power over women’s decisions,⁵³ and left women at the mercy of finding cooperative providers rather than allowing them the right to make healthcare decisions for themselves.⁵⁴

48. See, e.g., *Singleton v. Wulff*, 428 U.S. 106, 106–08 (1976) (holding that two doctors had standing to challenge a Missouri law that denied Medicaid benefits for abortions not deemed medically necessary, and finding that patients’ and physicians’ interests were one and the same); *Doe v. Bolton*, 410 U.S. 179, 192–93 (1973) (arguing that both a woman’s privacy right and “the physician’s right to practice his profession” could be violated by abortion restrictions); *United States v. Vuitch*, 402 U.S. 62, 71–73 (1971) (holding the District of Columbia’s abortion statute as not unconstitutionally vague and suggesting that abortion is not fundamentally different from any other surgery such that doctors must have leeway in using their professional judgment); *People v. Belous*, 458 P.2d 194, 202–06 (Cal. 1969) (challenging California abortion laws as infringing the constitutional rights of doctors). See Appleton, *supra* note 2, at 203–04; Siegel, *Roe’s Roots*, *supra* note 2, at 1884.

49. See Appleton, *supra* note 2, at 199–200 (discussing the “medical-counselor” model in which doctors actively participate in the woman’s decisionmaking regarding abortion); Mary Anne Wood & W. Cole Durham, Jr., *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 B.Y.U. L. REV. 783 (1978) (critiquing the Court’s emphasis on the doctor-patient relationship in trying to resolve the abortion controversy).

50. 410 U.S. 179 (1973).

51. *Id.* at 192. See Wood & Durham, *supra* note 49.

52. *Bolton*, 410 U.S. at 196–97.

53. See generally Wood & Durham, *supra* note 49.

54. Indeed, Nan Hunter has argued that the Court’s decision in *Roe v. Wade* can best be understood as the Court’s attempt to delegate to physicians juridical authority over the procreative questions presented by abortion. Hunter, *supra* note 47, at 194–97.

C. THE PARADOX: PROTECTING ACCESS TO ABORTION-RELATED HEALTHCARE

Abortion scholarship has uniformly criticized the medical model of abortion reform for deferring women's decisionmaking to the judgment of physicians.⁵⁵ However, the early abortion decisions present a paradox: On the one hand, the Court's recognition of abortion within the medical model of reform subordinated women's right to choose abortion to the judgment of their providers. On the other hand, these medical reform cases framed abortion within the context of healthcare. Specifically, in cases in which the Court characterized abortion within the healthcare model, the Court's analysis set forth abortion as an integral aspect of women's health rather than strictly as a decisional right. As a result, the healthcare model made the Court more willing to protect access to abortion-related healthcare, respect the privacy of the consumer-provider relationship, and reject attempts by legislators to restrict access to abortion procedures. In this Part, I discuss the Court's shifting analysis between the competing healthcare model and the choice model of the abortion right. I focus my discussion on four areas: funding, services, informed consent, and legislative deference.

I. Funding

The Court's shifting analysis between the competing models of abortion as healthcare and choice first appeared in a series of cases challenging restrictions on federal and state funding for abortions for low-income women.⁵⁶ In 1977, the majority in *Maier v. Roe*⁵⁷ upheld limits on public funding for abortions that were not medically necessary. The Court explained:

The . . . regulation places no obstacles—absolute or otherwise—in the pregnant woman's path to an abortion. . . . The State may have made childbirth a more attractive alternative, *thereby influencing the woman's decision*, but it has imposed no restriction on access to abortions that was not already there. The indigency that may make it difficult—and in some cases, perhaps, impossible—for some women to have abortions is neither created nor in any way affected by the . . . regulation.⁵⁸

55. See discussion *supra* Part I.B.

56. See, e.g., *Harris v. McRae*, 448 U.S. 297 (1980) (upholding the Hyde Amendment's restriction on the use of federal funds for medically necessary abortions under Medicaid program); *Poelker v. Doe*, 432 U.S. 519 (1977) (per curiam) (upholding a city's refusal to provide publicly financed hospital services for non-therapeutic abortions); *Maier v. Roe*, 432 U.S. 464 (1977) (upholding prohibitions on state funding for non-medically necessary abortions); *Beal v. Doe*, 432 U.S. 438 (1977) (upholding limits on state funding for non-therapeutic abortions).

57. 432 U.S. 464.

58. *Id.* at 474 (emphasis added).

The majority failed to recognize that funding restrictions on abortion affected the right of access and instead framed the issue of access to services in terms of how the effect of funding influenced a pregnant woman's *decisionmaking*.

Similarly, three years later in *Harris v. McRae*,⁵⁹ the majority upheld the Hyde Amendment, which denied public funding for certain medically necessary abortions.⁶⁰ The majority identified the right of abortion as a right to choose to terminate a pregnancy and described limits on access to healthcare that resulted from funding restrictions for abortion-related healthcare as simply the state expressing a preference for childbirth.⁶¹ The Court explained that the abortion right “protects the woman from unduly burdensome interference with her freedom to decide whether to terminate her pregnancy . . . [but does not prevent the state] from making ‘a value judgment favoring childbirth over abortion and . . . implement[ing] that judgment by the allocation of public funds.’”⁶² The majority characterized women seeking abortion as rights holders who were not harmed by the lack of funding for abortion healthcare because their right of choice remained intact.

While the majorities in *Maier* and *Harris* identified the abortion right as the decision to terminate a pregnancy, the dissent in these funding cases consistently characterized abortion as healthcare. The dissent in *Maier v. Roe* stated that “indigency makes access to competent licensed physicians not merely ‘difficult’ but ‘impossible.’ As a practical matter, many indigent women will feel they have no choice but to carry their pregnancies to term because the State will pay for the associated medical services.”⁶³ The *Maier* dissent highlighted that choice and access to healthcare are integrally linked, and that the practical effect of burdening an individual's right of access to the means of effectuating that choice is in effect to unconstitutionally burden the choice itself.⁶⁴ Similarly, in *Beal v. Doe*,⁶⁵ which denied Medicaid funding for non-therapeutic abortions, the dissent framed the funding issue specifically by asserting abortion as healthcare:

[O]ur abortion cases compel the conclusion that elective abortions constitute medically necessary treatment for the condition of pregnancy. . . .

. . . .

59. 448 U.S. 297.

60. *Id.* at 326–27.

61. *Id.* at 314–15; see also *Maier*, 432 U.S. at 474 (“The State may have made childbirth a more attractive alternative, thereby influencing the woman's decision, but it has imposed no restriction on access to abortions that was not already there.”).

62. *Harris*, 448 U.S. at 314 (final two alterations in original) (quoting *Maier*, 432 U.S. at 474).

63. 432 U.S. at 483 (Brennan, J., dissenting).

64. *Id.* at 487.

65. 432 U.S. 438 (1977).

Pregnancy is unquestionably a condition requiring medical services. Treatment for the condition may involve medical procedures for its termination, or medical procedures to bring the pregnancy to term, resulting in a live birth. “[A]bortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy”⁶⁶

These two dissents characterized pregnant women seeking abortion as healthcare consumers, not simply as rights holders exercising a right of choice.

The dissent in *Harris v. McRae* highlighted the fundamental distinction in the way the majority characterized the nature of the right of abortion: “[T]he Court suggests that withholding of funding imposes no real obstacle to a woman deciding whether to exercise her constitutionally protected procreative choice For a poor person attempting to exercise her ‘right’ of freedom of choice, . . . [the funding restrictions] have precisely the same effect as an outright prohibition.”⁶⁷

Thus, for the dissent, not only was abortion recognized as an aspect of healthcare, but the abortion right included access to abortion services. This led to the conclusion that laws that restricted access also restricted the right itself. The dissent’s analysis relied on a view of abortion as inextricably intertwined with healthcare to reach the conclusion that limits on access to abortion-related healthcare *necessarily* limited the abortion right. Under this analysis, denying a pregnant woman the ability to *obtain* an abortion had the effect of denying her constitutional right of abortion. The *Harris* dissent stated:

Under the Hyde Amendment, federal funding is denied for abortions that are medically necessary and that are necessary to avert severe and permanent damage to the health of the mother. The Court’s opinion studiously avoids recognizing the undeniable fact that for women eligible for Medicaid—poor women—denial of a Medicaid-funded abortion is equivalent to denial of legal abortion altogether.⁶⁸

Rather than casting abortion as a decisional right, the dissent specifically connected the right to women’s healthcare needs and addressed the healthcare consequences that would result for pregnant women who could not afford abortions.

2. Access to Abortion Services

In *City of Akron v. Akron Center for Reproductive Health*,⁶⁹ the majority struck down provisions of an Akron, Ohio, ordinance that

66. *Id.* at 449 (final two alterations in original) (citation omitted).

