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DISCERNING THE MEANING OF *GONZALES V. CARHART*: THE END OF THE PHYSICIAN VETO AND THE RESULTING CHANGE IN ABORTION JURISPRUDENCE.

*Peter M. Ladwein**

INTRODUCTION

Gonzales v. Carhart[1] represents a seismic shift in our nation's abortion jurisprudence. Upholding the Partial-Birth Abortion Ban Act of 2003,[2] despite the lack of a health exception, it signals the end of what can be termed the "physician veto." This veto can be globally defined as the placing of dispositive weight in our nation's abortion jurisprudence on the autonomy and judgment of physicians who favor abortion rights, at the expense of undergoing the more difficult and deeper process of engaging issues of women's liberty and equality vis-à-vis the nature of the unborn fetus and of abortion itself. While physician autonomy and judgment are deeply intertwined concepts, the emphasis has shifted over the years from physician autonomy in *Roe v. Wade*[3] to physician judgment in *Stenberg v. Carhart*.[4] From *Roe* until the more recent *Carhart* decision, this dispositive weight—the veto—has shielded the right to abortion in a manner that approaches the absolute through the erection of an impenetrable wall of deference to physician autonomy and judgment in this area of their practice.[5]

* Candidate for Juris Doctor, Notre Dame Law School, 2009; B.A., Economics, Northwestern University, 2004. Many thanks to Professor O. Carter Snead for his insight and wisdom as this Note was prepared; to my family, to whom I owe everything; and to the Note Editors of the *Notre Dame Law Review* for the many hours they spent in helping to make this Note a reality.

1 127 S. Ct. 1610 (2007). I shall refer to *Gonzales v. Carhart* as "*Carhart*" throughout this Note; I shall refer to *Stenberg v. Carhart*, 530 U.S. 914 (2000), as "*Stenberg*" throughout.

2 18 U.S.C. § 1531 (Supp. V 2005).

3 410 U.S. 113 (1973).

4 530 U.S. 914.

5 More than a few have taken this autonomy for granted in defending it. *See, e.g.*, Michael Brophy, *Partial Birth Abortion: The Supreme Court's Ruling in* Gonzales v.

In 1973, Professor Laurence Tribe, writing about the just-decided *Roe v. Wade*, characterized *Roe* as a case about role allocation. He argued that, "when one sets aside the misleading language of *Roe* and focuses instead on the substance of *Roe's* holding," one sees that the *Roe* Court was "choosing among alternative allocations of decision making authority" between women and the government, deciding in favor of women's autonomy.[6] As a matter of role allocation, only after *Carhart* has Professor Tribe been proven to be correct: the abortion debate is now one whose terms are *solely* the scope of a woman's interests versus the scope of society's (a society that includes women opposed to abortion) interests in the life of the fetus. No longer may

Carhart, MED. MALPRACTICE L. & STRATEGY (Phila., Pa.), June 2007, at 1, 10 (noting post-*Carhart* concerns about the increasing degree of intrusion by government into the practice of medicine); Lawrence O. Gostin, *Abortion Politics: Clinical Freedom, Trust in the Judiciary, and the Autonomy of Women*, 298 JAMA 1562, 1563 (2007) (noting disapprovingly that "[b]ecause the Partial-Birth Abortion Ban Act criminalizes a medical procedure recognized by the profession, it creates a chilling effect on the freedom to practice in accordance with the exercise of clinical judgment"); Tom C.W. Lin, *Treating an Unhealthy Conscience: A Prescription for Medical Conscience Clauses*, 31 VT. L. REV. 105, 121 (2006) ("By protecting the autonomy of physicians, conscience clauses safeguard the freedom of choice for all citizens in a democratic society. . . . This autonomy applies to all physicians; no special exception should be made for those in the area of female reproductive care."). Others frame the physician autonomy issue as more closely linked to patient autonomy: impinging on physician autonomy should be read as unconstitutionally impinging on patient autonomy. *See, e.g.*, B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277, 329–32 (2007) (discussing individuals' "constitutional right to protect their health by making autonomous medical treatment decisions"); Robin Toner, *Democrats Attack Bush on Women's Health Issues*, N.Y. TIMES, July 18, 2007, at A13 ("'We know that five men don't know better than women and their doctors what's best for women's health,' Mr. Obama said, alluding to . . . Gonzales v. Carhart."). The specific sense of autonomy for physicians to perform abortions finds its roots in *Roe*. *See* Brophy, *supra*, at 1–2 ("Under the right of privacy, physicians were granted in *Roe v. Wade* the freedom to use their 'medical judgment for the preservation of the life or health of the mother.'" (quoting *Roe*, 410 U.S. at 165)); *infra* Part I. Assertions of physician autonomy by doctors refusing to perform abortions demonstrate that the "physician autonomy as protective of patient constitutional rights" argument is not as neat as it would seem. *See* Courtney Miller, Note, *Reflections on Protecting Conscience for Health Care Providers: A Call for More Inclusive Statutory Protection in Light of Constitutional Considerations*, 15 S. CAL. REV. L. & SOC. JUST. 327, 340 (2006) ("Behind the [affirmative] access [to abortion] issue lies a 'clash of autonomies:' patient autonomy versus physician moral autonomy. The abortion choice, the legal right which is rooted in an autonomy right, has provoked a call for a legal right to choose *not* to participate in abortion . . . .").

6 Laurence H. Tribe, *Foreword: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 10–11 (1973) (emphasis omitted).

unqualified deference to physicians be used to shield this core debate from flowering in our jurisprudence.[7]

Of course, in the "partial-birth abortion"[8] ("intact D & E") context, this core debate may turn out to be quite ugly. To say that judicial decisionmaking about this method of abortion has tested the strength of the Justices' professional and personal relationships with each other seems to be a serious understatement. In *Stenberg*, Justice Thomas described the arguments of Justices Stevens and Ginsburg as simply "too offensive[] to merit further discussion."[9] Justice Ginsburg, taking the unusual step of reading her dissent in *Carhart* from

7 Certainly, the degree to which *Carhart* eliminates the "physician veto" will depend on how much precedential weight is given to *Carhart* in the future. If *Carhart*'s precedential value is limited in the future to its specific facts, then this removal of the "physician veto" will only apply to the Court's intact D & E jurisprudence. However, if *Carhart* is read in light of *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992), and its precedential value is understood as building on *Casey*, then the Court will no longer be inclined to unquestioningly defer to physician judgment in the future the way it did in *Roe* and *Stenberg*. To understand the marked difference between *Stenberg* and *Carhart* in their approach to physician judgment, see *infra* Parts III–IV.

8 Intact D & E (Dilation & Extraction) is distinct from nonintact D & E in that nonintact D & E is a much more common procedure involving dismemberment of a fetus older than thirteen weeks as it is pulled out of the womb. *See* Gonzales v. Carhart, 127 S. Ct. 1610, 1620–21 (2007); *Stenberg*, 530 U.S. at 924–26. Intact D & E has been used far less, usually after the fetus has reached sixteen weeks of age, and involves delivering the fetus feet first up to the point where the skull can be collapsed by opening it with scissors and vacuuming out its contents before delivering the rest of the otherwise intact, but dead, fetus. *See Carhart*, 127 S. Ct. at 1621–22; *Stenberg*, 530 U.S. at 927–28. Exhaustive descriptions of the intact D & E and nonintact D & E procedures and their history are available elsewhere. *See, e.g.*, Barbara Jean Bailey, Commentary, *Congress Ignores the Parameters of the Health Exception*, 27 J. LEGAL MED. 71, 75–76 (2006); Gail Glidewell, Note, *"Partial Birth" Abortion and the Health Exception: Protecting Maternal Health or Risking Abortion on Demand?*, 28 FORDHAM URB. L.J. 1089, 1095–99 (2001) (discussing, in addition, lower courts' treatment of bans on intact D & E prior to the *Stenberg* decision); Scott A. Hodges, Comment, *Constitutional Law: Beyond the Bounds of* Roe: *Does* Stenberg v. Carhart *Invalidate the Partial-Birth Abortion Ban Act of 2003?*, 57 OKLA. L. REV. 601, 603–05 (2004).

9 *Stenberg*, 530 U.S. at 1008 (Thomas, J., dissenting). Justices Stevens and Ginsburg, each in separate concurrences, noted that the nonintact D & E procedure, involving piece-by-piece fetal dismemberment as it is pulled through the woman's cervix, was equally as gruesome as the intact D & E procedure in question, resulting in there being no ethically principled way to ban one procedure but not the other. *See id.* at 946–47 (Stevens, J., concurring); *id.* at 951–52 (Ginsburg, J., concurring). Citing these "equally gruesome" statements, Justice Thomas responded: "The question whether States have a legitimate interest in banning the procedure does not require additional authority. In a civilized society, the answer is too obvious, and the contrary arguments too offensive, to merit further discussion." *Id.* at 1007–08 (Thomas, J., dissenting) (citations omitted).

the bench,[10] called the *Carhart* decision "alarming" for "refus[ing] to take *Casey* and *Stenberg* seriously"[11] and took the Court to task for invoking an "antiabortion shibboleth."[12] Besides these examples of loose name-calling, the members of the Court used polar opposite, and perhaps ideologically-driven, language to describe the particular procedure in question.[13]

This Note chronicles the life and death of the "physician veto" as it has been used to shield the right to abortion ever since *Roe*.[14] Part I describes the two types of "physician veto" that *Roe* instituted: (1) the predication of the right to abortion on the physician's *autonomy* and right to privacy in her practice, and (2) the protection of the right to abortion, behind physician *judgment*, all the way up to live birth with the requirement of a health exception. Part II describes how *Planned Parenthood of Southeastern Pennsylvania v. Casey*[15] (1) attempted to remove *Roe*'s physician autonomy veto, and (2) maintained the health exception as a sufficient veto to shield the abortion right behind physician judgment. Part III describes the Court's effort in *Stenberg* to revive the predication of the abortion right on physician's rights[16] (namely, deference to physician judgment) and explains how it

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10 *See* Kenneth L. Karst, *The Liberties of Equal Citizens: Groups and the Due Process Clause*, 55 UCLA L. REV. 99, 130 n.176 (2007).

11 *Carhart*, 127 S. Ct. at 1640 (Ginsburg, J., dissenting).

12 *Id.* at 1648 (Ginsburg, J., dissenting).

13 One can fully appreciate this marked difference in language among the members of the Court only by reading the majority opinions and dissents in *Carhart* and *Stenberg*. An illustrative example of the difference in language is that the wing of the Court that would have struck down the Federal Partial-Birth Abortion Ban Act as unconstitutional described the intact D & E procedure in purely medical terms as a "breech extraction of the body" and "partial evacuation of the intracranial contents" of the fetus. *Stenberg*, 530 U.S. at 928. The wing of the Court that did uphold the federal ban cited testimony from witnesses to the intact D & E procedure that the partially delivered fetus' fingers were "'clasping and unclasping'" and the "'little feet were kicking,'" but when the physician opened the head with scissors the "'baby's arms jerked out . . . like a flinch'" and as the contents of the baby's head were vacuumed out "'the baby went completely limp.'" *Carhart*, 127 S. Ct. at 1622 (quoting H.R. REP. No. 108-58, at 3 (2003)); *see also Stenberg*, 530 U.S. at 963 (Scalia, J., dissenting) (describing same); *id.* at 984–88, 1007 (Thomas, J., dissenting) (describing late term abortions in graphic, lay terms).

14 The way *Carhart* laid to rest the "physician veto" can only be understood in the context of the climactic battle within the Court over the last eight years over the intact D & E question; hence the citation of the evocative language *supra* notes 5–13. Appreciating that context will enrich the future debate over abortion, the modified nature of which this Note seeks to expose.

15 505 U.S. 833 (1992).

16 Of course, this revival was not meant to displace the primacy of a woman's liberty set out in *Casey*. *See infra* Part II. Rather, it seems meant to move back toward

thereby created the means for the present Court to eliminate the "physician veto." Part IV analyzes the *Carhart* decision in light of all the preceding discussion, describing the removal of the physician veto that *Casey* had maintained in the health exception requirement.

It must be recognized that this Note is not meant to be a critique or support of *Carhart* in terms of the substantive abortion issue at question. Neither is it intended to be an in-depth analysis of the intricacies of the Court's holdings in its abortion cases, as this has been exhaustively achieved elsewhere in the sources cited throughout this Note.[17] Rather, it is an attempt to understand the precedential value of how *Carhart* will affect future abortion jurisprudence. In doing so, it exposes for future academic and legal discussion the plain fact that *Carhart* invites society to engage the abortion debate in a new way. Our jurisprudence is now invited to consider the abortion right—with its attendant philosophical and medical questions concerning women's liberty, equality, and health, and the fetus' life and nature—without abbreviating the discussion through unqualified deference to the judgment of a physician who supports abortion rights.

I. *Roe*'s Strict Scrutiny Solicitude for Doctors: The Birth of the "Physician Veto"

Roe considered abortion to be a "fundamental" right, and thus held that any laws burdening abortion rights would have to withstand strict scrutiny.[18] In its application of the strict scrutiny test, the *Roe* Court relied heavily on two "physician vetoes" to shield this newly found fundamental right from regulation based on the states' interests in the life of the fetus. First, and most important at the time, was the Court's predication of the right to abortion on the physician's

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an absolute right to abortion, which *Casey* had called into question with its concern for society's interest in the life of the unborn. *See infra* Part III.

