

PREGNANCY’S RISKS AND THE HEALTH EXCEPTION IN ABORTION JURISPRUDENCE

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ABSTRACT

Current abortion jurisprudence provides logically sufficient grounds for universal access.

Under the health exception, abortion-regulating legislation must explicitly permit abortion access when a pregnancy threatens a pregnant person’s health. This article argues that, given the universal risks of pregnancy and birth, the reasoning of the health exception supports abortion access for all pregnancies, pre-and post-viability.

Though the Court has presumed risks in pregnancy to be rarities, contemporary medical research into pregnancy and birth make clear how sweepingly common, unpredictable, severe, and multiple health risks remain. Since 1999, maternal mortality and morbidity rates – both persistently worse for people of color – have been increasing. Combining the legal standard and medical research, this article demonstrates that according to the logic of the health exception, abortion should be permitted in all circumstances, as each pregnancy and birth poses a threat to the pregnant person’s health.

This logical consequence has implications for abortion access. If the health exception were given the effect this article argues both jurisprudence and medical research mandate, abortion should be available whenever sought, viability-defining legislation notwithstanding.

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INTRODUCTION

Jurisprudence mandates that abortion-regulating legislation must explicitly permit abortion access when a pregnancy threatens a pregnant person’s life or health. As a general rule, statutes that limit access to abortion but do not specify a “health exception” are, *per se*, unconstitutional.¹ This article argues that, given the universal and inherent risks of pregnancy and birth, the health exception provides sufficient grounds for abortion access for all pregnancies, pre- and post-viability.

Pregnancy and birth are fraught with health dangers and pain for the pregnant person.² They prove lethal with frightening frequency.³ Since 1999, maternal mortality and morbidity rates—both persistently worse for people of color⁴—have been increasing.⁵ Through the health exception established in *Roe v. Wade*, the Supreme

1. *Gonzales v. Carhart*, 550 U.S. 124, 125 (2007). Notwithstanding, the rule held.

2. *See, e.g., id.* at 140 (“[I]n a cesarean section, the doctor removes the fetus by making an incision through the abdomen and uterine wall to gain access to the uterine cavity.”).

3. *See* Weinberger v. Wiesenfeld, 420 U.S. 636, 639 (1975) (“Paula died in childbirth.”); Emily E. Petersen et al., *Racial/Ethnic Disparities in Pregnancy-Related Deaths—United States, 2007–2016*, 68 MORBIDITY & MORTALITY WKLY. REP. 762 (2019), available at https://www.researchgate.net/publication/335663086_RacialEthnic_Disparities_in_Pregnancy-Related_Deaths_-_United_States_2007-2016 (“During 2007–2016, a total of 6,765 pregnancy-related deaths occurred in the United States (PRMR = 16.7 per 100, 000 births). PRMRs were highest among black (40.8) and AI/AN (29.7) women; these rates were 3.2 and 2.3 times the PRMR for white women (12.7). From 2007–change significantly over time.”).

4. *Id.*; *see also* GOPAL K. SINGH, DEP’T OF HEALTH AND HUM. SERV., HEALTH RES. AND SERV. ADMIN., MATERNAL AND CHILD HEALTH BUREAU, MATERNAL MORTALITY IN THE UNITED STATES, 1935–2007: SUBSTANTIAL RACIAL/ETHNIC, SOCIOECONOMIC, AND GEOGRAPHIC DISPARITIES PERSIST (2010) (“The risk of maternal mortality remained 3 to 4 times higher among black women than white women during the past 6 decades.”); *cf.* Marian F. MacDorman et al., *Is the United States Maternal Mortality Rate Increasing? Disentangling trends from Measurement Issues*, 128 OBSTET. GYNECOL. 447 (2016) (suggesting that U.S. mortality rates are even higher).

5. Holly B. Shulman et al., *The Pregnancy Risk Assessment Monitoring System (PRAMS): Overview of Design and Methodology*, 108 AM. J. PUB. HEALTH 1305 (2018), available at <https://www.cdc.gov/prams/pdf/methodology/PRAMS-Design-Methodology-508.pdf>; American College of Obstetricians and

Court has tacitly acknowledged these risks. It recognized that a pregnant person's health may be at odds with fetal life, and it established that the pregnant person's interest in their own health trumps, regardless of fetal viability.⁶ The health exception may be understood as the doctrinal assertion that a person's wellbeing matters despite their reproductive capacity; it prioritizes a pregnant person's health over the fetus in gestation. In short, the health exception is a doctrinal escape hatch from abortion limitations when pregnancy threatens health.

Yet, the health exception's logical heft and the protection for pregnant people that it should provide through the full course of pregnancy have been underutilized and given short shrift, despite both legal doctrine and medical realities making it essential and widely applicable. Though the Court's presumption has been that these risks threatening pregnant people are rarities, a medical understanding of pregnancy establishes that the risks are sweepingly common.⁷ Contemporary medical findings about pregnancy make clear how frequent, unpredictable, severe, and numerous the risks of pregnancy remain.⁸ Moreover, the physiological byproducts of pregnancy and the act of giving birth itself can present hazards to health.⁹ The full ramifications and doctrinal implications of these risks must be acknowledged in the context of abortion access.