67. 448 U.S. at 347 (Marshall, J., dissenting).

68. *Id.* at 338.

69. 462 U.S. 416 (1983) (holding unconstitutional several provisions of an Akron, Ohio, ordinance requiring performance of all second-trimester abortions in a hospital, parental consent, informed consent, a twenty-four-hour waiting period, and the disposal of fetal remains).

required all second-trimester abortions to be performed in a hospital. The Court argued that by “preventing the performance of D&E abortions in an appropriate nonhospital setting, Akron has imposed a heavy, and unnecessary, burden on women’s access to a relatively inexpensive, otherwise accessible, and safe abortion procedure . . . and therefore unreasonably infringes upon a woman’s constitutional right to obtain an abortion.”⁷⁰

Critically, the Court specifically identified abortion as encompassing the right to *obtain* abortion-related healthcare, and not solely as a decisional right. The Court noted that the hospitalization requirement both increased the cost and decreased the availability of second-trimester abortions, concluding that, “a second-trimester hospitalization requirement may force women to travel to find available facilities, resulting in both financial expense and additional health risk. . . . [that] may significantly limit a woman’s ability to obtain an abortion.”⁷¹ In the majority’s view, restriction of access to abortion services was tantamount to restricting the abortion right itself. Thus, the majority view that abortion-related healthcare was an integral aspect of the right of abortion led to the conclusion that laws limiting access to abortions violate the constitutional right of abortion.

Presaging the Court’s later shift, the *Akron* dissent narrowly circumscribed abortion as a right to *decide* to terminate a pregnancy and distanced the abortion procedure from the provision of healthcare. Drawing upon the abortion-as-choice model first articulated in *Maher v. Roe*, the dissent asserted that “*Roe* did not declare an unqualified ‘constitutional right to abortion.’ Rather, the *Roe* right is intended to protect against state action ‘drastically limiting the availability and safety of the *desired service*’ against the imposition of an ‘absolute obstacle’ on the abortion *decision*.”⁷² Justice O’Connor’s dissent reinforced the notion that the abortion right is limited to the right to make the decision to terminate a pregnancy that is unconnected from access to abortion services when she concluded that “[a] health regulation, such as the hospitalization requirement, simply does not rise to the level of ‘official interference’ with the abortion *decision*.”⁷³ Justice O’Connor continued to characterize the abortion right as a “decision,” noting that the “abortion cases demonstrate that an ‘undue burden’ has been found for the most part in situations involving absolute obstacles or severe limitations on the abortion *decision*.”⁷⁴ The abortion right was identified narrowly by the dissent as the right to make a decision, and abortion services were not

70. *Id.* at 438–39.

71. *Id.* at 435.

72. *Id.* at 464 (O’Connor, J., dissenting) (emphasis added) (citations omitted).

73. *Id.* at 467 (emphasis added).

74. *Id.* at 464 (emphasis added).

understood as integral to the decision, but as mere regulation of the medical profession.

The *Akron* dissent's reasoning bifurcated abortion into two aspects: decisional autonomy and the abortion procedure. It specifically identified abortion as a right to make the abortion decision and relegated the abortion procedure to the status of a "desired service" rather than healthcare necessary for the exercise of the right in question. In doing so, the dissent reinforced the idea that the right of abortion was a decisional right that was unrelated to the healthcare necessary to effectuate the right. The dissent went on to describe that a regulation must not significantly burden a protected right to terminate a pregnancy, "by substantially limiting access to the *means of effectuating that decision*."⁷⁵ The comparison in the use of language to describe abortion between the majority and the dissent reveals the fundamental difference in the way they viewed the abortion right. The majority engaged in a detailed discussion of the effect of the Akron ordinance on the availability, cost, and access to abortions.⁷⁶ By contrast, the dissent made no reference to abortion within the context of healthcare and dismissed the Akron regulation as a state's legitimate interest "in maintaining medical standards,"⁷⁷ rather than touching upon the constitutional right to obtain an abortion.

3. *Informed Consent*

The Court's characterization of abortion as healthcare led to the Court's analysis that the consumer-provider relationship was central to the abortion right. Based on this analysis, the Court rejected legislative attempts to intrude upon the privacy of that relationship through informed consent laws. For example, in *City of Akron*,⁷⁸ the Court specifically connected the right of abortion as healthcare to the necessity to protect the consumer-provider relationship:

because abortion is a medical procedure, . . . the full vindication of the woman's fundamental right necessarily requires that her physician be given "the room he needs to make his best medical judgment." The physician's exercise of this medical judgment encompasses both assisting the woman in the decisionmaking process and implementing her decision should she choose abortion.⁷⁹

75. *Id.* at 463 (quoting *Carey v. Population Servs. Int'l*, 431 U.S. 628, 688 (1972)) (emphasis added).

76. *Id.* at 434-35 (comparing the cost of a second-trimester abortion in a hospital setting versus a clinic and the availability of hospitals willing to perform second-trimester abortions, both in Akron and nationwide).

77. *Id.* at 459 (quoting *Roe v. Wade*, 410 U.S. 113, 154 (1973)).

78. 462 U.S. 416 (1983) (holding unconstitutional several provisions of an Akron, Ohio, ordinance requiring performance of all second-trimester abortions in a hospital, parental consent, informed consent, a twenty-four-hour waiting period, and the disposal of fetal remains).

79. *Id.* at 427 (citations omitted).

The Court's analysis began by acknowledging abortion as a "medical procedure" in order to emphasize the central importance of the informed consent dialogue to the abortion right. Its description of the role of the provider in the abortion decision stressed that a woman's ability to receive neutral, unbiased, and confidential healthcare advice from her provider was integral to the abortion right. In rejecting the informed consent provisions, the Court recognized that the ordinance attempted to replace the judgment of providers in the delivery of abortion services with the judgment of legislators, arguing that a state did not have "unreviewable authority to decide what information a woman must be given before she chooses to have an abortion. It remains primarily the responsibility of the physician to ensure that appropriate information is conveyed to his patient, depending on her particular circumstances."⁸⁰ Similarly, in *Thornburgh v. American College of Obstetricians and Gynecologists*,⁸¹ the Court rejected an informed consent provision, arguing:

The printed materials required by [the ordinance] seem to us to be nothing less than an outright attempt to wedge the Commonwealth's message discouraging abortion into the privacy of informed-consent dialogue between the woman and her physician. . . . Forcing the physician or counselor to present the materials and the list to the woman makes him or her in effect an agent of the State in treating the woman and places his or her imprimatur upon both the materials and the list.⁸²

Again, this description conveys that the consumer-provider relationship is integral to the decision itself and therefore is central to the abortion right. It is this view that informed the Court's analysis that intrusion into the consumer-provider relationship was an obstacle to the abortion right.

By contrast, in *City of Akron*, Justice O'Connor chided in her dissent that it "is certainly difficult to understand how the Court believes that the physician-patient relationship is able to accommodate any interest that the State has in maternal physical and mental well-being in light of the fact that the record in this case shows that the relationship is nonexistent."⁸³ Similarly, Justice White's dissent in *Thornburgh* questioned

80. *Id.* at 443. *But see* Appleton, *supra* note 2, at 216–26 (arguing that the *Akron* decision continues to characterize the rights of physicians as central to the abortion right); Susan Frelich Appleton, *More Thoughts on the Physician's Constitutional Role in Abortion and Related Choices*, 66 WASH. U. L.Q. 499, 501 (1988) (same).

81. 476 U.S. 747 (1986) (invalidating sections of the Pennsylvania Abortion Control Act that required women seeking abortions be advised at least twenty-four hours in advance that there may be detrimental physical and psychological effects from abortion, of the probable gestational age of the child and the availability of medical care for birth, of reporting requirements of persons performing abortions, and of a requirement that a second physician be present during post-viability abortions in order to give medical care to a potentially viable fetus).

82. *Id.* at 762–63.