17 For examples of such useful sources, see generally 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 (1985); Tribe, *supra* note 6; Bailey, *supra* note 8; Glidewell, *supra* note 8; Hodges, *supra* note 8.

18 "Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest,' and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake." Roe v. Wade, 410 U.S. 113, 155–56 (1973) (citations omitted). Only at the end of the first trimester was the state's interest in the health of the mother "compelling." *See id.* at 163; *infra* note 26. Only at the point of viability would there be a compelling state interest to proscribe abortion, and such proscriptions would be valid only with exceptions for the life or health of the mother. *See Roe*, 410 U.S. at 163–64; *infra* notes 22, 65 and accompanying text.

autonomy, protected by the constitutional right to privacy.[19] The *Roe* Court expressed nearly unqualified solicitude for the physician's autonomy in her abortion practice. *Roe*'s progeny established the constitutional permissibility of state regulations and policies that might chill a *woman's* access to abortion,[20] but it remained impermissible to chill the physician's autonomy in deciding whether and when to perform an abortion. Second, *Roe* required that if a state restricts or prohibits postviability abortions, the law must contain an exception for the health of the mother, defined broadly as including "all factors . . . relevant to the well-being of the patient."[21] Whether an abortion was medically necessary in this sense was to be determined solely by the woman's doctor.[22]

Part II shows how *Casey* replaced the first physician veto—predication of the abortion right on unqualified physician autonomy—with the shield of a woman's liberty, but kept the second veto—physician judgment exercised in the health exception. It is first necessary, however, to recall the history and nature of the physician-autonomy veto. This is because although *Casey* eliminated it as an express shield, *Stenberg* backtracked to *Roe*'s physician-predication model by predicating the right to a popularly disfavored method of late-term abortion on deference, in the face of contested physician judgment, to physicians who favor intact D & E abortion. As this Note is principally concerned with the backfiring of this effort in *Carhart*, it is worth going back to *Roe* to examine the origins of the physician veto.

A. Roe's *Central Effect: Shielding the Abortion Right by Predicating It on a Physician's Autonomy*

By its language, the privacy interest *Roe* invoked was not intrinsically devoted—surprisingly—to protecting the privacy of a woman's

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19 *See infra* Part I.A.

20 *See infra* note 45 (discussing abortion funding cases in which the government policy of not funding abortions results in indigent women not being able to obtain free abortions, but also in which physician autonomy was not burdened by the same policies, allowing them to be constitutional).

21 Doe v. Bolton, 410 U.S. 179, 192 (1973).

22 *See Roe*, 410 U.S. at 164–65 ("For the stage subsequent to viability, the State in promoting its interest in the potentiality of human life may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, *in appropriate medical judgment*, for the preservation of the life or health of the mother." (emphasis added)); *see also Doe*, 410 U.S. at 192 ("[*M*]*edical judgment* may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health." (emphasis added)).

decision to abort her pregnancy.[23] Rather, it was devoted to "vindicat[ing] the right of the physician to administer medical treatment according to his professional judgment," for "the abortion decision *in all its aspects is inherently, and primarily, a medical decision, and basic responsibility for it must rest with the physician*."[24] The Court deemed that the Constitution protected the physician's decision, but not necessarily the woman's. The physician's decision was to be completely unfettered, aside from the usual malpractice remedies,[25] in the first trimester, and relatively unfettered in the second trimester.[26] This trimester framework, protective of physician autonomy, "ensured that

23 *See Roe*, 410 U.S. at 152–53. Some commentators who believe that unrestricted abortion is a prerequisite to gender equality have highlighted this facet of *Roe* quite forcefully. While *Roe* made abortion legal and relatively available, these commentators were disturbed that the right to abortion, conferred by *Roe*, was not based singularly on their status as women, but rather was based on their status as patients. *See, e.g.*, Appleton, *supra* note 17, at 192–200 ("Under the Court's approach, which encourages states to advance medical reasons for their antiabortion laws, a woman's constitutional right of reproductive control owes its scope, if not its very existence, to the state of the art of contemporary medicine and the safety of its procedures."); Andrea Asaro, *The Judicial Portrayal of the Physician in Abortion and Sterilization Decisions: The Use and Abuse of Medical Discretion*, 6 HARV. WOMEN'S L.J. 51, 52–61 (1983) ("Blackmun subsumed the woman's right to privacy within the ambit of the doctor-patient relationship, and ultimately subordinated her interest to the physician's."); Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. REV. 375, 382 (1984) ("Academic criticism of *Roe* . . . might have been less pointed had the Court placed the woman alone, rather than the woman tied to her physician, at the center of its attention."); *see also infra* notes 33–43 and accompanying text (comparing arguments of these commentators that rooting the abortion right in physician autonomy stunted gender equality efforts with that of Professor Tribe, who argued that the physician autonomy root of *Roe* did not alter the fundamental substantive outcome of protection for the abortion right).

24 *Roe*, 410 U.S. at 165–66 (emphasis added).

25 *See id.* at 166 ("If an individual practitioner abuses the privilege of exercising proper medical judgment, the usual remedies, judicial and intra-professional, are available.").

26 Because the *Roe* Court found that "[m]ortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low as or lower than the rates for normal childbirth," *id.* at 149, *Roe* decided that "[f]or the stage prior to approximately the end of the first trimester, the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician" free of *any* state regulations, *id.* at 164. Under *Roe*, it was not until the second trimester that the state could interfere with the physician's conduct in order to safeguard the health of the abortion-seeking woman, but these interferences in the name of maternal health were expressly intended to *not* be undue interferences with physician autonomy in providing abortions. *See id.* at 163 ("Examples of permissible state regulation in this area are requirements as to the qualifications of the person who is to perform the abortion; as to [her] licensure . . . ; as to the facility . . . ; and the like. . . . [P]rior to this 'compelling' point [of viability in the third trimester] . . . the judgment

the woman's liberty interest would face off against the state's fetal interest only with respect to exceedingly rare, post-viability abortions"[27] and thus shielded the abortion right from regulation based on a state's concern for the life of the fetus.

Certainly, the Court expressed solicitude for the liberty of the woman to choose to terminate her pregnancy. However, it only did so in a derivative way by characterizing the woman's choice as joint with and dependent upon her physician's choice.[28] The Court did state that "[t]his right of privacy . . . is broad enough to encompass a woman's decision whether or not to terminate her pregnancy,"[29] but as Professor Tribe pointed out many years ago, the Court made this assertion "without once explaining what it means by 'privacy.'"[30] The implicit explanation can be found in the Court's language focusing on the privacy of the physician-patient relationship and the *physician's* autonomy. It was the *physician* who was to exercise completely unfettered choice in the first trimester of pregnancy, for it was the *physician* who, during the first trimester, "in consultation with his patient, [was] free to determine, without regulation by the State, that, in his medical judgment, the patient's pregnancy should be terminated."[31]

The right to privacy in *Roe* was thus more a right for physicians to perform abortions than for women to obtain them.[32] Derivatively, the

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[of the physician to perform the abortion] may be effectuated by an abortion free of interference by the State.").

27 Caitlin E. Borgmann, *Winter Count: Taking Stock of Abortion Rights After* Casey *and* Carhart, 31 FORDHAM URB. L.J. 675, 690 (2004). Of course, this reads into Professor Borgmann's argument about the trimester framework as protective of abortion rights an understanding of the primary work that physician autonomy is doing at the foundation of this protection. Professor Borgmann continued, "The strength of the state's interest in fetal welfare is inversely proportional to that of the woman's liberty. The Court could not expand *Roe*'s recognition of the state's interest in the fetus into the pre-viability stage without placing the woman's liberty fundamentally at risk." *Id.*

28 *See* Appleton, *supra* note 17, at 200 ("[O]nly the professional advice of the physician would allow the woman to 'choose' and to do so rationally regardless of her initial, uncounseled preference."); Asaro, *supra* note 23, at 61 ("The *woman's* right to an abortion is not squarely recognized as such, as an aspect of her right to privacy; instead it is tied to the *physician's* right to exercise *his* best medical judgment.").

29 *Roe*, 410 U.S. at 153.

30 Tribe, *supra* note 6, at 3.

31 *Roe*, 410 U.S. at 163. It is also worth noting that in the same paragraph, following the Court's privacy-breadth assertion the Court stated that "[a]ll these are [health] factors the woman and her responsible physician necessarily will consider in consultation." *Id.* at 153.

32 While "physicians might have been less pleased with the decision," Ruth Bader Ginsburg and the commentators cited *supra* note 23 would have preferred that the right to abortion be premised on a "constitutionally based sex-equality perspective"

woman benefited from almost complete liberty to obtain a first trimester abortion, but her physician could theoretically turn her away. Put another way, in the first trimester of pregnancy, *Roe* only contemplated the *physician* as being completely unbound by regulations of the state *and* the demands of nonstate actors (e.g., the woman), whereas the woman could be subject to the refusal of the nonstate actor who was her physician.

This physician-centered reasoning in *Roe* was not lost on commentators at the time. The question for some was whether the language meant anything at all, given "the reality that . . . freestanding abortion clinics . . . will almost surely regard the family's or woman's own decision as dispositive."[33] Professor Tribe acknowledged that *Roe* and its companion case, *Doe v. Bolton*,[34] contained "much . . . that [could] be read to suggest a desire to make the ultimate decision that of a medical expert."[35] But he doubted that the Court "intended any real medical veto over the choice to abort" and suggested that *Roe*'s "medico-technocratic terms" were little more than a public relations effort to enhance "the public acceptability of its result."[36] Professor Tribe was certain that "[i]n no event does the medical terminology alter the substantive result."[37]

For some academics, however, the language meant everything and the substantive result was less than desirable, for it "reinforce[d] this image of the woman as an essentially passive receptor of her physician's wise counsel, as merely the object on which the physician must be permitted to exercise medical discretion."[38] Then-Judge Ruth Bader Ginsburg argued, contrary to Tribe's nonimportance thesis, that the physician-centered language of *Roe* was the very source of criticism that the *Roe* Court "read[] its own values into the due process

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and not on a "medically approved autonomy idea." Ginsburg, *supra* note 23, at 382, 386.

33 Tribe, *supra* note 6, at 38 n.168; *see also* Appleton, *supra* note 17, at 201–02 (discussing doctors who view their roles in providing abortions as purely instrumental, rejecting the *Roe* Court's interpretation of their role as being one of counseling).

34 410 U.S. 179 (1973).

35 Tribe, *supra* note 6, at 37.

36 *Id.* at 38 n.168; *see also* Asaro, *supra* note 23, at 60 ("Tactically, of course, it may well be that Blackmun's exaltation of the physician is simply offensively sexist rhetoric, and that what counts is the decision itself granting, certainly in the first trimester, the woman's right to terminate her pregnancy, as an aspect of the right to privacy.").

37 Tribe, *supra* note 6, at 38 n.168.

38 Asaro, *supra* note 23, at 60; *see also* Appleton, *supra* note 17, at 202 ("Yet, contrary to Tribe, the Court's language acknowledges the ethical aspects of each abortion decision but appears to assign responsibility for them to the physician and not his patient.").

clause," which "might have been less pointed had the Court placed the woman alone, rather than the woman tied to her physician, at the center of its attention."[39] Still, whatever Justice Blackmun's driving motivation—whether it was sexism,[40] preferential concern for doctors over women,[41] or, most plausibly,[42] a desire to shield the abortion right behind a constitutionally impenetrable wall in the right to privacy in the physician-patient relationship—the practical effect was to

39 Ginsburg, *supra* note 23, at 382.

40 *See* Asaro, *supra* note 23, at 93 ("However offensive and sexist Blackmun's rhetoric of medical discretion may have seemed, as a practical matter it better served the women's rights at stake than does the Court's newer 'freedom of choice' language.").

41 This may be a plausible argument, given that Justice Blackmun was general counsel to the Mayo Clinic for a decade. *See, e.g.*, Linda Greenhouse, *How a Ruling on Abortion Took On a Life of Its Own*, N.Y. TIMES, Apr. 10, 1994, § 4, at 3 ("The premise of the opinion was that unwanted pregnancy presents women with potential medical and social problems that 'the woman and her responsible physician necessarily will consider in consultation' when deciding how to proceed. The point of view, reflecting Justice Blackmun's sympathy for the medical profession developed during a decade as general counsel to the Mayo Clinic, was that of a doctor seeking the ability to exercise informed medical judgment about a patient's problem without government intrusion."). However, see *infra* note 42 for why this was not plausibly Justice Blackmun's primary animating desire.

42 *Roe* has been subjected to scathing criticism, even by abortion supporters, and the question is why Justice Blackmun would expose himself to such criticism. Professor John Hart Ely wrote in 1973 an article criticizing the *Roe* decision: "It is bad because it is bad constitutional law, or rather because it is *not* constitutional law and gives almost no sense of an obligation to try to be." John Hart Ely, *The Wages of Crying Wolf: A Comment on* Roe v. Wade, 82 YALE L.J. 920, 947 (1973). Professor Ely supported abortion, *see id.* at 923, but was struck by how poorly reasoned the decision was, in his view. He opined, "Certainly, many will view it as social progress. (Surely that is the Court's view . . . .)" *Id.* at 946. It seems highly doubtful that Justice Blackmun was bending over backwards because he was sexist; if he was sexist he would not have written the opinion that struck down abortion restriction laws throughout the nation. It also seems highly doubtful that he was bending over backwards just because he cared so much about physician autonomy per se; abortion would be an oddly controversial hornets' nest (that could breed what Professor Ely thought was bad reasoning) in which to exalt physician autonomy so resoundingly. Thus, it seems most plausible that Justice Blackmun's aim was to shield the abortion right behind physician autonomy for the sake of the right to abortion itself. Ultimately, it may be impossible to precisely determine Justice Blackmun's motivating intentions, as his opinions through the years seem to have been written or unduly influenced by the law clerks rotating through his office through the years. *See generally* David J. Garrow, *The Brains Behind Blackmun*, LEGAL AFF., May-June 2005, at 27, 28 (noting, after researching Blackmun's recently opened archives, that "Blackmun allowed his clerks to play influential roles not only in drafting the two opinions [*Roe* and *Doe*] but also in honing the constitutional standards that made the two cases famous"). In any event, what is of principle concern here is the *effects* of Justice Blackmun's language in *Roe.*

shield a woman's right to abortion behind physician autonomy.[43] The next subpart discusses how the cases following *Roe* largely used this "physician veto" to impede various attempts by states to insert their laws into the abortion decisionmaking process.