This article has three parts. Part I tracks the health exception through abortion jurisprudence, establishing that it has consistently offered broad protections to pregnant people. Part II examines recent medical research into pregnancy and birth, and finds that every pregnancy presents risks to health. Part III combines the legal standard and medical research to demonstrate that under the logic of the health exception, abortion should be permitted in all circumstances, as each pregnancy—up to and including birth itself—poses a threat to a pregnant person's health.

Gynecologists, *Severe Maternal Morbidity: Screening and Review*, 5 OBSTETRIC CARE CONSENSUS (Sept. 2016), <https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2016/09/severe-maternal-morbidity-screening-and-review> (“Like maternal mortality, severe maternal morbidity is increasing in the United States.”); William N. Callaghan et al., *Severe Maternal Morbidity among Delivery and Postpartum Hospitalizations in the United States*, 120 OBSTET. GYNECOL. 1029 (2012); see also CENTERS FOR DISEASE CONTROL AND PREVENTION, SEVERE MATERNAL MORBIDITY IN THE UNITED STATES, <http://www.cdc.gov/reproductivehealth/maternalinfanthealth/severematernalmorbidity.html>; Petersen, *supra* note 3; Donna L. Hoyert, & Arialdi M. Miniño, *Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018*, 69 NAT'L VITAL STAT. REPORTS, 2 (2020).

6. See *Roe v. Wade*, 410 U.S. 113, 164 (1973).

7. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 850–51 (1992) (“The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter, except perhaps in those rare circumstances in which the pregnancy is itself a danger to her own life or health, or is the result of rape or incest.”).

8. See *infra* Section II.A.

9. See *infra* Section II.B.

I. THE HEALTH EXCEPTION: DOCTRINE

The health exception has been part of abortion jurisprudence since abortion was first recognized as a constitutional right.¹⁰ The underlying logic of the health exception is even older still. This section, first, reviews Supreme Court precedent on the doctrine and, second, offers an explanation of the exception's legal basis.

A. JURISPRUDENCE ESTABLISHING, AND REAFFIRMING, THE HEALTH EXCEPTION

Whereas health-justified laws that limit abortion arise from a state's interest in the health of pregnant people broadly and collectively, the health exception protects an individual pregnant person's interest in their own health. While the state's interest in health might find use in limiting abortion, the health exception tilts toward abortion availability. The health exception is therefore distinct from state interests that might justify limits on abortion, both in what work it does and how it does it. This section reviews the cases that have inscribed the health exception as a cornerstone for abortion access.

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

The Supreme Court first recognized the health exception in *Roe v. Wade*, in which it held unconstitutional Texas statutes that prohibited abortion except where necessary to save a pregnant person's life.¹¹ The Court, finding the right to abortion fundamental, concluded that limiting access to abortion to only those instances in which the pregnant person's life was at risk was too restrictive; abortion must also be permitted to preserve a pregnant person's health.¹²

Roe recognized two distinct interests in the health of pregnant individuals. The first interest belonged to the state — to preserve the health of pregnant people generally.¹³ The second interest in health belonged to the pregnant person — to preserve their own health. The health exception is the doctrinal manifestation of this second interest. This interest in health was individual, personal, and particular.¹⁴ Importantly, *Roe* instructed that, where triggered, the health exception

10. *See Roe*, 410 U.S. at 113.

11. *See id.* at 153 (recognizing abortion to be a fundamental right that fell within the right of personal privacy, in turn founded in the Fourteenth Amendment's protection of personal liberty).

12. *See* 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, 230 (1985) ("When *Roe v. Wade* held that the state must allow therapeutic abortions after viability, the Court established that even compelling governmental interests do not defeat all competing claims.").

13. *Roe*, 410 U.S. at 163. The Court identified the state's interests in regulating abortion as "protection of health, medical standards, and prenatal life." *Id.* at 155. Under the trimester framework laid out in *Roe*, the state could not impose health-justified regulations on access to abortion during the first trimester. Thereafter, the Court determined that the state interest in health became "compelling" and could justify abortion-limiting regulation, "to the extent that the regulation reasonably relates to the preservation and protection of maternal health." *Id.* at 163. The state interest in prenatal life is outside the scope of this article, except as it intersects with the health exception.

14. *See id.* at 165.

overrode any state interest to the contrary.¹⁵ From viability forward, though the state could regulate abortion, and “go so far as to proscribe” it, abortion must be allowed “when it is necessary to preserve the life or health of the mother.”¹⁶ The Court thus recognized the health exception — a personal interest in health superseding the state’s general interest in regulating abortion for any reason. *Roe* did not explain the exception’s legal origin or limit the exception.

Roe did not define health in its holding but twice referenced an earlier case, *United States v. Vuitch*, 402 U.S. 62 (1971), in which the Supreme Court rejected the district court’s finding that the word “health” in a statute prohibiting abortion but for situations where life and health were at risk was vague.¹⁷ Though “true that the legislative history of the statute gives no guidance as to whether ‘health’ refers to both a patient’s mental and physical state,”¹⁸ the Court in *Vuitch* reasoned that the meaning of the term, as well as a prior district court opinion interpreting the statute and subsequent appellate decision following that “construction” provided enough definitional guidance to instruct a doctor and a jury as to permissible—and impermissible—behavior and, thus, satisfied due process.¹⁹ In this way, *Roe* folded *Vuitch*’s reading of health into its own.