83. *Akron*, 462 U.S. at 473 (O'Connor, J., dissenting) (citations omitted). Further, the Court failed to acknowledge that the limited nature of the consumer-provider relationship in the context of abortion is due in large part to the failure of the medical profession after 1973 to make a concerted

the importance of the consumer-provider relationship in the right of abortion, stating that while, arguably, the right of abortion

may extend to a woman's *decision regarding abortion*. . . . I cannot concede the possibility that the Constitution provides more than minimal protection for the manner in which a physician practices his or her profession or for the "dialogues" in which he or she chooses to participate in the course of treating patients.⁸⁴

Justice White's analysis was premised on the fundamentally different way he conceptualized the right of abortion: For the majority, the provision "intrude[d] upon the discretion of the pregnant woman's physician" and violated "the privacy of the informed-consent dialogue between the woman and her physician."⁸⁵ For Justice White, pregnant women were rights holders to the extent that they could choose an abortion. Regulation of doctors was merely regulation of a profession, completely unconnected to the right of abortion. Justice White argued that "regulation of the practice of medicine, like regulation of other professions and of economic affairs generally, was a matter peculiarly within the competence of legislatures, and that such regulation was subject to review only for rationality."⁸⁶ His argument relied on the assumption that women who seek abortions were exercising rights that were unconnected from seeking healthcare. It is on this basis that he justified his argument that informed consent did not infringe on the essential right of women to choose abortion, but was merely regulation of the medical profession.⁸⁷

4. *Regulation of Abortion Procedures*

Finally, because the Court acknowledged abortion as integrally related to healthcare, it was more willing to defer to the judgment of providers instead of legislators in setting policies relating to abortion procedures. Thus, for example, the Supreme Court in *Danforth*,⁸⁸ struck down legislative attempts to define viability recognizing that such an attempt was in fact an attempt to limit access to abortion.⁸⁹ In striking down the statute's definition of viability, the Court stated:

[I]t is not the proper function of the legislature or the courts to place viability, which essentially is a medical concept, at a specific point in

effort to train doctors to do abortions and to encourage doctors to integrate abortion into ordinary practice. See Marcia Angell & Michael Greene, *Where Are the Doctors?: As States Use Medically Dubious Tactics to Roll Back Access to Contraception and Abortion, The Medical Profession Stands Mute*, USA TODAY, May 16, 2012, at A7; Emily Bazelon, *The New Abortion Providers*, N.Y. TIMES MAG., July 18, 2010, at 30-47; Irin Carmon, *Doctors Caught in the Abortion Wars*, SALON (June 7, 2012, 11:45 AM), http://www.salon.com/2012/06/07/doctors_caught_in_the_abortion_wars; discussion *infra* Part III.

84. 476 U.S. 747, 802 (1986) (White, J., dissenting) (emphasis added).

85. *Id.* at 762 (majority opinion).

86. *Id.* at 802 (White, J., dissenting).

87. *Id.* at 803-04.

88. 428 U.S. 52 (1976).

89. *Id.* at 64.

the gestation period. The time when viability is achieved may vary with each pregnancy, and the determination of whether a particular fetus is viable is, and must be, a matter for the judgment of the responsible attending physician.⁹⁰

The Court's rationale was explicitly based on a view that abortion was healthcare and therefore properly within the purview of the medical community, not the political agendas of legislators. However, the Court's analysis also revealed the double-edged sword of the medical model of abortion rights: The Court deferred to the decisionmaking of providers and thereby undermined the women's rights basis of abortion. At the same time, it was because the Court characterized abortion as healthcare that it was able to reject attempts to replace the judgment of healthcare providers with the political agenda of the legislature and protect the right of providers to deliver abortion services free of legislative agendas.

The *Danforth* Court also rejected legislative attempts to prohibit the use of saline amniocentesis after the first twelve weeks of pregnancy.⁹¹ In reaching its conclusion, the Court chose to rely heavily on the record of medical testimony rather than on the legislative agenda.⁹² The Court stated:

The State . . . would prohibit the use of a method which the record shows is the one most commonly used nationally by physicians after the first trimester and which is safer, with respect to maternal mortality, than even continuation of the pregnancy until normal childbirth. Moreover, as a practical matter, it forces a woman and her physician to terminate her pregnancy by methods more dangerous to her health than the method outlawed.⁹³

The Court thereby deferred to providers' testimony as to the most commonly used and safest method of post-first-trimester abortions. This deference was the result of the Court's characterization of abortion as a medical procedure and not as a political or constitutional right.

By contrast, in *Gonzales v. Carhart*,⁹⁴ the Court upheld the so-called Partial Birth Abortion Ban that stripped providers of the ability to use a specific method of abortion known as intact dilation and evacuation ("intact D&E"),⁹⁵ even when necessary to protect the health of the pregnant woman seeking the abortion.⁹⁶ In so doing, the Court permitted

90. *Id.*

91. *Id.* at 79. Saline amniocentesis is a method of inducing abortion whereby amniotic fluid is withdrawn and saline is inserted into the amniotic sac. *Id.* at 75–76. It is the most commonly used and safest method of abortion in the first twelve weeks of pregnancy. *Id.* at 78–79.

92. *Id.* at 64, 78–79.

93. *Id.* at 78–79.

94. 550 U.S. 124 (2007).

95. This procedure is also referred to as intact dilation and extraction ("intact D&X"). *Id.* at 170 n.1 (Ginsburg, J., dissenting). The term "partial-birth abortion" is not a medical term but a term created by legislators. *Id.* Intact D&E is a variation of the D&E procedure in which the fetus is removed from the uterus intact instead of dismembered *in utero*. *Id.* at 178.

96. For discussions of the role of the doctor-patient relationship in the abortion decision, see

Congress to divest providers of the ability to use the intact D&E procedure, based exclusively on congressional findings that ran contrary to medical testimony.⁹⁷ The Court deferred to congressional findings that the partial birth abortion procedure was never medically necessary, despite the fact that significant medical authority contradicted these findings.⁹⁸ As Justice Ginsburg described in her dissent, the congressional findings ignored the letters of numerous individual physicians as well as statements from nine professional health organizations including the American College of Obstetricians and Gynecology, the American Public Health Association, and the California Medical Association.⁹⁹ Instead, Congress chose to rely on the testimony of six physicians, none of whom had ever performed an intact D&E, several of whom did not provide abortion services at all, and one who was not even an obstetrician-gynecologist.¹⁰⁰ The Court's decision to defer to congressional findings that were motivated by political instead of healthcare ends, and to specifically ignore the findings of three district courts that the congressional findings lacked adequate healthcare basis, evidenced the profound shift in the Court's view of abortion from an issue of healthcare to an issue of choice.

II. THE RHETORIC OF CHOICE

This Part argues that in case law and legislation the abortion right has been transformed from a right inherently related to healthcare to a narrowly circumscribed right of choice. This trend is reflected in the Court's current "rights holder" analysis in abortion cases. The same trend is evident in recent legislation such as anti-abortion laws based on the so-called woman-protective rationale and restrictions on the use of both public and private healthcare funds for abortions. I conclude that the rhetoric of choice over healthcare is coalescing in both the courts and the political arena and poses a significant threat to women's access to abortion-related healthcare.

Hunter, *supra* note 47, at 196 (tracing the Court's deference to medical authority in the abortion cases and arguing that such changes in attitude have been an "epiphenomenon of ideological shifts"); Theodore W. Ruger, *Health Law's Coherence Anxiety*, 96 GEO. L.J. 625 (2008) (discussing the de-emphasis of the doctor-patient relationship in a series of contexts, including abortion); Peter M. Ladwein, Note, *Discerning the Meaning of Gonzales v. Carhart: The End of the Physician Veto and the Resulting Change in Abortion Jurisprudence*, 83 NOTRE DAME L. REV. 1847 (2008) (arguing that *Gonzales* signals the end of the "physician's veto," defined to mean the autonomy and judgment of physicians in the abortion context).

97. *Gonzales*, 550 U.S. at 179 (Ginsburg, J., dissenting) ("[S]ignificant medical authority supports the proposition that in some circumstances, intact D&E is the safest procedure.").

98. *Id.* at 174-81.

99. *Id.* at 176.

100. *Id.* at 175.

A. THE RIGHT OF CHOICE IN THE COURT'S ABORTION ANALYSIS

Re-examining the roles of healthcare and choice in the abortion decisions reveals that the Supreme Court's evolving analysis sets forth these two elements as a "trade off." Specifically, rather than rehabilitating the *Roe* Court's original foundation of abortion as healthcare by reasserting women's constitutional right of choice, the Court's analysis in the most recent Supreme Court cases, *Casey* and *Gonzales*, identifies abortion exclusively as a right of choice, uncoupled from healthcare.