B. Roe*'s Progeny Illustrate Physician Autonomy as a Shield to Protect the Abortion Right*

As Professor Appleton points out, *Roe*'s progeny, particularly the informed consent cases,[44] demonstrate that *Roe*'s physician-autonomy rationale would shield abortion rights for some time.[45] Justice Blackmun, writing again for the Court in *Planned Parenthood of Central Missouri v. Danforth*,[46] was seemingly more concerned about a general informed consent requirement's effect on doctors than he was about any potential chilling effect on a woman's liberty to obtain an abortion. Notwithstanding the increased stress that some have argued informed consent laws may cause abortion-seeking women,[47] he wrote

43 *See* Asaro, *supra* note 23, at 91 ("Perhaps in the privacy of the doctor-patient relationship lay the true preservation of the woman's right to an abortion. At least in the absence of an express recognition of that right as an aspect of *her* right to privacy, judicial deference to medical discretion serves as a second-best alternative."). Whether it was the Court's *intention* to use physician autonomy as a shield for its ideological preference for abortion rights is beyond the scope of this Note. The discussion below is concerned with the practical *effects* of this physician autonomy shield.

44 *See* Appleton, *supra* note 17, at 207–26.

45 Professor Appleton, however, would note that this was an imperfect, perhaps even sexist, shield for the right. In another line of cases, the selective funding cases, the Court "held that the government had not infringed any protected privacy right by subsidizing childbirth but not abortion, even though such selective funding might totally foreclose some indigent women from obtaining both therapeutic and elective abortions." *Id.* at 205 (citing Williams v. Zbaraz, 448 U.S. 358 (1980); Harris v. McRae, 448 U.S. 297 (1980); Poelker v. Doe, 432 U.S. 519 (1977); Maher v. Roe, 432 U.S. 464 (1977); Beal v. Doe, 432 U.S. 438 (1977)). Professor Appleton finds these cases reconcilable with the idea rooted in *Roe* that it is not so much *women* who have a right to abortion in *Roe* as *doctors* who have a right to complete autonomy in their abortion practice. *See id.* at 205–06 ("In other words, in the funding cases the Court upheld antiabortion laws that foreclosed some women's reproductive choices but did not compromise a physician's exercise of medical judgment or decision-making authority."); *see also* Asaro, *supra* note 23, at 88–93 ("[L]egislation not directly interfering with the doctor-patient relationship has generally emerged from judicial scrutiny unscathed. Thus the ultimate erosion of Blackmun's medical discretion approach has occurred in the Supreme Court's decisions upholding state and federal restrictions on abortion funding.").

46 428 U.S. 52 (1976).

47 *See* Appleton, *supra* note 17, at 214–15 & n.226 (positing that providing a woman with information such as details of fetal anatomy "may cause emotional distress"); Susan Frelich Appleton, *More Thoughts on the Physician's Constitutional Role in*

that "it is desirable and imperative that [the choice to abort] be made [by the woman] with full knowledge of its nature and consequences. . . . [H]er awareness of the decision and its significance may be assured, constitutionally, by the State to the extent of requiring her prior written consent."[48] The physician, on the other hand, might be required, as with any other procedure, to tell the woman what would be done and its consequences.[49] But he could not be required to say any more for that would place him "in an undesired and uncomfortable straitjacket in the practice of his profession."[50] As in *Roe*, the Court's absolute solicitude for physician choice and autonomy overshadowed its concern for a woman's interest in obtaining an abortion.[51] The effect of this solicitude for physicians was to veto society's efforts to ensure that the grave choice to abort a fetus was a well-considered one according to its own standards.

Abortion and Related Choices, 66 WASH U. L.Q. 499, 504 (1988) [hereinafter Appleton, *More Thoughts*] (noting that the Court, in Thornburgh v. Am. Coll. of Obstetricians & Gynecologists, 476 U.S. 747, 762 (1986), posited that compelled information, such as the probable gestational age of the fetus, "might heighten patient anxiety"). *But see generally* Mary Anne Wood & W. Cole Durham, Jr., *Counseling, Consulting, and Consent: Abortion and the Doctor-Patient Relationship*, 1978 BYU L. REV. 783, 793 (arguing for a model of rational decisionmaking that includes fully informed consent because "when one adds concern for unborn life into the equation, the argument in the abortion context for protecting the woman's autonomy in the sense of rational rather than arbitrary choice seems overpowering").

48 *Danforth*, 428 U.S. at 67.

49 *See id.*

50 *Id.* at 67 n.8.

51 *Danforth* repeats that "*Doe* and *Roe* clearly establish that the State may not restrict the decision of the patient *and* her physician regarding abortion during the first stage of pregnancy." *Id.* at 66 (emphasis added); *see also* Appleton, *supra* note 17, at 209 ("Yet [the] footnote [cited *supra* note 50] hinted that the infringement of the *doctor's* freedom, not the patient's, might prove a more pressing concern in future cases."); Asaro, *supra* note 23, at 57 ("Although the case surely frees the woman and her physician from the constraint of statutory requirements of third-party consent, interestingly Blackmun twice gives his attending physician top billing. . . .").

Casting the Court's physician-centered approach into deeper relief, Professor Appleton offered three reasons these provisions could have been struck down. First, the Court could have read them as having the "unmistakable purpose of curbing abortion." Appleton, *supra* note 17, at 214. Second, the Court might have found the warnings on "abortion complications and details of fetal anatomy, pain sensitivity, and legal status" to have conveyed "speculative, if not erroneous," information. *Id.* (footnotes omitted). Third, the Court might have found the legislation "notably one-sided," failing to inform the women of the risks and burdens of carrying her fetus through to birth. *See id.* at 215–16.

City of Akron v. Akron Center for Reproductive Health, Inc.,[52] though written by Justice Powell instead of Justice Blackmun, used reasoning rooted in *Roe*[53] to strike down detailed informed consent requirements and a twenty-four hour waiting period[54] as unconstitutionally infringing upon a physician's autonomy. The Court initially remarked on the constitutional infirmity of what it considered to be an attempt to "persuade [the woman] to withhold [her consent] altogether" because the requirements were "a 'parade of horribles' intended to suggest that abortion is a particularly dangerous procedure."[55] However, the Court could not help but rely dispositively on *Roe*'s physician autonomy rationale. Thus, it struck down the *Akron* informed consent requirements for the "equally decisive" reason that they were an "intrusion upon the discretion of the pregnant woman's physician,"[56] and invalidated the twenty-four hour waiting period solely because it was "important to 'affor[d] the physician adequate discretion in the exercise of his medical judgment.'"[57] In a relatively similar decision, the Court, in *Thornburgh v. American College of Obstetricians & Gynecologists*,[58] relied on its concern for physician autonomy in striking down detailed informed consent provisions.[59]

52 462 U.S. 416 (1983).

53 *See infra* notes 56–57 and accompanying text.

54 *See Akron*, 462 U.S. at 422–25.

55 *Id.* at 444–45. The language concerning the impropriety of a state attempting to influence a woman's choice to obtain an abortion was not only overruled in *Casey*, *see* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 870 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.), but was also deeply unsatisfactory to Professor Appleton. *See* Appleton, *supra* note 17, at 222–26 ("[The Court] came only to the verge of recognizing that a woman may have rights superseding those of her doctor. . . . The Court refused to allow the state to place any meaningful burden on the physician while permitting the state to oversee the patient's receipt of information.").

56 *Akron*, 462 U.S. at 445.

57 *Id.* at 450 (alteration in original) (quoting Colautti v. Franklin, 439 U.S. 379, 387 (1979)).

58 476 U.S. 747 (1986).

59 *See id.* at 759–61. For a detailed explanation of *Thornburgh* and criticism of the Court's approach, see Appleton, *More Thoughts*, *supra* note 47, at 503–10 (arguing that *Thornburgh* and the cases it generated highlight the need to "separat[e] . . . the patient's interests in self-determination from the physician's interests in the unrestricted practice of his profession" because the way in which informed consent provisions in the abortion context are struck down, relying on physician autonomy as an anchor, belies an "explicit approval of patient ignorance and physician paternalism and its diminution of meaningful personal choice").

C. *The Birth of the Health Exception in* Roe

The *Roe* Court expressed solicitude for the health of the woman, but did so only by means of conceding that because second trimester abortions included more risks than earlier ones, the state had a compelling interest to protect the health of the woman.[60] However, close examination of *Roe*'s treatment of second trimester pregnancies, as compared to its treatment of first trimester pregnancies, demonstrates that this interest was derivative of the Court's foundational premise of physician autonomy. As important an interest as a woman's health was, it was not important enough to permit a state to regulate abortions *at all* in the first trimester of pregnancy.[61] This is especially noteworthy because abortion at any time is not without at least some small amount of risk.[62] Physician autonomy in the first trimester overshadowed a woman's health[63]—and thus her interest in health was subservient to the Court's solicitude for physician autonomy.

To say the woman's health interest was subservient to the physician's autonomy interest in *Roe* is not to say that it was unimportant. It was highly important, as it provided the only avenue by which states could regulate second trimester abortions so that physician autonomy would be less than absolute during that period, even if just a little less

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60 *See* Roe v. Wade, 410 U.S. 113, 163 (1973).

61 For an argument that *Roe*'s "paramount" concern was "the health and well-being of the pregnant woman," see Glidewell, *supra* note 8, at 1100–03. Undoubtedly, this was a concern of the Court, but its failure to allow states to regulate first trimester abortions *at all* so as to make them even safer for women demonstrates the Court's eagerness to either shield physicians as physicians or to shield the abortion right behind physicians' autonomy. It also calls into question whether women's health in *Roe* was the "paramount" premise on which all other reasoning in the decision rested.

62 The *Roe* Court implicitly acknowledged as much in stating "that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth." *Roe*, 410 U.S. at 163.

63 Certainly a woman could sue for malpractice and seek to surmount courts' deference to the accepted practices of the medical profession. *See supra* note 25. Structurally speaking, though, the physician was unfettered by state regulations during the first trimester, conceivably making it easier for malpractice to occur in the first place, and it is in that sense that physician autonomy overshadowed women's health in *Roe*. *See* Tribe, *supra* note 6, at 30 ("The fact that childbirth causes more women to die than do first-trimester abortions obviously does not warrant the Court's conclusion that state controls over first-trimester abortion procedures must be limited to requiring a licensed physician, or indeed that such controls must be limited to whatever state regulations exist governing medical practice generally. For it is conceivable that even very early abortions would in some particular category of cases pose substantial and distinctive risks to maternal life or health unless specified procedures were complied with.").

so.[64] The health interest was more important than even the state's postviability interest in the life of the fetus, as any postviability regulations or proscriptions of abortion under *Roe* would have to contain a health exception, thereby placing the woman's interest in her health above the interests of the fetus at all times right up until birth.[65] *Roe* and its companion case, *Doe*, gave extremely wide scope to this health concern, permitting abortions to be obtained for a wide range of reasons.[66] But even here physician autonomy played a key role: these health concerns were to be filtered through the physician's "medical judgment."[67] Thus, the health exception gave doctors a second veto against legislative attempts to restrict abortions, for, in light of the broad meaning of "health" in *Roe* and *Doe*, it provided doctors the discretion to procure a late-term abortion for a patient irrespective of postviability legislative prohibitions of abortions.[68]

Thus, the practical effect of *Roe*—whatever the Court's particular motivations—was to shield the constitutional right to abortion it created behind the two interrelated "physician vetoes" of (1) physician autonomy and (2) physician judgment, as conceived in the broadly-defined health exception. As the next Part will explain, the health exception would have a much larger role to play in shielding abortion rights after *Casey*. It would not be until *Casey* that the woman's liberty interest would stand on its own, fully independent of concerns about a physician's autonomy. However, *Casey* proved to be a demonstration that once the invincible wall of protection of physician autonomy was removed, a woman's liberty interest would have to engage society's interests in the life of the unborn in full daylight. Still, *Casey* main-

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64 *See Roe*, 410 U.S. at 163 ("[A] State may regulate the abortion procedure [in the second trimester, only] to the extent that the regulation reasonably relates to the preservation and protection of maternal health."); *supra* note 26.

65 *See Roe*, 410 U.S. at 163–64 ("If the State is interested in protecting fetal life after viability, it may go so far as to proscribe abortion during that period, except when it is necessary to preserve the life or health of the mother."); *supra* note 22.