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

In the companion case to *Roe*, *Doe v. Bolton*, 410 U.S. 179 (1973), the Court expanded on the health exception. *Doe* concerned a challenge to a Georgia statute that threatened abortion providers with a felony conviction and sentence of up to ten years in prison.²⁰ Unlike the statute at issue in *Roe*, this Georgia statute contained a health exception, albeit a narrow one: Abortion could be provided when a doctor, “based upon his best clinical judgment,” believed “continuation of the pregnancy would endanger the life of the pregnant woman or would *seriously and permanently* injure her health.”²¹

The district court upheld the statute but struck the cabining adjectives “seriously” and “permanently” from it as overly restrictive.²² The Supreme Court

15. *See id.* at 164–65 (“[S]ubsequent 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.”).

16. *Id.* at 163–64.

17. *United States v. Vuitch*, 305 F. Supp. 1032 (D.D.C. 1969), *rev’d*, 402 U.S. 62 (1971) (quoting D.C.C.E § 22-201).

18. *United States v. Vuitch*, 402 U.S. 62, 71 (1971) (“The House Report on the bill contains no discussion of the term ‘health’ and there was no Senate report.”).

19. *Id.* at 71–72 (referencing *Doe v. Gen. Hosp.*, 313 F. Supp. 1170 (D.D.C. 1970), *rev’d*, 434 F.2d 423, 427 (D.C. Cir. 1970)).

20. The statute was modeled on the American Law Institute (ALI), Model Penal Code, Section 230.3. *See Doe v. Bolton*, 410 U.S. 179, 182 (1973).

21. *Bolton*, 410 U.S. 179, 182–83 (1973) (emphasis added). *See generally* I. Glenn Cohen (arguing that exceptions for rape and incest, like a separate provision of this ALI statute, is a mental health exception).

22. *Bolton*, 410 U.S. at 186.

affirmed, holding that it was unconstitutional for the statute to prevent doctors from providing abortion “based upon his best clinical judgment that an abortion is necessary.”²³ The original statutory text providing an exemption for abortion only to avoid “serious[] or permanent[] injur[y] to health” was insufficient to safeguard health,²⁴ but the statute was valid as interpreted by the district court.²⁵

Importantly, the Court also elaborated on the meaning of health. Under *Doe*, health includes: “all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient.”²⁶ The purpose of this expansive idea of health was to provide broad latitude to the physician to “operate for the maximum benefit, not the disadvantage, of the pregnant woman.”²⁷ Of note, a doctor “is not now restricted to the situations originally specified. Instead he may range farther afield wherever his medical judgment, properly and professionally exercised, so dictates and directs him.”²⁸ In defining necessary, the Court deferred to medical practitioners, allowing a doctor to determine what was “necessary” in “his professional, that is his best[,] clinical judgment.”²⁹ *Doe* supplemented *Roe*’s requirement for a mandatory health exception with an encompassing definition of health.³⁰

3. *Planned Parenthood of Southeastern Pennsylvania v. Casey*, 505 U.S. 833 (1992)

Casey upheld the core ruling of *Roe*—that a woman’s decision to terminate a pregnancy is a liberty protected by the Fourteenth Amendment’s Due Process Clause—and reaffirmed the health exception as a central principle of abortion

23. *Id.* at 191.

24. Georgia’s General Assembly repealed the statute at issue in *Doe* one month later. See *Doe v. Bolton*, 126 F.R.D. 85, 86 (N.D. Ga. 1989). Subsequent actions by other states that had incorporated the ALI’s model statutes into their criminal codes indicate also that, after *Roe*, the ALI’s narrowly defined exceptions for health were widely regarded as unconstitutional. See *Doe*, 410 U.S. at 205–07 (setting out the Model Penal Code provision). In Delaware, for example, the Attorney General issued a policy statement indicating that in its opinion, consequent to *Roe* and *Doe*, “many portions of the Delaware abortion law were unconstitutional . . .,” modeled on the ALI, and hence were unenforceable. See *Del. Women’s Health Org., Inc. v. Wier*, 441 F. Supp. 497, 498–99 n.9 (D. Del. 1977). The South Carolina Supreme Court, too, held that the state’s abortion regulation, modeled on the ALI’s proposed code, despite having “joined the trend toward liberalization of its abortion statutes by the adoption of less stringent laws[. . .] falls to the ruling of the United States Supreme Court.” *State v. Lawrence*, 261 S.C. 18, 21–22, 198 S.E.2d 253, 255 (1973). The State Supreme Court of New Jersey, though finding an ALI-modeled statute valid as applied against a non-physician, regarded *Doe* as approving the lower court’s invalidation of the limits on health. See *State v. Norflett*, 67 N.J. 268, 279 (1975). The cabining of health justifications was understood, in 1973, by state and federal courts alike, to be unconstitutional per *Doe*.

25. *Bolton*, 410 U.S. at 191.

26. *Id.* at 192.

27. *Id.*

28. *Id.* at 191.