The Court's analysis in *Casey*¹⁰¹ specifically separated the decisional right to choose abortion from access to abortion-related healthcare, stating:

The fact that a law which serves a valid purpose, one not designed to strike at the right itself, has the incidental effect of making it more difficult or more expensive to procure an abortion cannot be enough to invalidate it. Only where state regulation imposes an undue burden on a woman's ability to make this *decision* does the power of the State reach into the heart of the liberty protected by the Due Process Clause.¹⁰²

The liberty right was championed by the Court as the decision to terminate a pregnancy, and was not related to one's ability to "procure" an abortion. Under the Court's analysis, limits on the healthcare necessary for abortion were identified as merely having "incidental effects" on the abortion right. Thus, the Court stated:

What is at stake is the woman's right to make the ultimate decision, not a right to be insulated from all others in doing so. Regulations which do no more than create a structural mechanism by which the State . . . may express profound respect for the life of the unborn are permitted, if they are not a substantial obstacle to the woman's exercise of the right to choose.¹⁰³

Again, the abortion right was cast in terms of decisionmaking, referring to abortion as "the ultimate decision" and "the right to choose." The Court's reasoning sought to limit abortion to a decisional right, unconnected from healthcare, to terminate a pregnancy. The Court asserted that "the right protects the woman from unduly burdensome

101. 505 U.S. 833 (1992). In *Casey*, physicians challenged amendments to the Pennsylvania abortion statute that required a woman seeking an abortion give her informed consent and that she be provided with certain information at least twenty-four hours in advance of the procedure. *Id.* at 84. The Act also required that a minor who seeks an abortion obtain the informed consent of her parents, with a judicial bypass option if the minor does not wish to or cannot obtain a parent's consent. *Id.* The Act required women seeking abortions to sign a statement indicating spousal notification of her intended abortion. *Id.* Finally, the Act imposed reporting requirements on facilities that provide abortions. *Id.*

102. *Id.* at 874 (emphasis added).

103. *Id.* at 877.

interference with her *freedom to decide whether to terminate her pregnancy*.”¹⁰⁴

The *Casey* opinion made almost no reference to abortion as women’s healthcare and relied instead on descriptions of abortion as a right of equal participation and personal choice. The opinion discussed abortion exclusively in rights holder language, stating:

[F]or two decades of economic and social developments, people have organized intimate relationships and made choices that define their views of themselves and their places in society, in reliance on the availability of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.¹⁰⁵

Further, the opinion described pregnant women who seek abortion in the now-famous imagery of rights holders:

These matters, involving the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, are central to the liberty protected by the Fourteenth Amendment. At the heart of liberty is the right to define one’s own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under compulsion of the State.

... [A pregnant woman’s] suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman’s role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.¹⁰⁶

This description presented the right exclusively in terms of personal choices and decisionmaking. This is in sharp contrast with the early recognition that “the abortion decision in all its aspects is inherently, and primarily, a medical decision.”¹⁰⁷ The opinion both championed abortion as central to women’s equality and citizenship and at the same time permitted states to dramatically regulate healthcare access for abortion. The Court’s decision balanced women’s decisionmaking with the state’s interest in potential fetal life and rested on the assumption that the abortion right solely encompassed the right of decisional autonomy and was independent of healthcare.

Further, the Court’s analysis isolated a pregnant woman’s right to choose abortion from her relationship with her provider. Again, in contrast to the early deference to the privacy of the consumer-provider dialogue which the Court identified as central to the abortion right, the

104. *Id.* at 874 (quoting *Maier v. Roe*, 432 U.S. 464, 473–74 (1977)) (emphasis added).

105. *Id.* at 856.

106. *Id.* at 851–52.

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

Casey Court deconstructed that relationship: “Whatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman’s position.”¹⁰⁸ Accordingly, the consumer-provider relationship “does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy.”¹⁰⁹

Finally, in *Gonzales v. Carhart*, the Court upheld for the first time an outright ban on the intact D&E abortion procedure and also upheld for the first time an abortion restriction that did not contain an exception for the health of the woman.¹¹⁰ The *Gonzales* Court isolated intact D&E from women’s healthcare by specifically omitting any discussion of the contexts in which pregnant women would seek a second-trimester abortion. This deliberate decision to omit the healthcare issues that gave rise to second-trimester abortions furthered the fiction that such procedures were “choices” that occurred in isolation of women’s healthcare. For example, an amicus brief filed on behalf of the American Medical Women’s Association described would-be parents who were forced to make the anguished decision to terminate a wanted pregnancy due to fetal abnormalities or maternal health.¹¹¹ The amicus brief described that the benefit of choosing the intact D&E procedure was that it allowed these patients, “to see and hold the fetus, and mourn its death.”¹¹² The Court chose to ignore this testimony and instead dismissed the decision to use the intact D&E by stating that, “expectant mothers, and society as a whole [will be better informed] of the consequences that follow from a decision to elect a late-term abortion.”¹¹³ This carefully chosen language ignored the medical necessity that drove the decision to seek a second-trimester abortion and instead sought to present women who underwent this procedure as merely rights holders who “elected” the procedure.

Further, the Court chose to include an overly detailed and gruesome description of the intact D&E procedure¹¹⁴ while omitting the medical

108. 505 U.S. at 884. The Court upheld amendments to the Pennsylvania abortion statute that required a woman seeking an abortion give her informed consent and that she be provided with certain information at least twenty-four hours in advance of the procedure. *Id.*

109. *Id.*

110. 550 U.S. 124, 160–68 (2007). In *Stenberg v. Carhart*, the Court invalidated an almost identical abortion restriction because it lacked an exception for the health of the mother. 530 U.S. 914, 938 (2000).

111. Brief of Amici Curiae Am. Med. Women’s Ass’n et al. in Support of Respondents, *Gonzales v. Carhart*, 550 U.S. 124 (2007) (No. 05-1382).

112. *Id.* at 15 n.10. Linda Greenhouse has pointed out that “[t]his description of compassionate doctors and women having abortions while in full possession of mothering instincts perhaps did not fit with the majority’s imagined scenario of deceitful physicians and women denying their true natures.” Linda Greenhouse, *The Counter-Factual Court*, 47 U. LOUISVILLE L. REV. 1, 15 (2008).

113. *Gonzales*, 550 U.S. at 160.

114. *Id.* at 137–40.

contexts that necessitated such second-trimester procedures.¹¹⁵ The Court in both the *Stenberg v. Carhart* and *Gonzales v. Carhart* decisions apologized to the reader and acknowledged that its “discussion may seem clinically cold or callous to some, perhaps horrifying to others.”¹¹⁶ However, when the Court considered a ban on saline amniocentesis in *Danforth*, it only briefly touched on the procedure, implying it did not find it necessary to discuss in graphic detail.¹¹⁷ Yet, in its detailed description of the intact D&E procedure, which the Court likened to “infanticide,” the woman herself was almost entirely missing from the Court’s description of the procedure: The Court referred to the fetus forty-one times in its graphic description but used the term “woman” only five times, and only once in reference to the intact D&E procedure.¹¹⁸ Thus, the Court described the procedure for the purpose of shocking the sensibilities of the reader rather than addressing the procedure in relation to women’s healthcare needs.

Next, early cases acknowledged the credentials and expertise of abortion providers, describing providers as, “eminent, Missouri-licensed obstetricians and gynecologists,”¹¹⁹ “an obstetrician and gynecologist of eminence,”¹²⁰ and as a “conscientious physician.”¹²¹ By contrast, the *Gonzales* Court repeatedly referred to physicians by the derogatory term “abortion doctor.”¹²² Similarly, both Justice Kennedy and Justice White had used the pejorative term “abortionist” in earlier dissenting opinions in *Stenberg v. Carhart*¹²³ and *Colautti v. Franklin*,¹²⁴ respectively. Further, providers’ medical judgment and expertise were devalued by the *Gonzales*

115. By contrast, Justice Ginsburg’s dissent addresses the medical necessity that gives rise to second-trimester abortions. *Id.* at 173 n.3 (Ginsburg, J., dissenting).

116. *Stenberg v. Carhart*, 530 U.S. 914, 923 (2000); see *Gonzales*, 550 U.S. at 134 (“The Act proscribes a particular manner of ending fetal life, so it is necessary here, as it was in *Stenberg*, to discuss abortion procedures in some detail.”).

117. 428 U.S. 52, 75–79 (1976). The Court struck down sections of a Missouri abortion statute that, *inter alia*, required women seeking abortions to sign a written consent, provide written spousal consent, and provide written parental consent in the case of unmarried minors, in addition to certain reporting and record-keeping requirements for physicians performing abortions and a requirement that physicians exercise professional care to preserve the life and health of an aborted fetus, failing which he or she may be deemed guilty of manslaughter. *Id.* at 58–59. See generally B. Jessie Hill, *Dangerous Terrain: Mapping the Female Body in Gonzales v. Carhart*, 19 COLUM. J. GENDER & L. 649 (2010) (discussing the graphic description of partial-birth abortion procedures within the themes of disappearance, dismemberment, and displacement of borders of the female body).

118. See Hill, *supra* note 117, at 660.

119. *Danforth*, 428 U.S. at 56.

120. *Poe v. Ullman*, 367 U.S. 497, 498 (1961).

121. *Doe v. Bolton*, 410 U.S. 179, 196 (1973).