66 *See* Doe v. Bolton, 410 U.S. 179, 192 (1973) ("[M]edical judgment may be exercised in the light of *all* factors . . . relevant to the well-being of the patient." (emphasis added)); *Roe*, 410 U.S. at 153 ("Psychological harm *may* be imminent. Mental and physical health *may* be taxed by child care." (emphasis added)).

67 *See Doe*, 410 U.S. at 192; *Roe*, 410 U.S. at 163. *But see* Bailey, *supra* note 8, at 72, 73 (arguing that "[m]aternal health . . . is controlling in [*Roe's* trimester] framework" and concluding that "the Court was ultimately concerned with protecting a woman's health, even where competing state interests become compelling [postviability]").

68 *But see* Bailey, *supra* note 8, at 73 (questioning whether psychological health alone could be "reason enough to justify termination of a pregnancy" because "*Doe* is not clear regarding whether one factor by itself could be enough to terminate a pregnancy").

tained *Roe*'s second physician veto—physician judgment—in the health exception requirement.

II. *CASEY'S* REWRITE OF *ROE*: THE NEW LIMITATION ON THE PHYSICIAN VETO

"[T]he state has legitimate interests from the outset of the pregnancy in protecting the health of the woman and the life of the fetus that may become a child."[69] With these words, *Casey* turned *Roe*'s premises completely upside down and inside out,[70] though basically adhering to the principle in *Roe* that the Constitution guarantees a right to abortion,[71] if only because of the need to maintain the Court's legitimacy in the public's eye.[72] The *Casey* Court made clear that the right to abortion was still operative, insisting that "[n]o evolu-

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

70 This point was not lost to those who would criticize *Casey* for not affirming unfettered abortion rights. *See, e.g.*, Borgmann, *supra* note 27, at 678–79, 689 ("[M]any do not comprehend the extent to which *Casey* in fact dismantled *Roe*'s protective framework. . . . *Casey*'s significant departures from *Roe*, including the undue burden standard, stem from the joint opinion's enhanced regard for the state's interest in the fetus."); Chris Whitman, *Looking Back on* Planned Parenthood v. Casey, 100 MICH. L. REV. 1980, 1983–88 (2002) (noting approvingly that with *Casey*, "professional medical decisionmaking has disappeared" as the premise of a woman's abortion right, but disapprovingly remarking that "[t]he *Casey* plurality opinion did not reaffirm *Roe*; it only reaffirmed 'the central holding of *Roe*,'" and that after *Casey* "it is apparent that only a sliver [of *Roe*] remains").

71 *Casey* purported to reaffirm "*Roe*'s essential holding" that (1) before viability a woman may obtain an abortion without undue state interference, (2) a state may restrict abortions after fetal viability so long as the law contains a life and health exception, and (3) the state has legitimate interests from the outset of the pregnancy in protecting the health of the woman. *See Casey*, 505 U.S. at 846. Of course, only the second "reaffirmation" is a direct carryover from *Roe*. The "undue burden" test in number one is a rewriting of *Roe*. *See infra* note 92. The state's interest in the woman's health during the *entire* pregnancy is also a rewriting of *Roe*. *See supra* note 26; *see also* Borgmann, *supra* note 27, at 680–82 ("These changes were far more than modest adjustments to *Roe*. Rather, they altered the very nature of the abortion right, demoting it from a fundamental right to something more enigmatic and certainly more fragile.").

72 *See Casey*, 505 U.S. at 861–869. The Court invoked stare decisis principles that counseled against changing the law simply because it disagreed with abortion, *see id.* at 864–65, central to which was the fear that entirely overruling *Roe* and returning abortion policy back to the states "would seriously weaken the Court's capacity to exercise the judicial power," because the Court could neither buy nor coerce adherence to its decrees, *id.* at 865. It should be noted that the discussion in this Part demonstrates that the Court did not follow stare decisis to the letter: it all but completely overruled *Roe*'s legal framework and explicitly overruled aspects of *Roe*'s physician autonomy progeny, *see supra* Part I.B, that were inconsistent with the state's "legitimate interest in promoting the life or potential life of the unborn," *see Casey*,

tion of legal principle has left *Roe*'s doctrinal footings weaker than they were in 1973."[73] Even assuming *Roe*'s premises were in error, the Court's opinion maintained that the error lay in its failure to give teeth to the strength of the state's interest in protection of fetal life.[74]

Casey's new, potent affirmation of a woman's liberty interest,[75] balanced against the state's interest in the life of the fetus, altered the terms of the debate by removing *Roe*'s first physician veto.[76] *Roe* had meant that with the problem of irreconcilable disagreement over abortion policy, doctors who provided abortions carried the veto because they were to be given absolute autonomy in the first trimester, and nearly impenetrable autonomy in the second trimester.[77] *Casey*, for all its seismic shifts, quietly demoted the oracular physician's voice in *Roe* into a voice that could only be heard through the requirement that restrictions on postviability abortions must contain a health exception.[78] In other words, legislative attempts to regulate abortion, while still running into a constitutional wall, would not, in theory, be automatically abbreviated by a physician's claim to an impenetrable zone of autonomy in her abortion practice. Under *Casey*, the constitutional wall protecting the abortion right would be constructed with two pillars—liberty and the woman's health—derivative not of the woman's relationship with her physician, but of her status as a woman.[79]

A. *The First Pillar: Liberty Supersedes the Right to Privacy Justification and the First Physician Veto of* Roe

First, *Casey* removed *Roe*'s foundation for a right to abortion as consisting in a right to privacy. The common perception today that abortion law is premised on a woman's right to privacy[80] is flatly incor-

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505 U.S. at 870 (joint opinion of O'Connor, Kennedy & Souter, JJ.), while maintaining the status quo in the key headline-making area of a basic right to abortion.

73 *Casey*, 505 U.S. at 857 (majority opinion).

74 *See id.* at 858.

75 *See infra* Part II.A.

76 See *supra* Part I.A for a discussion of the genesis of this first veto.

77 *See supra* note 26 and accompanying text.

78 This remaining veto would become central to the debate over restrictions on methods of abortion that apply pre- and postviability. *See infra* Parts III–IV.

79 *See infra* note 86 and accompanying text.

80 *See, e.g.*, Maureen Dowd, Op-Ed., *Naughty Harry: Lawyering Without a License*, N.Y. TIMES, Oct. 19, 2005, at A21 (failing to mention the liberty anchor of women's right to abortion and instead mentioning the "right to privacy"); Todd S. Purdum, *Defining Terms: The Supreme Court's Biggest Question*, N.Y. TIMES, Sept. 18, 2005, § 4, at 1 (noting that "'privacy' has become [a] neutral-sounding shorthand" for the abortion right); Dan Savage, Op-Ed., *Can I Get a Little Privacy?*, N.Y. TIMES, Nov. 16, 2005, at

rect, as the *Casey* plurality only spoke of a constitutional right of privacy "*between* a pregnant woman *and her physician*."[81] This comports fully with the notion, discussed above,[82] that the right to privacy in *Roe* was more protective of a physician's autonomy, and, by extension, his relationship with his patient, than of a woman's choice. Perhaps Justices O'Connor and Ginsburg, the only two women to serve on the Court so far, recognize this. As Justice O'Connor's opinion in *Casey* unambiguously stated, "[t]he controlling word in the cases before us is 'liberty,'"[83] not privacy.

In case there was any doubt that privacy is no longer the legal premise of the right to abortion, and is not going to reappear any time soon in the Court's abortion jurisprudence, Justice Ginsburg herself asserted in her dissent in *Carhart* that "legal challenges to undue restrictions on abortion procedures do not seek to vindicate some generalized notion of privacy; rather, they center on a woman's autonomy to determine her life's course, and thus to enjoy equal citizenship stature."[84] Far from being a derivative—even if a substantial—premise, a woman's liberty, as of *Casey*, was to be the grounding premise of the right to abortion.[85]

A23 (assuming the privacy justification of *Roe* is still the controlling justification for abortion rights in the Due Process Clause).

81 Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (joint opinion of O'Connor, Kennedy & Souter, JJ.) (emphasis added).

82 *See supra* Part I.A.

83 *Casey*, 505 U.S. at 846 (majority opinion); *see also id.* at 869 (joint opinion of O'Connor, Kennedy & Souter, JJ.) ("From what we have said so far it follows that it is a constitutional liberty of the woman to have some freedom to terminate her pregnancy.").

84 Gonzales v. Carhart, 127 S. Ct. 1610, 1641 (2007) (Ginsburg, J., dissenting). Of course, Justice Ginsburg was more interested in rooting abortion in equal protection, as a matter of gender equality. *See generally* Ginsburg, *supra* note 23, at 386 ("Overall, the Court's *Roe* position is weakened, I believe, by the opinion's concentration on a medically approved autonomy idea, to the exclusion of a constitutionally based sex-equality perspective.").

85 Some who argue that women's equality demands completely unfettered abortion note this shift away from privacy, and even laud it.

> Although it is impossible to know for sure why the Justices in *Casey* chose to focus on liberty rather than privacy, one reason that immediately suggests itself is the Court's desire to reaffirm *Roe* without being dependent on *Roe*'s vulnerable constitutional doctrine. Thus, *Casey* avoided the quicksand of privacy jurisprudence by relying directly on the . . . liberty interest . . . .

Erin Daly, *Reconsidering Abortion Law: Liberty, Equality, and the New Rhetoric of* Planned Parenthood v. Casey, 45 AM. U. L. REV. 77, 121 (1995).

The point is worth noting carefully because *Casey* completely reversed the derivative position of the woman in *Roe* and, by doing away with the privacy justification for the abortion right, made it clear that "[w]hatever constitutional status the doctor-patient relation may have as a general matter, in the present context *it is derivative of the woman's position*."[86] Rather than receiving absolute deference, "the doctor-patient relation here is entitled to [only] the *same* solicitude it receives in other contexts."[87]

However, as *Roe* itself acknowledged,[88] and as *Casey* stressed,[89] a woman's liberty to obtain an abortion is not absolute. Thus, the *Casey* plurality did not mention *Roe*'s strict scrutiny test[90] used during the previous two decades. Rather, the *Casey* plurality adopted the "undue burden" test[91] whereby a law regulating previability abortions would be invalidated if it has the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable

86 *Casey*, 505 U.S. at 884 (joint opinion of O'Connor, Kennedy & Souter, JJ.) (emphasis added); *see also* Daly, *supra* note 85, at 126 (noting that the *Casey* plurality "[d]irectly repudiat[ed] its former characterization of the doctor-patient relationship").

87 *Casey*, 505 U.S. at 884 (joint opinion of O'Connor, Kennedy & Souter, JJ.) (emphasis added); *see also id.* at 886 ("And while the [twenty-four hour] waiting period does limit a physician's discretion, that is not, standing alone, a reason to invalidate it.").

88 *See* Roe v. Wade, 410 U.S. 113, 153 (1973) ("[A]ppellant and some *amici* argue that the woman's right is absolute and that she is entitled to terminate her pregnancy at whatever time, in whatever way, and for whatever reason she alone chooses. With this we do not agree.").

89 *See Casey*, 505 U.S. at 887 (joint opinion of O'Connor, Kennedy & Souter, JJ.) ("Even the broadest reading of *Roe*, however, has not suggested that there is a constitutional right to abortion on demand.").

90 *See supra* note 18.

91 *Casey*, 505 U.S. at 874 (joint opinion of O'Connor, Kennedy & Souter, JJ.). To briefly summarize *Casey*'s undue burden analysis, *Casey* upheld a detailed informed consent requirement, admittedly meant to dissuade women from choosing abortion, because it was not a "substantial obstacle" to the woman's ultimate choice. *See id.* at 883–85. *Casey* upheld a twenty-four hour waiting period requirement because whatever health risks and financial costs might possibly accrue from waiting another day for an abortion, they were so marginal as to not place a "substantial obstacle" in the woman's path. *See id.* at 885–87. *Casey* also upheld a parental consent requirement, relying largely on established precedent rather than fully reanalyzing the question in light of the "undue burden" test. *See id.* at 899. As noted *infra* note 94, *Casey* struck down a spousal notification requirement as placing a "substantial obstacle" in the path of abortion-seeking women who have abusive spouses and as offending modern understandings of a woman's equality in a marriage. *See Casey*, 505 U.S. at 887–98 (majority opinion). The medical emergency provision is discussed *infra* note 105 as part of the discussion on the facial health exception requirement.

fetus."[92] This was not lost on Justice Blackmun in his concurrence, as he argued forcefully for application of *Roe*'s strict scrutiny standard.[93] Justice Blackmun did not take exception to the "undue burden" test itself, but rather praised it when arriving at a strict scrutiny-friendly result in striking down Pennsylvania's spousal notification requirement.[94] He took exception to the "undue burden" framework as used to uphold the Pennsylvania statute's other provisions,[95] which he considered to fail strict scrutiny review.[96]

Why did the *Casey* Court remove the physician autonomy veto that had served abortion rights so well since *Roe*? The gender equality theorist's reading is that Justice Blackmun's views had evolved for the better. He, Justice Stevens, and the plurality "agreed that although the *Roe* attitude towards women may have been acceptable in 1973, it no longer fit[] women's role in society."[97] Another reading assumes that *Roe* was not necessarily intended to be sexist and would instead view it as concerned with physician autonomy as a means of protecting the right to abortion at a time when perhaps a woman's liberty theory might prove too politically untenable.[98] By 1992, the Court may have felt that societal attitudes toward women had sufficiently changed to viably premise abortion rights on women's status as women, instead of on physician autonomy. But whatever its motivations, the Court was

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92 *Casey*, 505 U.S. at 877 (joint opinion of O'Connor, Kennedy & Souter, JJ.). For a helpful explication of the "undue burden" test, see Glidewell, *supra* note 8, at 1105–08. Glidewell notes that "the Joint Opinion revised the standard of review for restrictions on the abortion right, from a fundamental right subject to strict scrutiny review under *Roe*, to a 'liberty interest' subject to an 'undue burden' analysis under *Casey*." *Id.* at 1105 (footnotes omitted); *see also* Borgmann, *supra* note 27, at 682–89 (arguing that the undue burden standard is devoid of content and that "the joint opinion's determinations in *Casey* about which restrictions were permissible seemed to reflect little more than the Justices' own views as to which kinds of burdens were acceptable"). How this *purpose* and *effect* test was applied in *Carhart* is discussed *infra* Part IV.