29. *Id.*

30. As in *Roe*, vagueness was also alleged against the text that remained after the district court struck the constitutionally offensive limitations from the statute. *Doe*, 410 U.S. at 191–92. But *Doe* held that the remaining statute was not vague, a proposition for which it cited *United States v. Vuitch*, 402 U.S. 62 (1971). See *Doe*, 410 U.S. at 191.

jurisprudence.³¹ The state may “regulate, and even proscribe abortion” after viability,³² “so long as the law creates an exception ‘for pregnancies which endanger the woman’s life or health.’”³³ Consistent with *Roe*’s articulation of the exception, the plurality opinion is clear and unwavering. As in *Roe*, state restrictions after viability are permissible “provided the life or health of the mother is not at stake.”³⁴ *Casey* so clearly accepted that mental health was part of health, unmodified, that it asserted as much as if a truism.³⁵

Nevertheless, *Casey* altered the abortion-regulation landscape. *Casey* established viability as the single threshold after which abortion could be prohibited and asserted a new standard of review for abortion-restrictive statutes—the undue burden test.³⁶ In this new jurisprudential regime, health-justified abortion regulations

31. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 847 (1992) (“It is a promise of the Constitution that there is a realm of personal liberty which the government may not enter.”).

32. *Id.* at 879 (“We also reaffirm *Roe*’s holding that ‘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.’” (quoting *Roe v. Wade*, 410 U.S. at 164–65)).

33. *Id.* at 846.

34. *Id.* at 871–72, 846 (“Second is a confirmation of the State’s power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman’s life or health.”).

35. *See id.* at 882 (“It cannot be questioned that psychological well-being is a facet of health.”). The Court’s discussion in *Harris v. McRae* of *Roe*, cited in *Casey*, buttresses this inclusion of mental health in the concept of health safeguarded by the health exception.

It is evident that a woman’s interest in protecting her health was an important theme in *Wade*. In concluding that the freedom of a woman to decide whether to terminate her pregnancy falls within the personal liberty protected by the Due Process Clause, the Court in *Wade* emphasized the fact that the woman’s decision carries with it significant personal health implications—both physical and psychological. 410 U.S. at 153. In fact, although the Court in *Wade* recognized that the state interest in protecting potential life becomes sufficiently compelling in the period after fetal viability to justify an absolute

criminal prohibition of nontherapeutic abortions, the Court held that even after fetal viability a State may not prohibit abortions “necessary to preserve the life or health of the mother.

Harris v. McRae, 448 U.S. 297, 316 (1980) (quoting *Roe*, 410 U.S. at 164)). *See also Doe v. Bolton*, 410 U.S. 179, 191–92 (1973) (“That statute has been construed to bear upon psychological as well as physical wellbeing. This being so, the Court concluded that the term ‘health’ presented no problem of vagueness. ‘Indeed, where a particular operation is necessary for a patient’s physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered.’ *Id.* at 72. This conclusion is equally applicable here.” (quoting *United States v. Vuitch*, 402 U.S. 62, 72 (1971))). Courts continue to recognize mental health as a component of health for purposes of the health exception. *See Summit Med. Ctr. of Ala., Inc., v. Siegelman*, 227 F. Supp. 2d 1194, 1200 (2002); *see also Women’s Med. Prof’l Corp. v. Voinovich*, 130 F.3d 187, 210 (6th Cir. 1997), *cert. denied*, 523 U.S. 1036 (1998) (“An adequate life and health provision must cover not only situations where the woman is facing physical harm but also ‘situations where a woman is faced with the risk of severe psychological or emotional injury which may be irreversible.’”); *Casey*, 505 U.S. at 882 (“It cannot be questioned that psychological well-being is a facet of health.”). *See generally Bolton*, 410 U.S. at 192; Brief for Respondent at 46–48, *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830), 2000 WL 340275 at *46.

36. *Casey*, 505 U.S. at 870, 877 (citations omitted) (“A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.”).

were valid, subject to constraints, from the outset of pregnancy.³⁷

These changes were consequential and lessened somewhat judicial protection of the right to abortion, but they did not affect the clarity or meaning of the health exception. Indeed, the undue burden test does not apply to questions of access where the pregnant person's health was threatened. Post-viability, "the State's interest in fetal life is constitutionally adequate to justify a legislative ban on non-therapeutic abortions," but not those that are therapeutic.³⁸ *Casey* overruled *City of Akron v. Akron Center for Reproductive Health*, 462 U.S. 416 (1983), which held certain health-justified regulations unconstitutional, and *Thornburgh v. American College of Obstetricians and Gynecologists*, 476 U.S. 747 (1986), "to the extent" that those cases invalidated statutes requiring "the giving of truthful, non-misleading information" about the abortion procedure and "the attendant health risks and those of childbirth."³⁹ But *Casey* did not overrule those cases whole cloth and left standing the portions of those opinions that addressed matters other than the state interest in fetal life.⁴⁰ Thus, those decisions' language on the imperativeness of safeguarding the pregnant person's health can be understood as ratified, not overruled, by *Casey*.

When applying the health exception, however, the plurality seemed to equivocate. *Casey* applied the requirement for a health exception to a Pennsylvania statute that plaintiffs asserted defined health too narrowly.⁴¹ Most of the challenged statutory provisions involved time-sensitive abortion access. They required women in Pennsylvania seeking an abortion to provide informed consent and receive information 24 hours before the procedure.⁴² If the patient were a minor, she would be required to obtain one parent's consent or a judicial bypass. If the patient were married, she would be required to sign a document verifying that she had notified her husband. The statute at issue set out an extremely limited zone of health within which patients would be exempted from these restrictions: "Medical emergency."⁴³ The statute defined "medical emergency" as:

That condition which, on the basis of the physician's good faith clinical judgment, so complicates the medical condition of a pregnant woman as to necessitate the immediate abortion of her pregnancy to

37. *See id.* at 878 ("Regulations designed to foster the health of a woman seeking an abortion are valid if they do not constitute an undue burden."); *see also id.* at 878 ("Unnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.").