122. *Gonzales v. Carhart*, 550 U.S. 124 *passim* (2007). Justice Ginsburg pointed out the use of this derogatory term in her dissent. See *id.* at 186–87 (Ginsburg, J., dissenting). She also highlighted the district court’s references to physicians who testified on this procedure in the lower court hearings as “extraordinarily accomplished” and “very experienced.” *Id.* at 177.

123. 530 U.S. 914, 956–79 (2000) (Kennedy, J., dissenting).

124. 439 U.S. 379, 401–09 (1979) (White, J., dissenting).

Court when, for example, the Court suggested that a provider's choice of the intact D&E procedure was a "preference"¹²⁵ chosen for "mere convenience."¹²⁶ The Court went further in isolating abortion from healthcare by fundamentally challenging the legitimacy of the consumer-provider relationship.¹²⁷ In marked contrast to earlier case law that viewed the consumer-provider relationship as integral to the abortion right, the Court in *Gonzales* suggested that providers might intentionally seek to withhold information about the details of the abortion procedure from their female patients.¹²⁸ This would cause women to later regret their decision as they came to understand what they had allowed a doctor to do to their "unborn child."¹²⁹ The majority thereby no longer presented providers as protecting their pregnant patients' best interests, but instead as attempting to trick their unsuspecting and emotional patients into terminating their pregnancy through a method akin to infanticide that their patients would later come to profoundly regret.¹³⁰ Far from the early characterization of abortion as a decision to be taken in consultation with a compassionate and empathetic physician, the Court now sought to *protect* women from their providers. In doing so, the Court went so far as to uphold an outright ban on the procedure instead of seeking to combat the perceived problem through increased informed consent requirements.¹³¹

The *Casey* and *Gonzales* decisions mark a shift in the Court's analysis of abortion from a right of healthcare to a limited right of choice. While the early case law of abortion consistently recognized abortion as an aspect of women's healthcare, acknowledged the expertise and judgment of providers, recognized the centrality of the consumer-provider relationship, and protected access to abortion procedures, none of these elements appear in the Court's current analysis. Indeed, the Court's current analysis has not only severed abortion from healthcare, but also appears hostile to abortion providers. It suggests that pregnant women seeking abortion must be protected from providers who might seek to trick them, referring to providers by derogatory terms such as "abortion

125. 550 U.S. at 134 ("Abortion methods vary depending to some extent on the preferences of the physician . . .").

126. *Id.* at 166.

127. *Id.* at 159.

128. *Id.* at 184 (Ginsburg, J., dissenting).

129. *Id.* at 159–60 (majority opinion) ("In a decision so fraught with emotional consequence some doctors may prefer not to disclose precise details of the means that will be used . . . [as] [i]t is self-evident that a mother who comes to regret her choice . . . when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child . . .").

130. *See id.*; Greenhouse, *supra* note 112, at 7; *see also* Susan Frelich Appleton, *Reproduction and Regret*, 23 YALE J.L. & FEMINISM 255 (2011) (comparing the Court's regret analysis in *Gonzales* with its regret analysis in other reproductive decisionmaking contexts).

131. *Gonzales*, 550 U.S. at 179 (Ginsburg, J., dissenting).

doctors” and “abortionists”¹³² and describing the consumer-provider relationship as “nonexistent.”¹³³ The critical difference in these decisions hinges on how the Court understands abortion: as a decisional right instead of a right to healthcare. The Court’s current analysis identifies abortion as a narrow right to choose to terminate a pregnancy and uncouples the abortion decision from access to healthcare. It is based on this premise that the Court has upheld legislation that restricts access to healthcare while nominally reaffirming the “essential holding of *Roe*.”¹³⁴

B. THE WOMAN-PROTECTIVE ANTI-ABORTION ANALYSIS

While courts have narrowly circumscribed abortion to a right of choice, the same trend is occurring in the political arena. Anti-abortion groups have used woman-protective arguments to challenge women’s access to abortion by questioning their ability to make the abortion decision. This recent woman-protective argument transforms the political dialogue around abortion away from protecting the life of the fetus to protecting women from the regret and depression that can result from abortion.¹³⁵ Thus, the woman-protective argument conflates healthcare and choice: A woman must be protected from the abortion *decision* because the choice is harmful to her physical and mental *health*.

While traditional abortion laws refer to abortion as the termination of pregnancy, the woman-protective model recasts abortion as the termination of a relationship between a pregnant woman and her child. For example, a woman-protective anti-abortion bill recently introduced in South Dakota refers to abortion as “the decision of a pregnant mother considering termination of her relationship with her child.”¹³⁶ This bill follows a similar bill passed in 2005 by the South Dakota legislature based on the woman-protective reasoning that, “by having an abortion, her existing relationship and her existing constitutional rights with regards to that relationship will be terminated.”¹³⁷ The 2005 bill required the doctor to advise the pregnant woman of all known medical risks of having an abortion, including “depression and related psychological distress[, and] [i]ncreased risk of suicide ideation and suicide.”¹³⁸ It stated

132. *Id.* at 186–87.

133. *City of Akron v. Akron Ctr. for Reprod. Health*, 462 U.S. 416, 473 (1982) (O’Connor, J., dissenting).

134. *Planned Parenthood of S.E. Pa. v. Casey*, 505 U.S. 833, 846 (1992).

135. Siegel, *The New Politics*, *supra* note 11, at 993. See Eileen Fegan, *Reclaiming Women’s Agency: Exposing the Mental Health Effects of ‘Post Abortion Syndrome’ Propaganda*, in *WOMEN, MADNESS, AND THE LAW: A FEMINIST READER* 169 (Wendy Chan et al. eds., 2005); Emily Bazelon, *Is There a Post-Abortion Syndrome?*, N.Y. TIMES MAG., Jan. 21, 2007, at 41.

136. H.B. 1254, 2012 Leg. Assemb., 87th Sess. (S.D. 2012). The bill was halted through an injunction issued on June 30, 2011. *Planned Parenthood Minn. v. Daugaard*, 799 F. Supp. 2d 1048, 1077 (D.S.D. 2011).

137. H.B. 1166, 2005 Leg. Assemb., 80th Sess. (S.D. 2005).

138. *Id.* The bill was halted by preliminary injunction and is currently on appeal in the Eighth

that its purpose was “to fully protect . . . the mother’s fundamental natural intrinsic right to a relationship with her child.”¹³⁹ By describing abortion as terminating a woman’s relationship with her child, the bill takes abortion outside of the medical care context and situates it instead in the realm of relationships and choices.

The dissent in *Beal v. Doe* succinctly explained that “[a]bortion and childbirth, when stripped of the sensitive moral arguments surrounding the abortion controversy, are simply two alternative medical methods of dealing with pregnancy.”¹⁴⁰ The use of language in woman-protective legislation is very far from this early characterization. By referring to abortions as the “decision to terminate a relationship,” the legislation fails to acknowledge that abortion is an aspect of reproductive healthcare and also fails to acknowledge the medical necessity that may drive the abortion decision: either the health of the mother or of the fetus. The shift in the terminology used in woman-protective legislation to describe the nature of abortion further reveals the shift in focus from abortion as women’s healthcare to abortion as women’s decisionmaking.

The most recent South Dakota bill is designated as an “informed consent” bill but focuses exclusively on ensuring that the pregnant woman’s *decisionmaking* is adequate.¹⁴¹ For example, it requires the doctor to meet personally with the pregnant woman to determine whether she was subjected to “pressure, undue influence, or coercion”¹⁴² in making her decision to terminate her pregnancy. In making the determination, the doctor must assess, “her medical and personal circumstances”¹⁴³ to determine if risk factors associated with adverse psychological outcomes exist, such as “[p]ressure from others,”¹⁴⁴ “disparity in age between the mother and father,”¹⁴⁵ “a medical history that includes a pre-abortion mental health or psychiatric problem,”¹⁴⁶ and whether the woman is “twenty-two years old or younger.”¹⁴⁷ Thus, under the guise of determining coercion, the doctor is in fact asked to assess the pregnant woman’s ability to give consent. The informed consent evaluation by the provider

Circuit. See *Planned Parenthood Minn. v. Rounds*, 662 F.3d 1072, 1072–73 (8th Cir. 2011).

139. H.B. 1215, 2006 Leg. Assemb., 81st Sess. (S.D. 2006) (repealed by voter referendum Nov. 7, 2006). The Women’s Health and Human Life Protection Act banned abortion except to save the life of the pregnant woman. *Id.* The law provided that abortion “will terminate the life of a whole, separate, unique, living human being,” and that the mental and physical health risks of abortion include depression and suicide ideation. *Id.*; see also Siegel, *The New Politics*, *supra* note 11, at 992.

140. 432 U.S. 438, 449 (1977) (Brennan, J., dissenting) (quoting *Roe v. Norton*, 408 F. Supp. 660, 663 n.3 (D. Conn. 1975)).