93 *See Casey*, 505 U.S. at 926 (Blackmun, J., concurring in part and dissenting in part).

94 *See id.* at 924–925 ("In striking down the Pennsylvania statute's spousal notification requirement, the Court has established a framework for evaluating abortion regulations that responds to the social context of women facing issues of reproductive choice.").

95 *See supra* note 91.

96 *See Casey*, 505 U.S. at 934–40 (Blackmun, J., concurring in part and dissenting in part) ("Application of the strict scrutiny standard results in the invalidation of all the challenged provisions . . . .").

97 Daly, *supra* note 85, at 128.

98 *See supra* note 42. *But see* Asaro, *supra* note 23, at 60, 93 (arguing that Justice Blackmun was simply sexist).

not yet willing to allow the debate between the competing interests of women's liberty and equality on the one hand, and the life of the unborn on the other, to occur entirely unimpeded by physician vetoes. Instead, it maintained the health exception as a background physician veto—a safety valve that continued to protect the abortion right all the way up until live birth.

B. Casey*'s Second Pillar: Maintaining the Health Exception Physician Veto as a Safety Valve*

Casey maintained *Roe*'s second physician veto[99]—the health exception requirement—as a safety valve for women's access to abortion. It did this even while raising women's health to a freestanding premise in its abortion jurisprudence in two different ways.[100] First, it removed the cloak of physician autonomy that *Roe* had placed over the first trimester and replaced it with the principle that the state "has interests from the outset of the pregnancy in protecting the health of the woman."[101] Now, instead of waiting for malpractice to occur and for the woman to go through the taxing lawsuit process,[102] the state could say something about a physician's abortion practice from the very beginning of the pregnancy to protect the woman's health. Second, it confirmed the postviability holding of *Roe*, without modification, that the state "'may, if it chooses, regulate, and even proscribe, abortion except where it is necessary, *in appropriate medical judgment*, for the preservation of the life or health of the mother.'"[103]

Initially, given *Roe*'s premises, this health protection might seem to be geared only toward the idea of obtaining a safe abortion for the woman.[104] It might also seem that the *Casey* plurality's language was clear enough: if the government wants to restrict postviability abortions, it must include a health exception as a facial matter in the law

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99 *See supra* Part I.C.

100 *Roe* had taken the women's health interests to be derivative of a physician's judgment. *See supra* Part I.A–C.

101 *Casey*, 505 U.S. at 846 (majority opinion).

102 *See supra* note 63 and accompanying text.

103 *Casey*, 505 U.S. at 879 (joint opinion of O'Connor, Kennedy & Souter, JJ.) (emphasis added) (quoting Roe v. Wade, 410 U.S. 113, 164–65 (1973)). It is precisely the interpretation of this language—whether it involves a facial requirement or a balancing test—that would help fuel bitter division in the Court in *Stenberg*. *See infra* Part III.

104 *See supra* note 26.

itself. The tricky and unanswered question, however, would be what the scope of that health exception should be.[105]

If any credence can be given to the idea that a woman may suffer adverse effects from an abortion—whether it be physical harms[106] or long-lasting psychological harms[107]—then it would appear that the

105 *Roe* and *Doe* had endorsed an unlimitedly wide scope for this health exception. *See supra* note 66 and accompanying text. For a thorough history of the treatment of the *scope* of the health exception (whether it should include only significant physical health risks or should also include more liberal understandings of mental health issues) over the years by the courts since before *Roe*, see Glidewell, *supra* note 8, at 1116–29. *Casey*, while not stating that the health exception necessarily need be narrow, upheld a medical emergency provision that allowed circumvention of the statute's other provisions in the narrow health circumstance of a "'serious risk of substantial and irreversible impairment of a major bodily function.'" *Casey*, 505 U.S. at 879 (majority opinion) (quoting 18 PA. CONS. STAT. § 3203 (1990)). The *Casey* Court determined that since the lower courts read the provision to include the health risks of "three serious conditions . . . : preeclampsia, inevitable abortion, and premature ruptured membrane," the health exception was wide enough to survive the undue burden test. *Id.* at 880. Professor Caitlin Borgmann believed that this analysis put into question whether the health exception after *Casey* was truly an independent facial requirement.

> [T]he opinion troublingly closed its discussion of the medical emergency exception by concluding that "the medical emergency definition *imposes no undue burden* on a woman's abortion right." That formulation seemed to subsume the medical emergency exception within the undue burden test rather than treating it as a separate, categorical requirement.

Borgmann, *supra* note 27, at 699–700 (quoting *Casey*, 505 U.S. at 880). However, it seems that at least Justice O'Connor was crystal clear about the idea that *Casey* meant the health exception requirement was facially required at all times. *See infra* notes 133–35 and accompanying text. In light of Justice O'Connor's clarity, it appears that *Casey* held that the health exception was facially required and the only question was what scope it must have to be constitutionally sufficient under either an undue burden or independent health exception analysis. Professor Borgmann was optimistic that *Stenberg*, discussed *infra* Part III, had clarified this problem. "In sum, [*Stenberg*'s] treatment of the health exception requirement clarified important aspects of the requirement that had been uncertain after *Casey*. The health exception requirement is an independent one; it is not subject to the undue burden test." Borgmann, *supra* note 27, at 713; *see also id.* at 706–13 (discussing fully this health exception argument). In light of the *Carhart* decision, it appears that *Stenberg* worsened, rather than clarified, the problem that Professor Borgmann believed existed in *Casey*. *See infra* Part IV.

106 *See* Stenberg v. Carhart, 530 U.S. 914, 928–38 (2000) (discussing arguments about the comparative physical health risks of nonintact D & E versus intact D & E abortions, including possible severe damage to a woman's reproductive system for both methods).

107 *See generally* Brief of Sandra Cano, the Former "Mary Doe" of *Doe v. Bolton*, and 180 Women Injured by Abortion as Amici Curiae in Support of Petitioner, Gonzales v. Carhart, 127 S. Ct. 1610 (2007) (No. 05-380), 2006 WL 1436684 (quoting 178 of 2000 affidavits on file in which women discuss their emotional distress after obtaining an

state has an interest, under *Casey*, in seeking to prevent those adverse effects, as long as the prevention does not constitute an "undue burden" on the woman's election of the abortion. In upholding Pennsylvania's informed consent requirement, which furthered the state's interest in fetal life and "express[ed] a preference for childbirth over abortion,"[108] the *Casey* plurality (including Justice O'Connor) took cognizance of potential adverse effects of abortion on a woman. "In attempting to ensure that a woman apprehend the full consequences of her decision, the State furthers the legitimate purpose of reducing the risk that a woman may elect an abortion, only to discover later, with devastating psychological consequences, that her decision was not fully informed."[109] Society, through its legislatures, had the last word—not the physician—in determining that these adverse effects might exist, and in determining what information a woman should receive to "ensur[e] a decision that is mature and informed."[110]

While the plurality's language, quoting *Roe* directly,[111] seemed clear enough that there must be a health exception in laws restricting abortions after fetal viability, that question remained to be tested after *Casey*. These three elements—undue burden, health exception, and the state's interest in fetal life—would be the core elements in the Court's bitter division in its 2000 *Stenberg* decision and in *Carhart* as the Court struggled over how to address attempts to ban intact D & E abortions. The struggle would center around the "liberal" wing of the Court attempting to use the physician-judgment veto that *Casey* maintained in the health exception requirement in order to justify constitutional protection of the procedure. The "conservative" wing of the Court would refuse to give such heightened deference to physician judgment as a means of avoiding a direct assessment of the central issues in the debate.

III. THE "HEALTH EXCEPTION" DEBATE IN *STENBERG V. CARHART*: THE BEGINNING OF THE END OF THE PHYSICIAN VETO ERA

As Justice Ginsburg pointed out in her passionate dissent in *Carhart*, the Court was "for the first time since *Roe* . . . bless[ing] a prohibition [of abortion] with no exception safeguarding a woman's

abortion); Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 835 n.68 (2007) (gathering sources that advance the argument that abortion is harmful to women, but ultimately not agreeing with them).

108 *Casey*, 505 U.S. at 883 (joint opinion of O'Connor, Kennedy & Souter, JJ.).

109 *Id.* at 882.

110 *Id.* at 883.

111 *See supra* note 103 and accompanying text.

health."[112] This Part describes how this occurred. Interestingly, the *Stenberg* majority (which included Justice Ginsburg) was most significantly responsible for the seismic shift in abortion jurisprudence that occurred with *Carhart*'s apparent expulsion of the health exception as a bright-line requirement for laws restricting abortion. How? It seems that the *Stenberg* majority was attempting to revive a long-lost premise—heightened judicial deference to doctors—from *Roe* as a means of justifying constitutional protection for what even Justices Ginsburg and Stevens acknowledged is a "gruesome" method of abortion.[113] What is most telling is that the *Stenberg* Court took its focus off the woman's liberty interest exalted in *Casey*, and instead spent its ink creating the "significant medical authority" test.

A. *The* Stenberg *Majority's Pyrrhic Victory: Turning the Health Exception into a "Significant Medical Authority" Balancing Act*

Casey's plurality opinion affirmed without modification *Roe*'s holding that postviability abortions could be regulated, even proscribed, "'except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother.'"[114] It seemed to be categorical enough: postviability, a health exception in any law proscribing abortions is required—end of discussion.[115] Previability, regulations would be subject to *Casey*'s articulated "undue burden" test. However, attempts to ban intact D & E abortions seemed to throw a wrench into Justice O'Connor's categorical machinery in *Casey*. As the Court carefully noted, such bans affect an abortion procedure that is performed both before and after the fetus

112 *Carhart*, 127 S. Ct. at 1641 (Ginsburg, J., dissenting).

113 *See id.* at 1647; Stenberg v. Carhart, 530 U.S. 914, 946 (2000) (Stevens, J., concurring).

114 *Casey*, 505 U.S. 833, 879 (joint opinion of O'Connor, Kennedy & Souter, JJ.) (quoting Roe v. Wade, 410 U.S. 113, 164–65 (1973)).

115 See *supra* note 105 and accompanying text. Some commentators have argued, in the wake of the *Stenberg* decision and the Partial-Birth Abortion Ban Act, that the *Casey* Court was not as unequivocal as it might seem. *See, e.g.*, Bailey, *supra* note 8, at 74 ("Unfortunately, although the *Casey* Court defined 'undue burden,' it did not offer specific guidance regarding what a 'health exception' necessarily entails. . . . [T]he failure of the Supreme Court to explicitly define specific aspects of the mandated 'health exception' became increasingly important with the introduction of the partial-birth abortion procedure just months after *Casey* was decided in 1992."). However, notwithstanding uncertainty over the *scope* of the health exception requirement, what seems unequivocal, at least to Justice O'Connor, is *Casey*'s requirement that laws restricting abortion have a facial health exception. *See infra* notes 133–35 and accompanying text.

is viable.[116] Thus, one law would span both of *Casey*'s categories, and the question would be, which of *Casey*'s tests—the undue burden standard or the health exception requirement—would apply? The *Stenberg* majority's answer may have temporarily won the battle for relatively unfettered abortion rights, but it ultimately enabled the *Carhart* majority to remove the physician-judgment veto that remained in the health exception requirement after *Casey*.

The majority's opinion in *Stenberg* indicates on its face that Nebraska's law banning intact D & E abortions, since it applied previability,[117] was unconstitutional for each of *Casey*'s "two *independent* reasons."[118] First was the seemingly categorical reason that the law lacks any exception "'for the preservation of the . . . health of the mother.'"[119] It was apparently unconstitutional for the additional categorical reason that the law "'imposes an undue burden on a woman's ability' to choose a [nonintact] D & E abortion, thereby unduly burdening the right to choose abortion itself."[120]

It might appear from this superficial maintenance of *Casey*'s categories that the *Stenberg* majority simply assumed the greater hurdle (the no-undue-burden requirement) included the lesser (the

116 *See Carhart*, 127 S. Ct. at 1632; *see also id.* at 1641 (Ginsburg, J., dissenting) ("[Today's decision] blurs the line, firmly drawn in *Casey*, between previability and postviability abortions."); *Stenberg*, 530 U.S. at 930 ("The fact that Nebraska's law applies both previability and postviability aggravates the constitutional problem presented."). One explanation of why Justice Ginsburg may have been uncomfortable with this line-blurring in *Carhart* is that it strengthens the states' interest in the life of the nonviable fetus, representing a further departure from what some consider to be *Roe*'s unjustified nominalism in calling an unborn fetus at whatever stage of development a nonperson, while calling a baby a person at the instant of birth. *See generally* Ely, *supra* note 42, at 924 ("[T]he Court's defense [in *Roe* of the viability line] seems to mistake a definition for a syllogism."); Richard Smith, *Location and Life: How* Stenberg v. Carhart *Undercut* Roe v. Wade, 9 WM. & MARY J. WOMEN & L. 255 (2003) (arguing *Roe* engaged in unjustified nominalism and that *Stenberg* undermined *Roe* in this regard). Another explanation for Justice Ginsburg's discomfort might be the argument, cast into stark relief with the debate over intact D & E abortions, that the viability line drawn in *Roe* was not only arbitrary, but was also mere dicta in *Roe* and *Casey*. *See generally* Randy Beck, *The Essential Holding of* Casey: *Rethinking Viability*, 75 UMKC L. REV. 713, 721 (2007) ("Rethinking the viability line would be analogous to reexamining [*Roe*'s] trimester framework . . . .").