38. *Id.* at 860.

39. *Id.* at 882.

40. *Id.* ("To the extent *Akron I* and *Thornburgh* find a constitutional violation . . . those cases go too far . . . and are overruled.") (emphasis added).

41. *Id.* at 880.

42. *Id.* at 844 (citing the Pennsylvania Abortion Control Act of 1982, as amended in 1988 and 1989; 18 PA. CONS. STAT. §§ 3203–3220 (1990)).

43. *Id.* at 879.

avert her death or for which a delay will create serious risk of substantial and irreversible impairment of major bodily function.⁴⁴

The statute constrained a doctor's ability to safeguard the pregnant person's health along a number of variables. The risk itself had to be of a certain magnitude—"serious."⁴⁵ The degree of harm that risk must pose must be "substantial" or "irreversible" and must target a "major bodily function."⁴⁶ Under the statute, the threatened harm must rise to what is now recognized as the level of permanent disability in order for a patient to be exempt from the challenged regulations.⁴⁷

Pennsylvania argued to the district court that the statute satisfied the health exception because it encompassed threats to health that required immediate attention.⁴⁸ The district court rejected that argument, identifying "three serious conditions, *e.g.* preeclampsia, inevitable abortion, and premature ruptured membrane,"⁴⁹ that required "immediate medical care under generally accepted medical standards"⁵⁰ but that did not qualify under the act because the degree of harm threatened did not rise to the statute's threshold. Stating that "[a] pregnant woman, or any other person for that matter, should not be required to bear that risk,"⁵¹ the district court found the statute's medical emergency definition unconstitutional and permanently enjoined all portions of the act containing the definition of medical emergency.⁵²

The Third Circuit reversed, not finding that the statute as written was constitutional but instead interpreting the phrase "serious risk" to cover the conditions the district court had found it impermissibly excluded.⁵³ Introducing a term that would have continued importance, the Third Circuit used the word "significant" in its ruling, interpreting "the medical emergency exception as intended by the Pennsylvania legislature to assure that compliance with its abortion regulations would not in any way pose a significant threat to the life or health of a woman."⁵⁴ The Supreme Court in *Casey* upheld the statute. But what the Court upheld was

44. 18 PA. CONS. STAT. § 3203.

45. *Id.*

46. *Id.*

47. *See* 42 U.S.C. § 12102 (defining disability).

48. *Planned Parenthood of Se. Pa. v. Casey*, 744 F. Supp. 1323, 1377–78 (E.D. Pa. 1990), *aff'd in part, rev'd in part*, 947 F.2d 682 (3d Cir. 1991), *aff'd in part, rev'd in part*, 505 U.S. 833 (1992).

49. *Id.* at 1378.

50. *Id.*

51. *Id.*

52. *See id.*

53. *Planned Parenthood of Se. Pa. v. Casey*, 947 F.2d 682, 701 (3d Cir. 1991) *aff'd in part, rev'd in part*, 505 U.S. 833 (1992) ("The dispute between the parties concerns the meaning of the phrase 'serious risk.' The Commonwealth insists that whenever these conditions exist, there is a 'serious risk' of substantial and irreversible impairment of a major bodily function. The clinics argue that no such 'serious risk' exists until the woman has actually experienced shock or contracted an infection. We conclude that the clinics' interpretation is unduly restrictive.")

54. *Id.*

not the statute's plain text, but rather the appellate court's interpretation of it.⁵⁵

Thus, consistent with prior cases, the *Casey* plurality held that abortion regulation must include a health exception. But new in *Casey* was apparent equivocation on the level of risk necessary to trigger the health exception. The Supreme Court had never before indicated that a threat to health had to be of a set degree or kind to qualify for the health exception; to the contrary, the Court had been explicit that there was no such requirement, beyond a doctor's good faith assessment.⁵⁶ In *Casey*, however, the Court appears to tacitly embrace the limitation articulated by the Third Circuit—that the threat to health must be “significant.”⁵⁷ However, the statute provides a complicated landscape for drawing general conclusions about the health exception because the “emergency” scenarios it addresses are so extreme, amounting to permanent disability.

The health exception under *Roe* and *Doe* permits abortion where it is necessary for the pregnant person's health, without specifically addressing “emergency.” Emergency is a subset of necessary, and it is narrower. Medical emergencies are the most extreme instances of health necessity—when the exception for life and the exception for health bleed together. Faced with this clear discrepancy between the Pennsylvania law and its governing precedent, the Court in *Casey* could have limited the health exception to scenarios of certain urgency, where the threat was imminent, or immediate, as that was the factual scenario presented. But it did not. On the other hand, the Court also made no assertions that the emergency allocation before it covered the whole terrain of health that it had previously said must be protected.