141. H.B. 1254, 2012 Leg. Assemb., 87th Sess. (S.D. 2012).

142. *Id.* § 2(i).

143. *Id.* § 2.

144. *Id.* § 2(4)(b).

145. *Id.* § 2(1).

146. *Id.* § 2(4)(f).

147. *Id.* § 2(4)(g).

is not intended to inform the pregnant woman of the medical risks associated with the abortion procedure, but to ensure that the pregnant woman is *capable* of decisionmaking.¹⁴⁸ The requirement that the doctor assess a pregnant woman's ability to make the abortion decision in light of her "medical and personal circumstances"¹⁴⁹ is reminiscent of the early case law that deferred to doctors to determine if abortion was in a woman's best interest, "in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient."¹⁵⁰ Thus, not only is healthcare severed from the abortion right, the woman-protective legislation also seeks to vest doctors with the right to determine whether a woman is capable of making the abortion decision.

The recent South Dakota bill also requires a pregnant woman who seeks abortion to consult with a registered non-medical "pregnancy help center"¹⁵¹ whose mission is to counsel women against having an abortion.¹⁵² The result is that a woman seeking abortion must seek "counseling" that fundamentally questions her decisionmaking in the context of abortion. The judge who issued an injunction halting the bill concluded:

Forcing a woman to divulge to a stranger at a pregnancy help center the fact that she has chosen to undergo an abortion humiliates and degrades her as a human being. The woman will feel degraded by the compulsive nature of the Pregnancy Help Center Requirements, which suggest that she has made the "wrong" decision, has not really "thought" about her decision to undergo an abortion, or is "not intelligent enough" to make the decision with the advice of a physician.¹⁵³

The South Dakota statute focuses exclusively on abortion as a right of decisionmaking and employs doctors and pregnancy help centers to challenge women's ability to make the abortion decision themselves. Thus, narrowing abortion to the right of choice has the potential to erode the last vestige of the abortion right, the ability of women to make reproductive choices.

The *Gonzales* Court employed a woman-protective analysis to argue that the *decision to choose* abortion harmed women.¹⁵⁴ The Court

148. *Id.* § 2(6) ("[T]he physician . . . [must make] a reasonable determination that the pregnant woman understands the information imparted, all material information about the risk of adverse psychological outcomes known to be associated with [abortion] . . .").

149. *Id.* § 2.

150. *Doe v. Bolton*, 410 U.S. 179, 192 (1973); see Wood & Durham, *supra* note 49.

151. S.D. H.B. 1254 § 2(3)(a).

152. *Id.* § 7(1) ("The pregnancy help center shall be permitted to interview the pregnant mother to determine whether the pregnant mother has been subject to any coercion to have an abortion, . . . and shall be permitted to inform the pregnant mother . . . [of] assistance that is available to the pregnant mother to help her maintain her relationship with her unborn child . . .").

153. *Planned Parenthood Minn. v. Daugaard*, 799 F. Supp. 2d 1048, 1060 (D.S.D. 2011).

154. *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007). The woman-protective anti-abortion legislation is based upon the premise that abortion harms women. For example, the South Dakota legislature used this reasoning to pass legislation banning abortion. See H.B. 1215, 2006 Leg. Assemb., 81st Sess.

suggested that women were unable to make effective decisions in this context because abortion fundamentally harmed women by breaking the bond between mother and child:

Respect for human life finds an ultimate expression in the bond of love the mother has for her child. . . . 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.¹⁵⁵

Thus, the Court fundamentally questioned women's *ability* to make this decision. In so doing, the Court, in effect, eroded the foundation of the narrowly circumscribed right by questioning women's ability to make the abortion decision itself. The Court stated:

It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.¹⁵⁶

The Court further concluded that because women may not understand the full extent of their choice until later and would come to regret their decision, the answer was to ban the procedure outright rather than to require informed consent to the procedure.¹⁵⁷

C. ABORTION AND HEALTH INSURANCE FUNDING

Numerous state legislatures have recently passed laws prohibiting the use of health insurance funds, both public and private, for abortion. This legislative trend is premised upon isolating abortion from healthcare: By preventing healthcare funds to be used for abortion, these laws by their very terms identify abortion services as *separate from* healthcare. For example, the Patient Protection and Affordable Healthcare Act sets forth rules by which qualified health plans can be offered on State "exchanges"

(S.D. 2006) (repealed by voter referendum Nov. 7, 2006) ("[The Women's Health and Human Life Protection Act's purpose] is to fully protect the rights, interests, and health of the pregnant mother . . . and the mother's fundamental natural intrinsic right to a relationship with her child. . . ."); see also Siegel, *The New Politics*, *supra* note 11, at 992.

155. *Gonzales*, 550 U.S. at 159 (citation omitted). It is important to note that the Court's reliance on the psychological harm of abortion and regret arise not from intact D&E specifically, but from abortion itself and therefore has wider implications for extending beyond the intact D&E context to abortion more generally. Chris Guthrie, Carhart, *Constitutional Rights, and the Psychology of Regret*, 81 S. CAL. L. REV. 877, 879-80 (2008) (arguing that states will use the psychology of regret from the *Gonzales* decision to justify wide-ranging constraints on the abortion right generally); Robin Toner, *Abortion Foes See Validation for New Tactic*, N.Y. TIMES, May 22, 2007, at A1 (arguing that the Court's regret analysis will "galvaniz[e] anti-abortion forces" and intensify "battle over new abortion restrictions in the states").

156. *Gonzales*, 550 U.S. at 159-60.

157. *Id.* at 160.

and specifically provides that “a State may elect to prohibit abortion coverage in qualified health plans offered through an Exchange.”¹⁵⁸ Twenty states have opted to limit abortion coverage in plans that will be offered through the insurance exchanges.¹⁵⁹ However, eight states have gone even further and passed legislation that prohibits coverage of abortion in all *private* health insurance plans.¹⁶⁰ The laws specifically exclude abortion from comprehensive health insurance coverage for women who have paid for health insurance out of their own personal funds.¹⁶¹ Further, the House recently passed the “No Taxpayer Funding for Abortion Act” which would expand the Hyde Amendment restrictions on the use of federal funds for abortions by prohibiting even indirect funding streams that could potentially be used for abortion services.¹⁶² The Act would deny tax credits to companies that offer private health plans that cover abortion services, would prevent anyone covered under an insurance policy that covers abortion from receiving federal subsidies or medical cost tax deductions, even if the abortion were paid for separately with personal funds, and would end the availability of reimbursement for abortion costs from medical savings accounts.¹⁶³

These laws single out one type of healthcare—abortion—from comprehensive healthcare coverage, even for private individuals using their own funds for health insurance. By prohibiting funding from private health insurance plans as well as imposing tax penalties on women who use private funds from medical savings accounts for abortions, the law sets forth abortion as a procedure that is separate from women’s healthcare. Further, requiring women, even those with comprehensive private insurance, to pay out of pocket for abortions reinforces the perception that abortion is a “choice” rather than healthcare. By severing both private and state health insurance funds for abortion, these laws isolate abortion as fundamentally different in kind from healthcare and a luxury that must be paid for from private funds.

158. 42 U.S.C. § 18023(a)(1) (2006). The law was accompanied by an Executive Order which stated that the abortion coverage exemption is in compliance with the Hyde Amendment restrictions on the use of state funds for abortions because policies on the exchanges may be paid for in part by tax credits or governmental subsidies. Exec. Order No. 13,535, 75 Fed. Reg. 15,597 (Mar. 29, 2010).

159. GUTTMACHER INST., STATE POLICIES IN BRIEF: RESTRICTING INSURANCE COVERAGE OF ABORTION (Dec. 1, 2012).

160. *Id.* The states that restrict abortion coverage in all private insurance plans include Idaho, Kansas, Kentucky, Missouri, Nebraska, North Dakota, Oklahoma, and Utah. *Id.* See *ACLU of Kan. & W. Mo. v. Praeger*, which challenged a Kansas law that denied coverage for elective abortion in comprehensive health insurance policies offered by private health insurance companies. 815 F. Supp. 2d 1204, 1221 (D. Kan. 2011). The law provided that abortion coverage could be obtained through purchase of a separate optional rider. H.B. 2075, 2011 Sess., § 8(a) (Kan. 2011).

161. Kan. H.B. 2075 § 8(a).

162. No Taxpayer Funding for Abortion Act, H.R. 3, 112th Cong., at 2–8 (1st Sess. 2011).

163. *Id.*; see *New Attacks on Women’s Rights: The House Passes a Sweeping Bill to Deny Access to Abortion*, N.Y. TIMES, May 10, 2011, at A26.