117 To be clear, if the law only applied postviability, then the undue burden analysis would not apply. Rather, the law would only need to contain a life and health exception for the mother. *See supra* note 71.

118 *Stenberg*, 530 U.S. at 930 (emphasis added).

119 *Id.* (quoting *Casey*, 505 U.S. at 879 (joint opinion of O'Connor, Kennedy & Souter, JJ.)).

120 *Id.* (quoting *Casey*, 505 U.S. at 874 (joint opinion of O'Connor, Kennedy & Souter, JJ.)).

health exception requirement). The Court stated that "[s]ince the law requires a health exception in order to validate even a postviability abortion regulation, it at a minimum requires the same in respect to previability regulation."[121] However, rather than rely on the simple logical step that health exceptions are necessarily required previability if they are required postviability, the Court accepted Nebraska's argument that "the law does not require a health exception unless there is a need for such an exception."[122] In deciding that there was a need for a health exception, "[t]he *Stenberg* Court seemingly added an element to the health exception"[123] and thereby conflated the application of *Casey*'s undue burden test with the health exception requirement.[124]

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121 *Id.*

122 *Id.* at 931.

123 Bailey, *supra* note 8, at 77. Bailey notes that the *Stenberg* Court's health exception analysis gave Congress legislative room, using *Stenberg*'s language, to justify outlawing intact D & E abortions without a health exception requirement. *See id.* at 77–78 ("Although the *Stenberg* Court further solidified the necessity of a health exception, the need for the support of a substantial medical authority paved the way for passage of the [Partial-Birth Abortion Ban] Act."). Using *Stenberg*'s health exception analysis as a justification for not including the exception in the Partial-Birth Abortion Ban Act, Congress determined that "'a ban on partial-birth abortion is not 'required' to contain a health exception, because the facts indicate that a partial-birth abortion is never necessary to preserve the health of a woman, poses serious risks to a woman's health, and lies outside the standard of medical care.'" *Id.* at 78 (quoting Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 note (Supp. V 2005)).

124 This seems to have caused some confusion among commentators, demonstrating that it is a very real conflation of the health exception requirement with the undue burden test. The *Stenberg* majority decided that a health exception is required for bans on intact D & E abortions because of the disputed possibility of increased health risks of obtaining nonintact D & E abortions vis-à-vis intact D & E abortions. *See Stenberg*, 530 U.S. at 930–38. It also decided that the language banning intact D & E abortions could be construed as banning nonintact D & E abortions and thereby placed an "undue burden" on women's ability to obtain late-term abortions, since nonintact D & E abortions were the most common method of late-term abortions. *See id.* at 938–47. Notwithstanding the separation of the issues just described, this conflation of the health exception with the undue burden test led one commentator to say that the first issue was "the extent to which Nebraska's ban on partial-birth abortion presents an undue burden on the mother's right to an abortion because of an increased health risk to the mother and, second, if Nebraska's ban extends to the dilation and evacuation [nonintact D & E] procedure." Richard Collin Mangrum, Stenberg v. Carhart*: Poor Interpretivist Analysis, Unreliable Expert Testimony, and the Immorality of the Court's Invalidation of Partial-Birth Abortion Legislation*, 34 CREIGHTON L. REV. 549, 552 (2001). Another commentator argued:

> Eliminating the [intact D & E] procedure as an option creates an undue burden to the woman's right to an abortion because when she is faced with alternatives that pose greater risks to her health, she may be forced to choose a riskier procedure or even opt out of an abortion altogether.

That added element would be the "substantial medical authority" test.[125]

In upholding a twenty-four hour waiting period requirement as not imposing an undue burden on a woman's ability to decide to abort her pregnancy, the *Casey* Court engaged a *calculus* of risks and costs. It determined that the marginal increase in these risks and costs was not so onerous as to constitute an "undue burden."[126] In upholding the medical emergency provision in the Pennsylvania statutes in question, the *Casey* Court did not engage in any calculus at all: the requirement was *categorical* and was satisfied by the lower courts having read a health exception into the medical emergency provision.[127]

The conflation in *Stenberg* of these two tests occurs when the majority engaged in an "undue burden"–like calculus to argue that Nebraska was wrong and that a health exception was indeed required in its law. That calculus involved the question of "whether protecting women's health requires an exception for those infrequent occasions" where a doctor believes that a woman's health requires an intact D & E.[128] The Court's answer was that a statute would be required to have a facial health exception if "in the process of regulating the *methods* of abortion, [it] *imposed significant health risks*."[129] To decide whether Nebraska's statute imposed significant health risks, the Court exhaustively recognized that conflicting and uncertain arguments were present before it concerning the marginal risks entailed in banning intact D & E abortions without a health exception[130] and "adopted a lenient test for determining whether one abortion procedure is safer than another."[131] Under this test, the Court held that a

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Janeen F. Berkowitz, Stenberg v. Carhart*: Women Retain Their Right to Choose*, 91 J. CRIM. L. & CRIMINOLOGY 337, 379 (2001).

125 *See* Bailey, *supra* note 8, at 77.

126 *See supra* note 91 and accompanying text.

127 *See supra* note 105 and accompanying text.

128 *Stenberg*, 530 U.S. at 934.

129 *Id.* at 931 (second emphasis added).

130 *See id.* at 931–38.

131 Glidewell, *supra* note 8, at 1139. Glidewell continues:

> Although it was undisputed in [*Stenberg*] that there were no medical studies documenting the comparative safety of [intact D & E] and [nonintact] D & E, the majority found this fact unimportant because there was substantial medical authority that [intact D & E] was medically necessary for some women in some circumstances.

Id. Justice Kennedy complained in his dissent in *Stenberg* that the "substantial medical evidence" standard of the majority seemed met only by "the individual views of Dr. Carhart and his supporters." *Stenberg*, 530 U.S. at 969 (Kennedy, J., dissenting). The majority responded that neither "absolute [medical] necessity" for the intact D & E

health exception was required where "*significant medical authority* supports the proposition that in some circumstances, [intact D & E] would be the safest procedure."[132]

Justice O'Connor, in her concurrence, seemed somewhat uncomfortable with the majority's transformation of the health exception requirement—which she, along with the Court, had categorically carried over from *Roe* into *Casey*—into a balancing test. Her concurrence mirrors the majority's *structure* in addressing the health exception and then the undue burden test, but is much more categorical about the need for a health exception. She was crystal clear that the undue burden test was an "alternative and independent ground" from the health exception requirement, even while agreeing with Justice Breyer that the greater included the lesser so that previability abortion restrictions required a health exception.[133] Her insistence that the "lack of a health exception [in the Nebraska statute] *necessarily* renders the statute unconstitutional"[134] betrays an uneasiness with the majority's decision to open the possibility that a health exception might not be required in an abortion restriction.[135]

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procedure nor "unanimity of medical opinion" was necessary to meet the "substantial medical authority" standard. *See id.* at 937 (majority opinion). Rather, there was a "judicial need to tolerate responsible differences of medical opinion" by defaulting to the view that a health exception is required since, if the doctors opposed to banning intact D & E turn out to be wrong in their estimations that a woman's health might require the procedure, the worst that could happen is that "the exception will simply turn out to have been unnecessary." *See id.*

132 *Stenberg*, 530 U.S. at 932 (emphasis added); *see also id.* at 937 ("Where a *significant body of medical opinion* believes a procedure may bring with it greater safety for some patients and explains the medical reasons supporting that view, we cannot say that the presence of a different view by itself proves the contrary." (emphasis added)).

133 *See id.* at 948 (O'Connor, J., concurring).

134 *Id.* (emphasis added).

135 Gail Glidewell suggests that Justice O'Connor was complicit with the majority in entertaining the possibility that "[i]f there were adequate alternative measures for a woman safely to obtain an abortion before viability, it is unlikely that prohibiting the [intact D & E] procedure alone would 'amount in practical terms to a substantial obstacle to a woman seeking an abortion.'" *See* Glidewell, *supra* note 8, at 1115 (quoting *Stenberg*, 530 U.S. at 951 (O'Connor, J., concurring)). However, Justice O'Connor states immediately thereafter that "[t]hus, a ban on partial birth abortion that only proscribed the [intact D & E] method of abortion and that *included an exception to preserve the life and health of the mother* would be constitutional in my view." *Stenberg*, 530 U.S. at 951 (emphasis added). Glidewell notes that "[i]t is revealing that Justice O'Connor's pointed statements did not make it into the majority opinion." Glidewell, *supra* note 8, at 1115. However, it is revealing not for the reason that Justice O'Connor agreed with the majority that a health exception might not be necessary, but rather for the reason that Justice O'Connor was taking the majority to task for not holding that the health exception was facially required, end of discussion.

While Nebraska lost this particular battle, the importance of Nebraska's argument cannot be overstated. Rather than saying "a health exception is necessary as per *Roe* and *Casey*" and calling it a day, the *Stenberg* majority allowed the possibility—even if only to reject it in this instance—that a health exception might not be required in a law restricting abortion. As will be seen,[136] this possibility was seized upon in *Carhart* to come to almost the exact opposite conclusion that *Stenberg* had arrived at less than seven years beforehand.

B. *What Was* Stenberg*'s Goal? Reviving the Physician Judgment Veto to Shield Unfettered Abortion Rights*

The trouble for the *Stenberg* majority arose with the claim that intact D & E is a procedure that is never necessary for the health of the mother.[137] *Casey* reaffirmed *Roe*'s "necessary, in appropriate medical judgment" language.[138] The implicit question in *Stenberg* was whether this language meant that (1) the law must simply have a facial health exception allowing physicians to autonomously make their own medical determinations about the health-necessity of a late-term abortion; (2) the law only requires a health exception when the *courts* decide "appropriate medical judgment" deems it necessary; or (3) the law only requires a health exception when the *legislatures* determine that "appropriate medical judgment" deems it necessary. Either of the first two answers would involve judicial deference to physicians. The first answer might provide too much deference to physicians because of the need to protect women's health from errant physicians adopting unsafe abortion procedures.[139] The Court's choice of the

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136 *See infra* Part IV.

137 *See Stenberg*, 530 U.S. at 937–38.

138 *See supra* note 103 and accompanying text.

139 The *Stenberg* majority was careful to argue against Justice Kennedy's assertion that its decision was granting "'unfettered discretion'" to physicians "in their selection of abortion methods." *Stenberg*, 530 U.S. at 938 (quoting *id.* at 969 (Kennedy, J., dissenting)). Justice Kennedy argued in dissent that "[i]n deferring to the physician's judgment, the Court turns back to cases decided in the wake of *Roe*, cases which gave a physician's treatment decisions controlling weight" and that "[n]o doubt exists that today's holding is based on a physician-first view which finds its primary support in that now-discredited case [*City of Akron*]." *Id.* at 968–69 (Kennedy, J., dissenting). Kennedy, who was one of the *Casey* joint opinion's authors, continued, "*Casey* recognized the point, holding the physician's ability to practice medicine was 'subject to reasonable . . . regulation by the State' and would receive the 'same solicitude it receives in other contexts.'" *Id.* at 969 (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 884 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.)). For what the *Stenberg* majority's intentions likely were in stating it was not granting "unfettered discretion" to physicians, see *infra* note 142 and accompanying text.

second answer over the third might imply that it was placing the health exception requirement at risk in the name of its own self-aggrandizement.[140] However, there could be reasons beyond pure self-aggrandizement to choose this path: the health exception requirement would arguably be at less risk in the hands of a pro-abortion-rights majority on the Court than in the hands of legislatures seeking to curb abortion. Moreover, assuming the *Stenberg* majority did not intend to place the health exception requirement at risk in the process of arguably granting physicians "absolute veto power over any abortion legislation even post viability,"[141] there must have been something else driving the Court. It would seem uncommonly unwise for that majority to risk a detriment to abortion rights even in the name of its own aggrandizement. That something else may have been an effort to reestablish physician judgment as paramount in questions of abortion regulation, as a means to protect the abortion right.[142]

As noted above, the legal reasoning that went into *Roe* was mostly defunct after *Casey*.[143] The privacy justification of *Roe*, protecting a physician's autonomy and relationship with his patient, was supplanted by *Casey*'s liberty justification.[144] *Casey* limited that liberty justification by abolishing the trimester framework in order to give real

140 Justice Kennedy expressed concern about this when he argued that "it is precisely where such [medical] disagreement exists that *legislatures* have been afforded the widest latitude." *Stenberg*, 530 U.S. at 970 (Kennedy, J., dissenting) (emphasis added). He thus saw the Court as taking the question of medical regulation in the face of medical disagreement out of the traditional hands of the legislature. It seems doubtful that the *Stenberg* majority did this only to aggrandize the Court; rather, it seems that aggrandizement, if Justice Kennedy's argument is correct, is a mere byproduct of the Court seeking to shield abortion rights from legislative incursion by deferring to the judgment of pro-abortion physicians.