Accordingly, while the Court upheld a health exception that the Third Circuit had said applied in situations of “significant” risk, the Court did not hold that risks only of that magnitude warranted an exception. For the legal standard, the Court referenced *Roe*, which as earlier established, does not demarcate a magnitude of risk necessary to trigger the health exception. “Petitioners argue that the definition is too narrow, contending that it forecloses the possibility of an immediate abortion despite some significant health risks. If the contention were correct,” the Court noted, “we would be required to invalidate the restrictive operation of the provision, for the essential holding of *Roe* forbids a State to interfere with a woman's choice to undergo an abortion procedure if continuing her pregnancy would

55. See *Casey*, 505 U.S. at 879–81 (quoting *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 499–500 (1985)) (“Normally . . . we defer to the construction of a state statute given it by the lower federal courts.”).

56. See *Doe v. Bolton*, 410 U.S. 179, 191 (1973).

57. *Casey*, 947 F.2d at 701 (“Moreover, we read the medical emergency exception as intended by the Pennsylvania legislature to assure that compliance with its abortion regulations would not in any way pose a significant threat to the life or health of a woman. We believe it should be interpreted with that objective in mind. While the wording seems to us carefully chosen to prevent negligible risks to life or health or significant risks of only transient health problems from serving as an excuse for noncompliance, we decline to construe ‘serious’ as intended to deny a woman the uniformly recommended treatment for a condition that can lead to death or permanent injury.”).

constitute a threat to her health.”⁵⁸ “Significant” describes the facts at hand in *Casey*—it does not state a new legal test or precondition. The Court does not indicate that if the threats to health had *not* been significant a health exception would be unavailable.

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

Stenberg addressed a statute that lacked “any exception” for the pregnant person’s health,⁵⁹ and for that reason, the Court found it unconstitutional.⁶⁰ Specifically, the Court invalidated a Nebraska law that criminalized the provision of intact dilation and extraction (D & E) procedures—a method of abortion—and allowed an exception in instances where the woman’s life was at risk, but not where her health was threatened.⁶¹ In doing so, the Court reaffirmed *Casey*’s holding that “the governing standard requires an exception ‘where it is necessary, in appropriate medical judgment for the preservation of the life or health of the mother.’”⁶²

The word “significant” does not appear in *Stenberg* and the majority does not use the word “serious” in conjunction with any legal standard.⁶³ In a decision addressing the health exception, the Court did not take *Casey* as having adjusted the requisite threshold of risk to require a serious or substantial threat. If “significant” was a necessary term, or mattered a great deal in health exception doctrine, following *Casey*, the Court would be expected to employ it in its next opinion on that question. But it was absent. It is thus especially notable that the *Stenberg* Court described the opinion as manifesting “a straightforward application of [*Casey*’s] holding.”⁶⁴ Within the extant constitutional framework, “a State may promote but not endanger a woman’s health when it regulates the methods of abortion.”⁶⁵ The Court cited a long line of cases recognizing that the need for a health exception was “ratified” in *Casey*.⁶⁶

In analyzing the need for a health exception, the Court, in an opinion by Justice Breyer, rejected Nebraska’s arguments that an exception was not necessary because the ban “would create no risk to the health of women” or that “safe

58. *Casey*, 505 U.S. at 880 (citing *Harris v. McRae*, 448 U.S. 297, 316 (1980)).

59. *Id.* at 879.

60. *Stenberg v. Carhart*, 530 U.S. 914, 946 (2000).

61. *See id.* at 921–22 (quoting NEB. REV. STAT. ANN. § 28–328(1) (Supp. 1999)) (“No partial birth abortion shall be performed in this state, unless such procedure is necessary to save the life of the mother whose life is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself.”).

62. *Id.* (quoting *Casey*, 505 U.S. at 879).

63. *See id.* at 936.

64. *Id.*

65. *Id.*

66. *Id.*; *see Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747, 768–769 (1986); *Colautti v. Franklin*, 439 U.S. 379, 400 (1979); *Planned Parenthood v. Danforth*, 428 U.S. 52, 76–79 (1976); *Doe v. Bolton*, 410 U.S. 179, 197 (1973).

alternatives remain available.”⁶⁷ Record evidence indicated otherwise, and the Court reasoned that though alternatives might be safe, the prohibited procedure would be “significantly *safer* in certain circumstances.”⁶⁸ The “procedure’s relative rarity” was dismissed as “beside the point”;⁶⁹ “the health exception question is whether protecting women’s health requires an exception for those infrequent occasions.”⁷⁰

The health exception inquiry, the Court made clear, was not about scale.⁷¹ The Court also clarified that it was flatly “wrong” to claim, as Justice Thomas did in dissent, that the health exception was limited “to situations where the pregnancy *itself* creates a threat to health.”⁷² The health exception guards the pregnant person’s health from state regulation that prohibits abortion or regulation that merely regulates a method of it. In both instances, the Court reasoned, “a risk to a women’s health is the same.”⁷³ Notably, *Stenberg* does not only compare the safety of one abortion procedure to another; it takes the rare step of comparing both of those to the risks of birth.⁷⁴

The *Stenberg* Court’s discussion of risk was bimodal: either risk was present, or not, and “the division of medical opinion about the matter at most means uncertainty, a factor that signals the presence of risk, not its absence.”⁷⁵ The Court’s evidentiary assessment can be understood as a risk-aversion calculus: in the instance where the health exception was essential but not required “then the absence of a health exception will place women at an unnecessary risk of tragic health consequences.”⁷⁶ In the instance where the health exception was mandated but undeployed then “the exception will simply turn out to have been unnecessary.”⁷⁷ The latter was less risky, and preferable.⁷⁸

67. *Stenberg*, 530 U.S. at 931–32.