Recently, the movement to isolate abortion from healthcare has gone even further to restrict state funding for *any* women's healthcare by organizations associated with performing abortions. For example, a recent Indiana law would prevent organizations such as Planned Parenthood from receiving state-allocated federal healthcare funding because they perform abortions at some of their clinics within the state.¹⁶⁴ The Indiana law prohibits state agencies from entering contracts with or making grants to "any entity that performs abortions or maintains or operates a facility where abortions are performed."¹⁶⁵ The effect of the law is to ban the use of Medicaid funds at Planned Parenthood clinics for any women's healthcare it provides, including breast cancer screenings, birth control, and routine gynecological exams.¹⁶⁶ The Obama administration blocked enforcement of the law, concluding that a state could not exclude doctors, providers, or clinics from Medicaid simply because they separately provide abortion services.¹⁶⁷ In addition, Kansas has enacted provisions to block Planned Parenthood from receiving any money under the Title X federal family planning program.¹⁶⁸ These funding controversies take the debate of abortion as healthcare or choice even further. Not only do they sever abortion from healthcare, but they also set forth abortion as threatening an organization's ability to deliver other types of healthcare to its low-income clients. This type of legislation goes beyond isolating abortion from healthcare, recasting abortion as antithetical to women's healthcare in general.

III. TOWARD A RESTORED RIGHT OF ABORTION

The foregoing discussion has drawn attention to the shift in the Court's analysis from recognizing abortion as an aspect of women's healthcare to exclusively identifying abortion as a right of choice. In this Part, I call for reintegrating healthcare as an integral aspect of the abortion right. My argument is not that abortion be re-categorized exclusively as a right of healthcare.¹⁶⁹ Rather, I argue that the prevailing characterization of abortion must be reformulated to recognize that the abortion right is a

164. H.B. 1210, 117th Gen. Assemb. (Ind. 2011).

165. *Id.* § 5.5(b)(2).

166. *Id.*; Robert Pear, *U.S. Says New Indiana Law Improperly Limits Medicaid*, N.Y. TIMES, June 2, 2011, at A15. The law cuts off \$3 million in public funds used to pay for women's health services like cancer screenings, sexually transmitted disease testing, and contraceptives. *Indiana: Planned Parenthood Funds Are Cut*, N.Y. TIMES, May 11, 2011, at A16.

167. Pear, *supra* note 166 (statement of Cindy Mann, a federal official who supervises Medicaid funding).

168. H.B. 2014, 84th Leg., Reg. Sess., § 107(1) (Kan. 2011); see *Planned Parenthood of Kan. & Mid-Mo. v. Brownback*, 799 F. Supp. 2d 1218, 1235 (D. Kan. 2011) (challenging the validity of the Kansas legislation).

169. B. Jessie Hill has argued for protection of reproductive rights as a right of healthcare under the U.S. Constitution similar to rights of healthcare identified in recent decisions by the Canadian Supreme Court and the Constitutional Court of South Africa. Hill, *supra* note 10, at 517-19.

composite of two equally important components: healthcare and decisional autonomy.

There are several reasons that it is necessary to balance autonomy and healthcare rather than to exclusively identify abortion as a right of healthcare. First, while international human rights frameworks and numerous national constitutions recognize healthcare as a human right to which individuals are entitled, the United States does not recognize a constitutional right of healthcare.¹⁷⁰ Thus, any recognition of abortion as an aspect of healthcare necessarily requires that such a right be expressed as a negative right that protects individuals against government interference with medical treatment decisions and the doctor-patient relationship.¹⁷¹ B. Jessie Hill has persuasively argued that identifying a negative right of healthcare would go a long way toward protecting reproductive rights by protecting women's decisionmaking and the privacy of the consumer-provider relationship.¹⁷²

Reorienting abortion exclusively within a healthcare framework, however, also carries the negative potential for returning to the early analysis that nominally recognized abortion as an aspect of women's health while actually placing the focus on the rights of doctors. Further, there is a danger in identifying abortion exclusively as a right of healthcare because opponents of abortion have used a healthcare rationale to pass regulations restricting abortion providers. For example, Targeted Regulation of Abortion Providers laws—also known as “TRAP” laws—have been used to single out the medical practices of clinics and doctors who provide abortions and have imposed requirements that are more restrictive and burdensome than those imposed on other medical providers.¹⁷³ Thus, the

170. See International Covenant on Economic, Social & Cultural Rights, art. 12, G.A. Res. 2200 (XXI) A, U.N. Doc. A/RES/2200 (III) (Dec. 16, 1966); Universal Declaration of Human Rights, art. 25, G.A. Res. 217 (III) A, U.N. Doc. A/RES/217(III) (Dec. 10, 1948); Rhonda Copeland & Sylvia Law, *Nearly Allied to Her Right “to Be”—Medicaid Funding for Abortion: The Story of Harris v. McRae*, in *WOMEN AND THE LAW STORIES*, *supra* note 22, at 207, 208–51 (describing the tension between state funding for abortion and positive rights of healthcare); Hill, *Reproductive Rights*, *supra* note 10 (arguing for recognition of reproductive rights as a negative right of health similar to in Canada and South Africa). See generally Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285 (2004); Serra Sippel, *Achieving Global Sexual and Reproductive Health and Rights*, 35 HUM. RTS. Q. 13 (2008); Cynthia Soohoo & Suzanne Stolz, *Bringing Theories of Human Rights Change Home*, 77 FORDHAM L. REV. 459 (2008). Further, the Center for Reproductive Rights has drawn an explicit connection between reproductive rights and human rights of health. CENTER FOR REPRODUCTIVE RIGHTS, <http://reproductiverights.org> (last visited Dec. 7, 2012).

171. See Hill, *Reproductive Rights*, *supra* note 10, at 502–03.

172. See *id.* Hill examines recent cases in Canada and South Africa in which the courts identified negative rights of healthcare as protecting a patient's right of decisionmaking and the privacy of the doctor-patient relationship. *Id.* at 517–19. Conducting a comparative analysis with U.S. constitutional law, Hill suggests that such a negative right of healthcare could effectively protect access to reproductive healthcare. *Id.* at 502–03.

173. See *Targeted Regulation of Abortion Providers*, CENTER FOR REPRODUCTIVE RIGHTS (Mar. 5, 2009), <http://reproductiverights.org/en/project/targeted-regulation-of-abortion-providers-trap>. A recent

healthcare rationale has the potential to be used by opponents of abortion to increase the cost and decrease the availability of abortion services by imposing unnecessary and excessive regulations on abortion providers.

In addition, identifying abortion exclusively as a right of healthcare could potentially single out therapeutic abortions for protection and erode support for elective abortions. This analysis would once again require women seeking abortion to find cooperative doctors and could shift women's decisionmaking to providers, who would be required to confirm medical necessity before an abortion could be performed. Scholarship has suggested that doctors currently exercise excessive decisionmaking in the context of women's reproductive healthcare, and framing abortion as healthcare has the potential to exacerbate this trend.¹⁷⁴ Finally, there is greater potential for poor women to experience a disproportionate burden of coercive state control of their reproductive healthcare if the right of abortion is recast exclusively as a healthcare right.¹⁷⁵

A reclaimed right of abortion would recognize pregnant women as healthcare consumers who, in accessing abortion healthcare services, are exercising constitutional rights. There have been gestures toward such an interpretation in two concurring opinions. For example, in his concurring opinion in *Doe v. Bolton*, Justice Douglas argued that abortion was a right of health that was related to privacy, describing the medical privacy right as "the right to care for one's health and person and to seek out a physician of one's own choice."¹⁷⁶ His concurrence identified abortion specifically as a right of privacy related to healthcare, rather than as a right of privacy related to procreation, marriage and childrearing.¹⁷⁷ He described this right of healthcare by stating: "The right to seek advice on one's health and the right to place reliance on the physician of one's choice are basic to Fourteenth Amendment values."¹⁷⁸ He also argued that the term "liberty" in the Fourteenth Amendment included, "the

TRAP law passed in Mississippi, for example, would require doctors who perform abortions to be obstetrician-gynecologists with admitting privileges at local hospitals. Robbie Brown, *Mississippi's Lone Abortion Clinic, Given Temporary Reprieve, Fields Rush of Calls*, N.Y. TIMES, July 3, 2012, at A13. Enforcement of the law, which would have closed Mississippi's only abortion clinic, was temporarily blocked by a federal district court because evidence strongly suggested that the purpose of the law was to stop abortions rather than protect women's health. *See id.*

174. *See, e.g.*, Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 565 (1993); Hill, *Reproductive Rights*, *supra* note 10, at 512–14; Michelle Oberman, *Mothers and Doctors' Orders: Unmasking the Doctor's Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U. L. REV. 451, 454–55, 471–78 (2000); Siegel, *Reasoning from the Body*, *supra* note 7, at 330 n.285.