141 Mangrum, *supra* note 124, at 579. The caveat to the absoluteness of this veto power would be that the Court must grant it in the first place.

142 Undoubtedly, the *Stenberg* majority's language that its decision was not granting "unfettered discretion" to physicians was not an indication that it was eager to limit physician autonomy, but rather seems to be an indication that it was acknowledging that too much physician autonomy could be dangerous to women's health. Short of that "too much autonomy" line, the *Stenberg* majority precisely relied on physician judgment to shield access to intact D & E abortions. Gail Glidewell's helpful explication of the *Stenberg* decision casts this into relief when she argues that the *Stenberg* Court's decision was entirely premised on a calculation of the speculative, but nonetheless theoretically possible, health risks to women of banning intact D & E. *See* Glidewell, *supra* note 8, at 1110–13. It was physicians who argued this risk was possible, and rather than turn to a notion of women's liberty in striking down a ban on intact D & E, the Court turned to a new "significant medical authority" test as the shield it would use to protect the use of intact D & E as an abortion method.

143 *See supra* Part II.

144 *See supra* Part II.A.

teeth to the state's interest in fetal life. Legally, all that was left of *Roe* was the postviability requirement that restrictions on abortion must include a life and health exception. And that health exception would be precious indeed for advocates of abortion rights, for depending on how broadly it would be interpreted, it could arguably circumvent postviability abortion restrictions with relative ease.[145]

Why would the *Stenberg* majority, including Justice Ginsburg, engage in logic that would open the door to the upholding of a law that omitted a health exception? The compelling answer seems to be that the *Stenberg* majority sought to use the physician-judgment veto remaining after *Casey* to justify striking down a ban on a popularly disfavored method of late-term abortion. As Justice Stevens complained in his concurrence, "[I]t [is] impossible for me to understand how a State has any legitimate interest in requiring a physician to follow any procedure other than the one that *he or she reasonably believes* will best protect the woman in her exercise of this constitutional liberty."[146] It would be one thing to simply require a facial health exception without much comment. It was entirely another to shore up the *Stenberg* decision with deference to physician judgment that resonates with common instinct that a doctor knows better than politicians whether intact D & E might be required late in a pregnancy, even though that doctor's decisionmaking may be colored by a fervent favoring of abortion rights.

However, there seemed more at play in *Stenberg* than just politicians versus doctors: there is an element of desiring to keep the abortion debate out of society and its legislatures in order to protect the abortion right from weakening. Even though Nebraska's law would "not save any fetus from destruction"[147]—or, to state it differently, even though Nebraska's law would not prevent a single woman from obtaining the abortion she seeks—Justice Ginsburg was concerned that "state legislators seek to chip away at the private choice shielded by *Roe v. Wade*."[148] While she prefers the abortion right to be premised solely on a woman's liberty,[149] she pulled out the physician veto card in this case of "emotional uproar"[150] as she, too, was eager to take the abortion prerogative out of society's purview and place it back in

145 *See supra* note 105.

146 Stenberg v. Carhart, 530 U.S. 914, 946 (2000) (Stevens, J., concurring) (emphasis added).

147 *Id.* at 951 (Ginsburg, J., concurring).

148 *Id.* at 952; *see also id.* at 946 (Stevens, J., concurring) (commenting that Justice Ginsburg had identified the underlying reason of the legislation).

149 *See supra* note 39 and accompanying text.

150 *Stenberg*, 530 U.S. at 951 (Ginsburg, J., concurring).

the physician's hands. She rounded out her concurrence by quoting Justice Stevens' comment that this should all be about what the "*doctor* 'reasonably believes'" is best for the woman's exercise of her abortion rights.[151]

While reading such intentions into *Stenberg*'s majority opinion might be a tricky and uncertain business, the "significant body of medical opinion" test articulated in *Stenberg* strongly suggests its efforts to renew the physician veto of *Roe*. Where *Casey* stated that the physician's position was derivative of the woman,[152] *Stenberg* implies that the woman's position is once again derivative of the physician's. *Stenberg*'s reasoning does not root itself in a woman's liberty or equality, but rather hinges entirely on her physician's judgment that a specific abortion procedure is necessary. There seems no other explanation for engaging in an argument so likely to result in a pyrrhic victory—likely, because once the categorical, bright-line health exception rule is transformed into the balancing calculus already handled by the "undue burden" test, the safety valve against any restrictions of abortions, whether pre- or postviability, is removed.[153]

IV. *CARHART*: REMOVING THE PHYSICIAN VETO AND ALLOWING THE ABORTION DEBATE TO TAKE FULL BLOOM

The *Stenberg* Court's efforts to revive solicitude for medical opinion regarding abortion allowed the *Carhart* Court "for the first time since *Roe* . . . [to] bless[] a prohibition with no exception safeguarding a woman's health."[154] Justice Kennedy was obviously displeased that the *Stenberg* Court had taken the undue burden test of *Casey* to mean some sort of strict scrutiny that would, like *Roe*, minimize the state's interest in the life of the fetus[155] and maximize the autonomy of the

151 *See id.* at 952 (emphasis added).

152 *See supra* note 86 and accompanying text.

153 The efficacy of the safety valve obviously depends on the scope of "health." *See supra* note 105.

154 Gonzales v. Carhart, 127 S. Ct. 1610, 1641 (2007) (Ginsburg, J., dissenting); *see also* Hill, *supra* note 5, at 319 ("[I]n a clear reversal of its prior approach to abortion cases—including that taken in [*Stenberg*]—the Court held that the absence of a health exception did not require invalidation of the PBABA on its face."); O. Carter Snead, *Unenumerated Rights and the Limits of Analogy: A Critique of the Right to Medical Self-Defense*, 121 HARV. L. REV. F. 1, 4 (2007), http://www.harvardlawreview.org/forum/issues/120/may07/snead.pdf ("*Carhart* seems to represent a departure from the virtually absolute privilege of a woman's health over the state's interest in promoting respect for fetal human life.").

155 *See Stenberg*, 530 U.S. at 960–61, 972 (Kennedy, J., dissenting) ("The *Casey* decision turned aside any contention that a person has the right to decide whether to have an abortion without interference from the State, and rejected a strict scrutiny

physician.[156] He wrote for the *Carhart* majority that a state's interest in the unborn "cannot be set at naught by interpreting *Casey*'s requirement of a health exception so it becomes *tantamount to allowing a doctor to choose the abortion method he or she might prefer.*"[157]

The independent requirements of *Casey* (the undue burden test and the health exception), muddled by the *Stenberg* Court in an effort to revive *Roe*'s physician veto, would, in *Carhart*, be folded together into the undue burden test,[158] which asks "'if [the law's] purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.'"[159] In analyzing the law's purpose, the *Carhart* majority decided that if the law's purpose is to further the state's interest in fetal life, then it will not require a health exception. Analyzing the law's effect, *Carhart* reconfigures *Stenberg*'s strict presumption in favor of medical opinion that favors abortion into a presumption in favor of society's wishes.

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standard of review as incompatible with the recognition that there is a substantial state interest in potential life throughout pregnancy." (internal quotation marks and citations omitted)).

156 *See id.* at 968–72 ("A ban which depends on the 'appropriate medical judgment' of Dr. Carhart is no ban at all. He will be unaffected by any new legislation. This, of course, *is the vice of a health exception resting in the physician's discretion.*" (emphasis added)).

157 *Carhart*, 127 S. Ct. at 1633 (emphasis added). It should be recalled that Justice Kennedy coauthored the *Casey* joint opinion that set out to reverse the first physician veto of *Roe*. *See supra* Part II.A.

158 *See* Hill, *supra* note 5, at 322. Professor Hill argues that *Carhart* is a "significant" modification of *Stenberg* because the *Carhart* Court

> analyzed the need for a health exception under the "undue burden" rubric, rather than treating it as a separate and independent constitutional requirement. Although some language in *Casey* could be read to suggest that the health exception was subject to undue burden analysis, the consensus had previously been that the health exception was a freestanding constitutional requirement.

Id. However, the discussion of *Stenberg*, *supra* Part III, indicates that *Carhart* did nothing to modify the fact that *Stenberg* allowed the possibility that a facial health exception might not be required. *Carhart* is different from *Stenberg* because of the way the Court treats the presence of medical disagreement, *see infra* Part IV.B, and not because of the determination that a facial health exception may not be required in laws restricting abortion procedures. If *Carhart* is a "significant" modification of *Stenberg*, then *Stenberg* is a complete hollowing out of all that remained of *Roe*'s actual legal premises (as opposed to its substantive abortion-right holding) after *Casey* with respect to the physician veto in the health exception requirement.

159 *Carhart*, 127 S. Ct. at 1632 (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 878 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.)).

A. *Examining the Purpose of the "Partial-Birth Abortion Ban": The State Interests Cited in* Carhart *Show No Special Solicitude for Physicians*

> Physicians are not entitled to ignore regulations that direct them to use reasonable alternative procedures. The law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community.
>
> —Justice Anthony Kennedy[160]

Unpacking Justice Kennedy's groundbreaking statement that a health exception does not mean a physician is "unfettered," one finds the Court, for the first time, explicitly making a conscious effort to flesh out what state interests are corollary to *Casey*'s newly vivified interest in the life of the fetus. This is done while repeatedly disavowing any physician judgment or autonomy veto that might be raised in an attempt to foreclose any jurisprudential consideration of these state interests.

For example, concern for the health of the woman, which in *Roe* meant concern only to ensure she receives a safe abortion,[161] now expressly includes concerns about the disputed adverse effects of abortion on women.[162] While the Court could not reliably quantify the phenomenon, it noted that "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."[163] The Court expressed concern that physicians

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160 *Id.* at 1636. For an in-depth discussion of two competing doctrines in our nation's jurisprudence regarding physician autonomy—public health restrictions of autonomy versus absolute physician autonomy—and how *Carhart* represents a shift from the notion of abortion as matter of physician autonomy to abortion as a matter of public health, see generally Hill, *supra* note 5.

161 *See supra* note 26.

162 *See supra* notes 106–07 and accompanying text.

163 *Carhart*, 127 S. Ct. at 1634. Many have seized upon this specific language of the Court as being offensively paternalistic. *See, e.g.*, Gostin, *supra* note 5, at 1564 ("The view that the state must protect women making autonomous reproductive decisions is premised on an antiquated notion about a woman's place in society and under the Constitution. This new paternalism implies that women are confused when they seek an abortion; or that abortion will cause feelings of guilt, shame, and sadness."). Yet, in evaluating such arguments, it must be recalled that it was a woman, Justice O'Connor, who first recognized in *Casey* the potentially adverse effects of abortion on women. *See supra* note 109 and accompanying text. It must also be noted that it was Mary Doe, from *Doe v. Bolton*, who filed the amicus brief in *Carhart* cataloguing the apparent fact that some—as yet indeterminate—percentage of women who have had an abortion have suffered long-term ill effects from their decision. *See generally*

were withholding information from women about what an abortion exactly entails, aggravating psychological harm to some women.[164] Thus, the Court opined in dicta that physicians ought not have full autonomy to "prefer not to disclose precise details of the means that will be used" and that "[i]t is . . . precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State."[165]

Another corollary interest that the *Carhart* Court recognized is that of "'drawing a bright line that clearly distinguishes abortion and infanticide.'"[166] The prerogative of drawing that line is not to lie with the physician, as it implicitly did in *Stenberg*.[167] *Carhart* sees it as a legitimate interest for society to say that a procedure has a "disturbing similarity to the killing of a newborn infant."[168] Justice Stevens took great exception to Nebraska's advancement of this interest in *Stenberg*, pointing out that nonintact D & E abortion is "equally gruesome" and that calling intact D & E any more akin to infanticide than nonintact D & E "is simply irrational."[169] Justice Ginsburg has been equally mystified at the attempt to distinguish fetal dismemberment inside the womb from the intact D & E skull-crushing procedure.[170] Assuredly,

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Brief of Sandra Cano, *supra* note 107 (quoting 178 affidavits of post-abortive women reporting adverse psychological effects that abortion caused them).

164 Specifically, 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 physician to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.

Carhart, 127 S. Ct. at 1634. These disputed adverse effects of abortion on women are obviously a huge flashpoint in our culture today, but the issue is one that the law—and society—will have to resolve. Whether this obverse health concern of *Carhart* is a result of the experience of nearly thirty-five years of widespread legal abortion in the United States, or whether it is simply a political weapon being wielded for ideological reasons, which must necessarily lie outside the cognizance of our government, will undoubtedly be deeply and passionately contested for years to come.

165 *Id.*

166 *Id.* at 1633–34 (quoting 18 U.S.C. § 1531 note (Supp. V 2005)).

167 The *Stenberg* majority's sanctioning of constitutional protection for both intact D & E and nonintact D & E implies that the government cannot distinguish one as being more akin to infanticide than the other, and thus that distinction was left to the individual judgment of the physician.

168 *Carhart*, 127 S. Ct. at 1633.