68. *Id.*

69. *Id.* at 934.

70. *Id.*

71. *Id.* (“[T]he health exception question is whether protecting women’s health requires an exception for those infrequent occasions. A rarely used treatment might be necessary to treat a rarely occurring disease that could strike anyone—the State cannot prohibit a person from obtaining treatment simply by pointing out that most people do not need it.”).

72. *Id.* at 931.

73. *Id.*

74. *Id.* at 935 (citing Brief for Am. Coll. of Obstetricians and Gynecologists et al. as Amici Curiae supporting Respondent, *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830) at 23 (“[T]he suggested alternative procedures involve similar or greater risks of cervical and uterine injury, . . . and ‘of course childbirth involves even greater cervical dilatation.’”)).

75. *Id.* at 937.

76. *Id.*

77. *Id.*

78. *Id.* at 936 (quoting Brief for Am. Coll. of Obstetricians and Gynecologists et al. as Amici Curiae supporting Respondent, *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830) at 21–22) (“Depending on the physician’s skill and experience, the D & X procedure can be the most appropriate abortion procedure for some women in some circumstances. D & X presents a variety of potential safety advantages over other abortion procedures used during the same gestational period. Compared to D & Es involving dismemberment, D & X involves less risk of uterine perforation or cervical laceration because it requires the physician to make fewer passes into the uterus with sharp instruments and

In light of these risks—and with Justice O'Connor in concurrence emphasizing the critical place of the health exception in *Casey's* framework, both pre- and post-viability⁷⁹—the Court held the statute unconstitutional for a straightforward reason: “we believe the law requires a health exception.”⁸⁰

Ultimately, *Stenberg* affirms that the health exception offers broad protection of a pregnant person's health and reflects that *Casey's* use of the term “significant” did not adjust the legal standard.

5. *Ayotte v. Planned Parenthood of Northern New England*, 546 U.S. 320 (2006)

In *Ayotte*, the Court adjusted its approach from *Stenberg*, but not with regard to the substance of the health exception or its necessity for rendering a statute constitutional. Rather, the Court shifted its stance as to remedy. At issue was a New Hampshire statute requiring parental notification “at least 48 hours” before a doctor could perform an abortion.⁸¹ The statute did “not explicitly permit a physician to perform an abortion in a medical emergency without parental notification.”⁸² Though the statute provided for a judicial bypass mechanism and immediate abortion where “necessary to prevent the minor's death and there is insufficient time to provide the required notice,”⁸³ the statute did not

reduces the presence of sharp fetal bone fragments that can injure the uterus and cervix. There is also considerable evidence that D & X reduces the risk of retained fetal tissue, a serious abortion complication that can cause maternal death, and that D & X reduces the incidence of a ‘free floating’ fetal head that can be difficult for a physician to grasp and remove and can thus cause maternal injury. That D & X procedures usually take less time than other abortion methods used at a comparable stage of pregnancy can also have health advantages. The shorter the procedure, the less blood loss, trauma, and exposure to anesthesia. The intuitive safety advantages of intact D & E are supported by clinical experience. Especially for women with particular health conditions, there is medical evidence that D & X may be safer than available alternatives.” (citation and footnotes omitted).

79. *Stenberg*, 530 U.S. at 930 (recalling that *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 880 (1992) assumed the existence of a pre-viability requirement of a health exception, as had the Court in *Harris v. McRae*, 448 U.S. 297, 316 (1980) (“Since 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.”)).

80. *Stenberg*, 530 U.S. at 937.

81. *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 323 (citing Parental Notification Prior to Abortion Act, N.H. REV. STAT. ANN. §§ 132:24–132:28 (2005) (repealed 2007)).

82. *Ayotte*, 546 U.S. at 324 (“The Act allows for three circumstances in which a physician may perform an abortion without notifying the minor's parent. First, notice is not required if ‘[t]he attending abortion provider certifies in the pregnant minor's record that the abortion is necessary to prevent the minor's death and there is insufficient time to provide the required notice.’ § 132:26(I)(a). Second, a person entitled to receive notice may certify that he or she has already been notified. § 132:26(I)(b). Finally, a minor may petition a judge to authorize her physician to perform an abortion without parental notification. The judge must so authorize if he or she finds that the minor is mature and capable of giving informed consent, or that an abortion without notification is in the minor's best interests. § 132:26(II). These judicial bypass proceedings ‘shall be confidential and shall be given precedence over other pending matters so that the court may reach a decision promptly and without delay,’ and access to the courts ‘shall be afforded [to the] pregnant minor 24 hours a day, 7 days a week.’ §§ 132:26(II)(b), (c). The trial and appellate courts must each rule on bypass petitions within seven days. *Ibid.*”).

83. *Id.*

exempt threats to the pregnant person's health from the notification or bypass requirements.

The District Court issued a permanent injunction, holding the act unconstitutional in part for lacking a health exception,⁸⁴ and the First Circuit affirmed.⁸⁵ In so ruling, the First Circuit noted that “[i]n all three” cases since *Roe* that addressed the question, “the Court has indicated that an exception must be provided when the restriction would place a woman’s health at risk.”⁸⁶ Instead of invalidating the statute entirely, as it had in *Stenberg*, however, the Supreme Court remanded the case to a lower court to determine whether, given the statute’s severability clause, the legislature would prefer for the statute to be fully invalidated, or to survive with an injunction prohibiting its application in circumstances that would impose an unconstitutional risk to health.⁸⁷ In doing so, it affirmed that a health exception was a constitutional imperative.