175. *See* Ehrenreich, *supra* note 174; Hill, *Reproductive Rights*, *supra* note 10, at 513; Oberman, *supra* note 174.

176. 410 U.S. 179, 219 (1973) (Douglas, J., concurring).

177. *Id.*

178. *Id.* at 219–20.

freedom to care for one's health and person, freedom from bodily restraint or compulsion, freedom to walk, stroll, or loaf."¹⁷⁹ This characterization intertwined privacy with healthcare and protected women as rights holders exercising a choice to access this healthcare. Further, by identifying abortion as related to a right of healthcare, as opposed to the majority's opinion that described it as a right of privacy related to procreation, Justice Douglas cast the right in a gender-neutral context. Not only has abortion been increasingly isolated as a decisional right, but opponents of abortion have also cast the right as part of a feminist agenda, thereby challenging its legitimacy by framing it as a *political*, as opposed to constitutional, right. Reasserting abortion as a right related to healthcare places the right in a gender-neutral, constitutional context and has the potential for generating greater support for the right to abortion within the population at large.¹⁸⁰

Further, Justice Blackmun's concurring opinion in *Casey* also identified abortion as a right of choice that is related to healthcare:

[T]his Court has recognized the vital liberty interest of persons in refusing unwanted medical treatment. Just as the Due Process Clause protects the deeply personal decision of the individual to *refuse* medical treatment, it also must protect the deeply personal decision to *obtain* medical treatment, including a woman's decision to terminate a pregnancy.¹⁸¹

Justice Blackmun's statement included both critical elements: He presented abortion as a decisional right and as a right to *obtain medical treatment*. Justice Blackmun's description also suggested that a woman's decision to obtain abortion-related healthcare was an exercise of her vital constitutional rights.

A restored right of abortion that recognizes healthcare as integral to these rights would reclaim the importance of the consumer-provider relationship but would reject the Court's early analysis that deferred women's right of choice to the judgment of their providers. Rather, the decisional right requires that women have access to unbiased healthcare advice from their abortion provider, free of state interference and political manipulation. Decisional autonomy is thereby dependent on a relationship between a pregnant woman and her provider.¹⁸² Doctors must give neutral medical advice free of values as to the outcome of the woman's

179. *Id.* at 213 (emphasis omitted).

180. See Hill, *Reproductive Rights*, *supra* note 10, at 504 (arguing that identifying abortion as a healthcare right within the human rights framework will produce this benefit).

181. 505 U.S. 833, 927 n.3 (Blackmun, J., concurring) (citations omitted).

182. Wood & Durham, *supra* note 49, at 789–91. The reformulated approach, which characterizes pregnant women seeking abortion as empowered healthcare consumers who, in accessing abortion services, are in fact exercising their constitutional rights, better reflects the current realities of women's experience of accessing healthcare. The Court's analysis should reflect these new realities: The role of the provider must be to offer objective counseling and then to implement whatever course the woman decides with respect to terminating her pregnancy.

deliberation; the abortion choice must be recognized as exclusively the woman's.¹⁸³ Medical advice is an integral aspect of a pregnant woman's exercise of decisional autonomy in the abortion decision. As a result, in order to protect the autonomy of women to make healthcare decisions, the Court must also protect the confidentiality of the consumer-provider relationship.¹⁸⁴

The effort to re-characterize abortion within the context of women's healthcare is taking hold in the medical community. Pro-choice physicians have come to recognize that courts and legislatures have so successfully isolated abortion from healthcare due in part to the fact that in the years since *Roe*, the medical community has marginalized abortion-related medical practice and has isolated providers in stand-alone clinics.¹⁸⁵ After 1973, the medical profession failed to make a concerted effort to train doctors to do abortions and encourage doctors to integrate abortion into ordinary practice.¹⁸⁶ Consequently, over the last thirty years abortion training has been steadily disappearing from residency programs that produce new doctors. In 1995, only 12% of OB-GYN residencies offered abortion training.¹⁸⁷ Further, medical schools have marginalized abortion-related medical practice by failing to train doctors to integrate abortion-related healthcare into their regular practice.¹⁸⁸ In 1973, hospitals made up 80% of the United States' abortion facilities, but by 1996, clinics performed 90% of abortions in the country.¹⁸⁹ As a result, the majority of abortions are performed in stand-alone clinics such as Planned Parenthood rather than by a woman's regular physician as an integrated part of her healthcare.¹⁹⁰

This trend is changing with a new push by pro-choice physicians to open residency and fellowship programs in contraception and abortion practice in medical schools across the country.¹⁹¹ This movement to reverse a thirty-year history that marginalized abortion-related healthcare and isolated providers of abortion represents an effort to integrate abortion as a seamless part of healthcare for women.¹⁹² It also helps protect doctors from being targets of anti-abortion protesters by replacing the model of stand-alone clinics with abortion practice spread

183. *Id.*

184. Nan Hunter has observed that once the conservative Court realized that doctors could not be trusted to impose traditional mores and that privacy of the doctor-patient relationship was a space in which women and doctors could make decisions that resisted traditional norms, the Court sought to reinstate the state into the doctor-patient relationship. Hunter, *supra* note 47, at 196.

185. Bazelon, *The New Abortion Providers*, *supra* note 83, at 32.

186. *Id.*

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.*

across a wide range of medical providers in hospitals and private practice.¹⁹³ This trend in the medical community should be mirrored by a similar shift in the legal analysis of abortion such that abortion is seen as both a right and, at the same time, an integrated part of women's healthcare.

The abortion right has been viewed as a right to choose to terminate a pregnancy and, alternatively, as the right of doctors to practice medicine according to their best judgment. Abortion must be reconstituted as a right that includes both the choice of the pregnant woman and healthcare. The challenge is to bring together these two strands, healthcare and decisional autonomy, in a way that keeps women as medical consumers central to the court's analysis. This analysis must recognize that, when pregnant women access abortion-related medical care, they are in fact exercising their constitutional rights.

CONCLUSION

Early dissenting opinions in the abortion cases argued that *Roe v. Wade* lacked constitutional foundation.¹⁹⁴ The current challenge to abortion rights, however, lies not in arguments over the existence of the right, but in the nature of the right itself. The vaunted characterization of pregnant women who seek abortion as rights holders, as expressed in *Casey*, is a tempting lure. However, this stripped-down version of the abortion right characterizes women who seek abortions as isolated rights holders, exercising constitutional (and perhaps political) rights of choice rather than as healthcare consumers whose constitutional right includes the right to obtain abortion-related healthcare. As seen in *Casey*, even when the majority acknowledges the "essential holding of *Roe*,"¹⁹⁵ the right to abortion is still vulnerable to significant erosion because the Court has narrowly defined the right as a decisional right of autonomy, disconnected from healthcare or healthcare services. This slender foothold of a right is particularly vulnerable to the woman-protective anti-abortion analysis, which fundamentally questions women's ability to make the abortion decision based on their nature as potential mothers.¹⁹⁶

193. *Id.* In a recent op-ed piece, two Harvard Medical School professors called on doctors to engage in civil disobedience to disobey laws such as those requiring them to perform state-mandated ultrasounds and read scripts to patients seeking abortion, unless such procedures are medically indicated. Angell & Greene, *supra* note 83; Carmon, *supra* note 83.

194. *See, e.g.*, Thornburgh v. Am. Coll. of Obstetricians & Gynecologists, 476 U.S. 747, 788 (1986) (White, J., dissenting) ("In my view, the time has come to recognize that *Roe v. Wade* . . . 'departs from a proper understanding' of the Constitution and to overrule it." (citations omitted)); Doe v. Bolton, 410 U.S. 179, 221-22 (1973) (Rehnquist, J., dissenting); *Roe v. Wade*, 410 U.S. 113, 172 (1973) (Rehnquist, J., dissenting) ("I have difficulty in concluding, as the Court does, that the right of 'privacy' is involved in this case.").

195. Planned Parenthood of S.E. Pa. v. Casey, 505 U.S. 844, 846 (1992).

196. In her dissent, Justice Ginsburg points out that this way of thinking about women reflects ancient and long-discredited views of women based on overbroad generalizations of women's

It is a critical time to reshape the legal, political, and cultural dialogue and reassert abortion as an expansive right that is inherently and inextricably related to women's health. Reclaiming the right as healthcare and not simply as "choice" has the potential to offer greater protection for access to abortion-related healthcare and casts the right in a gender-neutral context, thereby potentially increasing popular support for the right. Finally, resituating abortion within the context of healthcare recognizes the reality of women's reproductive lives that "choice" requires options and therefore must be anchored to meaningful access to affordable healthcare for birth control, childbirth, and abortion services.