169 Stenberg v. Carhart, 530 U.S. 914, 946 (2000) (Stevens, J., concurring).

170 *See id.* at 951 (Ginsburg, J., concurring) ("[T]he most common method of performing previability second trimester abortions is no less distressing or susceptible to gruesome description."); *see also Carhart*, 127 S. Ct. at 1647 (Ginsburg, J., dissenting) ("Nonintact D & E could equally be characterized as brutal, involving as it does tear-

part of the concern of Justices Ginsburg and Stevens is that if intact D & E is truly ethically indistinguishable from nonintact D & E, then the Court might face that fact some day and decide that nonintact D & E may also be banned. While the crossfire over this particular question necessarily involves highly evocative language, taking a step back, it can be recognized that Justices Ginsburg and Stevens may have a point,[171] and that the Court will undoubtedly have to grapple with this in the future now that *Carhart* has squarely placed decisionmaking authority on this issue not in the physician's hands, but in the hands of the legislatures.[172]

Finally, a notable corollary interest recognized in *Carhart* is that of a concern "with the effects on the medical community and on its reputation caused by the practice of partial-birth abortion."[173] While *Roe* did not expressly state that the medical community is responsible for maintaining its own standards and ensuring the quality of its own reputation, this was implied in its refusal to allow any state regulation of abortion in the first trimester, and to allow state regulation in the second trimester only to keep abortion safe.[174] *Roe* took the fact that first trimester abortion is statistically safer for the life of the woman than natural childbirth[175] as a license for the medical community to regulate itself in this area; it was not the state's business to make first trimester abortions even safer. *Carhart* turned this approach on its head; now legislatures may seek to maintain the high regard society has for the medical community by requiring that it not perform procedures repugnant to its sense of a physician's role in promoting life and well-being.[176]

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ing a fetus apart and ripping off its limbs." (internal quotation marks, citations, and alterations omitted)).

171 Inevitably, this sort of line drawing may involve distinctions that seem highly arbitrary and unfounded, *cf.* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 870 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.), fueled more by passionate interest in securing rights for either the woman or the fetus than by rational decisionmaking.

172 "Congress could nonetheless conclude that the type of abortion proscribed by the Act requires specific regulation because it implicates additional ethical and moral concerns that justify a special prohibition." *Carhart*, 127 S. Ct. at 1633. In *Casey*, the Court stated that "[c]onsistent with other constitutional norms, legislatures may draw lines which appear arbitrary without the necessity of offering a justification. But courts may not. We must justify the lines we draw." *Casey*, 505 U.S. at 870 (joint opinion of O'Connor, Kennedy & Souter, JJ.) (justifying the viability line as being the point at which a woman's liberty interest gives way to the life interest of the fetus).

173 *Carhart*, 127 S. Ct. at 1633.

174 *See supra* note 26.

175 *See supra* note 26.

176 The *Carhart* Court sanctioned Congress' findings that

Noting the interests highlighted by the *Carhart* majority accentuates what the Court was saying: that the lack of a health exception in a law restricting abortion does not automatically mean that the law has the "*purpose* . . . [of] 'plac[ing] a substantial obstacle in the path of a woman seeking an abortion.'"[177] It also accentuates the rational basis test announced by the Court for testing the purpose of a law restricting abortion:

> [w]here it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its *legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn.*[178]

Thus, at least when testing the legitimate *purpose* of a law restricting a particular method of abortion, there is reason to believe that it may always withstand the rational-basis purpose test[179] because any law restricting abortion could, by definition, further the state's interest in promoting respect for the life of the unborn. After *Carhart*, legislatures now have something to say about the medical profession's attitude toward the unborn and the physician veto retained by *Casey* is no longer absolute in its ability to facially invalidate a law lacking a health exception.

> [p]artial-birth abortion . . . confuses the medical, legal, and ethical duties of physicians to preserve and promote life, as the physician acts directly against the physical life of a child, whom he or she had just delivered, all but the head, out of the womb, in order to end that life.

Carhart, 127 S. Ct. at 1633 (quoting 18 U.S.C. § 1531 note (Supp. V 2005)); *cf.* Snead, *supra* note 154, at 5–6 ("In other words, the purpose of the law was actually to prevent the moral degradation of society. The Court thus held that the governmental interest in preventing this moral harm outweighed the individual's belief that a particular abortion procedure might be necessary for her health.").

177 *Carhart*, 127 S. Ct. at 1635 (emphasis added) (quoting *Casey*, 505 U.S. at 878 (joint opinion of O'Connor, Kennedy & Souter, JJ.)).

178 *Id.* at 1633 (emphasis added).

179 Whether such a law will withstand the *effects* test is another question. *See infra* Part IV.B. *Carhart*'s language is limited to this particular circumstance, where another abortion procedure is available for the gestation period in question. It will remain a question until the next major abortion battle before the Court implicating a health exception before we know whether the Court will limit the seismic removal of the absolute health exception requirement of *Roe* to the facts of *Carhart*, or whether it will extend it to future fact situations.

B. The Meaning of Disagreement over Health Risks: Testing the Effects of a Law

A law will be considered an unconstitutional undue burden on a woman's right to an abortion if it has the *effect* of subjecting women to significant health risks.[180] Like *Stenberg*, the *Carhart* Court faced hotly contested opinions about whether the Act "creates significant health risks for women."[181] Medical disagreement existed and was heavily documented,[182] but the question, as in *Stenberg*, was what to do in the face of that disagreement. Could the Act "stand when this medical uncertainty persists"?[183]

At this point, it should come as no surprise that the answer was a resounding "yes." The *Carhart* majority declared that "physicians are not entitled to ignore regulations that direct them to use reasonable alternative procedures"[184] and that "[t]he law need not give abortion doctors unfettered choice in the course of their medical practice, nor should it elevate their status above other physicians in the medical community."[185]

It is well known that Chief Justice Rehnquist, and Justices Scalia and Thomas have held the position for many years that the Constitution has nothing to say about abortion and that it is a question that should be left to the legislatures of the states.[186] In an all but explicit overruling of *Stenberg*, the *Carhart* majority paid homage to that position by holding that legislatures could properly consider issues of marginal safety—a balancing of risks—so long as the regulation was

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180 *See Carhart*, 127 S. Ct. at 1635 (citing *Casey*, 505 U.S. at 880 (1992)).

181 *Id.*

182 *See id.* at 1635–36. Congress had found that intact D & E is never a necessary abortion procedure. *See id.* at 1624. Meanwhile, "[t]he district courts had compiled a vast evidentiary record of medical opinion that intact D & E is a recognized method to protect the woman's health in appropriate cases." Gostin, *supra* note 5, at 1563; *see also Carhart*, 127 S. Ct. at 1636 (discussing the findings of the three district courts to pass on the issue); Snead, *supra* note 154, at 5 ("Opponents of the law argued that there were imaginable circumstances in which the procedure would be the safest method of abortion; defenders retorted that there were always safe alternatives available (including the *in utero* killing of the fetus followed by intact dilation and extraction).").

183 *Carhart*, 127 S. Ct. at 1636.

184 *Id.*

185 *Id.*; *see also* Planned Parenthoood of Se. Pa. v. Casey, 505 U.S. 833, 884 (joint opinion of O'Connor, Kennedy & Souter, JJ.) ("[T]he physician-patient relation here is entitled to the same solicitude it receives in other contexts.").

186 *See, e.g.*, *Casey*, 505 U.S. at 944–79 (Rehnquist, J., dissenting); *id.* at 979–1002 (Scalia, J., dissenting).

"rational and in pursuit of legitimate ends."[187] Noting the existence of medical uncertainty will not be the veto that *Stenberg* made it to be. Expressly laying to rest the physician veto, the Court declared that "[t]he Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman's health" given available alternative and safe procedures.[188]

The Court's decision in *Carhart* would have been much more difficult to reach had the *Stenberg* Court maintained the *Roe* and *Casey* bright-line health exception requirement. Since *Stenberg* turned the health exception rule into a balancing question, the Court in *Carhart* was able to engage in a functional analysis similar to that of *Stenberg*, while attaching a polar opposite significance to medical uncertainty claims raised by physicians in favor of permitting intact D & E. As Justice Kennedy indicated he would like to do in his dissent in *Stenberg*, the *Carhart* Court declared the physician veto a thing of the past.[189]

C. *Taking Stock: The Significance of* Carhart

The silver lining for those alarmed by the seismic shift that *Carhart* represents is that a court may always read the health exception into a law in an as-applied challenge.

> [An as-applied challenge] is the proper manner to protect the health of the woman if it can be shown that in discrete and well-defined instances a particular condition has or is likely to occur in which the procedure prohibited by the Act must be used. In an as-applied challenge the nature of the medical risk can be better quantified and balanced than in a facial attack.[190]

In such a challenge, the Court might engage in an analysis analogous to that which it used to uphold the medical emergency provision in *Casey*.[191] It seems that the point for the *Carhart* majority is that the law would not be struck down on its face when it furthers what the Court considers to be important state interests. Justice Ginsburg stated in her dissent that "[t]he very purpose of a health *exception* is to protect women in *exceptional* cases."[192] Given the Court's implicit rejection of the arguments that intact D & E was necessary for the psychological health of the woman who preferred it to the dismemberment method

187 *Carhart*, 127 S. Ct. at 1638.

188 *Id.*

189 *See supra* note 156 and accompanying text.

190 *Carhart*, 127 S. Ct. at 1638–39.

191 *See supra* note 105.

192 *Carhart*, 127 S. Ct. at 1651 (Ginsburg, J., disssenting).

of nonintact D & E,[193] it appears that Justice Kennedy and the *Carhart* majority are saying, "Justice Ginsburg, that's exactly the point."

Carhart might be read as a decision of only symbolic, moral, and/or political value. The strict construction the Court gave to the Partial-Birth Abortion Ban Act led it to conclude that the scope of the Act's prohibition was narrow and that prosecutorial discretion would be limited.[194] Additionally, as Justice Ginsburg warned the Court's majority, "[t]he [Partial-Birth Abortion Ban Act] saves not a single fetus from destruction, for it targets only a *method* of performing abortion."[195] One might even read the Court itself as suggesting that the Act was constitutional *because* it was merely symbolic, for a woman's ability to obtain late-term abortions is not hindered at all, as Justice Ginsburg implicitly noted: the far more common late-term abortion procedure, nonintact D & E, would still be available. Thus, there is a sense in which the law was a mere "'structural mechanism by which the State . . . may express profound respect for the life of the unborn'" because women may still "'exercise . . . the right to choose.'"[196]

Despite that symbolic aspect of *Carhart*, the decision has real teeth. *Carhart* plainly contradicts the part of *Stenberg* that revived judicial deference and solicitude to the privacy of a physician's choices, a physician's autonomy, and a physician's judgment, inaugurated in *Roe*. The argument that a physician ought to have absolute clinical freedom in the abortion context,[197] has been laid to rest—at least for now—by the Court's holding that the state has an interest in protecting the life of the fetus that cannot be automatically vetoed by facial attacks against its laws for failure to include a health exception. Though Congress' findings contained some factually incorrect state-

193 *See* Transcript of Oral Argument at 43, *Carhart*, 127 S. Ct. 1610 (No. 05-1382), *available at* www.supremecourtus.gov/oral_arguments/argument_transcripts/05-1382.pdf ("It's a very personal decision how the woman who has made this very difficult moral/religious decision to end her pregnancy . . . how does she want the fetus to undergo demise?").

194 *Carhart*, 127 S. Ct. at 1629.

195 *Id.* at 1647 (Ginsburg, J., dissenting).

196 *Id.* at 1627 (majority opinion) (quoting Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833, 877 (1992) (joint opinion of O'Connor, Kennedy & Souter, JJ.)).

197 *See, e.g.*, Gostin, *supra* note 5, at 1563 ("[The Partial-Birth Abortion Ban Act] creates a chilling effect on the freedom to practice in accordance with the exercise of clinical judgment. . . . Provided that medical procedures are recognized by distinguished medical opinion and chosen by patients in consultation with their physicians, these therapeutic decisions [to have an abortion] appear to be outside the legitimate sphere of state power.").

ments,[198] "[a] zero tolerance policy would strike down legitimate abortion regulations, like the present one, if some part of the medical community were disinclined to follow the proscription."[199] Society, through Congress, has now been allowed to act in the face of reasonable medical disagreement about the safety and preferability of a method of abortion.

CONCLUSION

This Note has traced the birth, life, and eventual death of the physician veto from *Roe* through *Carhart* as a means of understanding the meaning of *Carhart*. While gender equality theorists may not appreciate the outcome of *Carhart*, they ought to appreciate the implication of this discussion because the abortion debate may now take place on its core terms: the interests of women and the interests of unborn humans. These core terms, including the interests of women, need not hide any longer behind the law's granting of a veto power to ideologically driven physicians on either side of the debate. If *Carhart* has any staying power, it has enabled a full flowering of this debate by removing the physician veto so unique to the abortion context, and by clearing the way for a richer understanding of what interests are at stake for women and fetuses. It has allowed society, through its elected representatives, to exercise a newly, if only marginally, increased degree of autonomy in allowing the myriad voices and concerns surrounding abortion to enter into discussion with each other without judicial use of a physician's veto to silence the debate. Certainly, physicians' voices will play a necessary, but ancillary, role in the future. That ancillary role, if accepted gracefully, will add to an understanding of the interests at stake by providing an unbiased, objective, and expert understanding of women's health issues and the nature of the fetus, but will no longer inhibit the core issues from being considered on their own terms. That is the meaning of *Carhart*.

198 *See Carhart*, 127 U.S. at 1637–38. Specifically, it was incorrect for Congress to claim that no medical school taught the intact D & E procedure and to claim that a medical consensus existed that the prohibited procedure is never medically necessary. *See id.*

199 *Id.* at 1638.