As in *Casey*, the statute at issue in *Ayotte* concerned medical emergencies, not broader health,⁸⁸ and the parties below had discussed the extent of risks posed. Also as in *Casey*, as confirmed by *Stenberg*, *Ayotte* left the health exception standing without the risk threshold affected, despite mentioning that the facts supported “significant health risks.”⁸⁹ Specifically, the Court noted that “New Hampshire has conceded that, under our cases, it would be unconstitutional to apply the Act in a manner that subjects minors to significant health risks.”⁹⁰ That one party to litigation concedes that it would be unconstitutional to impose

84. *Planned Parenthood of N. New Eng. v. Heed*, 296 F. Supp. 2d 59, 68 (D.N.H. 2003).

85. *Planned Parenthood of N. New Eng. v. Heed*, 390 F.3d 53, 60–61 (1st Cir. 2004), *vacated sub nom.* *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006) (“regardless of the interests served by New Hampshire’s parental notice statute, it does not escape the Constitution’s requirement of a health exception”).

86. *Id.* at 60.

87. *Ayotte*, 546 U.S. at 332.

88. *Ayotte* speaks to the question of immediacy because time was the variable isolated by the statute. Within the confines of the parental notification requirement, a doctor would have to wait “at least” 48 hours before performing an abortion on a minor. *Ayotte*, 546 U.S. at 323–24. If there were a judicial bypass, a court was provided “seven calendar days” to rule on a judicial bypass petition, “and another seven calendar days on appeal.” *Id.* at 324. During those two weeks of judicial processing, the First Circuit held, “a minor’s health may be adversely affected.” *Planned Parenthood of N. New Eng.*, 390 F.3d at 62. Even when the courts act as expeditiously as possible, those minors who need an immediate abortion to protect their health are at risk. *Id.* Hence, the First Circuit’s finding of unconstitutionality was grounded, in part, in concerns about the clock: “Because its time requirement is drawn too narrowly, and because it fails to safeguard a physician’s good-faith medical judgment that a minor’s life is at risk against criminal and civil liability, the Act’s death exception is unconstitutional.” *Id.* at 64; *see also Ayotte*, 546 U.S. at 325–26 (“The Court of Appeals further found the Act unconstitutional because, in its view, the life exception forces physicians to gamble with their patients’ lives by prohibiting them from performing an abortion without notification until they are certain that death is imminent”); *Planned Parenthood of N. New Eng.*, 390 F.3d at 63 (“[T]he time component of the Act’s death exception forces physicians either to gamble with their patients’ lives in hopes of complying with the notice requirement before a minor’s death becomes inevitable, or to risk criminal and civil liability by providing an abortion without parental notice.”).

89. *See Ayotte*, 546 U.S. at 328.

90. *Id.*

“significant” health risks is hardly a clear statement of a constitutional floor, let alone one that shifts the long-established landscape. After *Ayotte*, too, the health exception stood and applied broadly.

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

The facts of *Gonzales* loosely track *Stenberg*'s. Federal law 18 U.S.C.A. § 1531 prohibited intact D & E abortions without a health exception. Congress purported to adjust its terms to avoid concerns that had bothered the Court at first consideration, in *Stenberg*, and at second, in *Ayotte*. In *Gonzales*, the Court deemed the revisions sufficient to muster constitutionality.⁹¹

Gonzales consolidated two cases, one originating in Nebraska and the other in California. Both district courts that heard challenges to the statute enjoined it, holding it unconstitutional for lack of a health exception, among other reasons.⁹² Both circuit courts affirmed the district courts' holdings and upheld the injunctions, determining that the Act's lack of a health exception was fatal under *Stenberg*.⁹³

The Supreme Court reversed. “Whatever one's views concerning the Case joint opinion, it is evident a premise central to its conclusion — that the government has a legitimate and substantial interest in preserving and promoting fetal life—would be repudiated were the Court now to affirm the judgments of the Courts of Appeals.”⁹⁴ In addressing the absence of the health exception, *Gonzales* asserted that the Act “would be unconstitutional” if it “subjected women to significant health risks.”⁹⁵ The Court then identified as relevant the “contested factual question” of “whether the Act creates significant health risks for women.”⁹⁶ In contrast to *Stenberg*, where the medical division of opinion over whether there was a threat to health was taken as indication that threat was possible, and should be guarded against via a health exception, the *Gonzales* Court deferred to Congress' dubious interpretation of the evidence that there was no such threat.⁹⁷ In light of the “documented medical disagreement,”⁹⁸ about the safety of two different methods of performing D & Es, one of which the legislation at issue prohibited, the legislature had “wide discretion” to pass legislation.⁹⁹ The Court, despite affirming its own role in inspecting the evidence, remained agnostic as to whether the Act imposed any threat to health.¹⁰⁰ Because ostensibly there was no

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

92. *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 808 (D. Neb. 2004); *Planned Parenthood Fed'n of Am. v. Ashcroft*, 320 F. Supp. 2d 957, 959–60 (N.D. Cal. 2004).

93. *Carhart v. Gonzales*, 413 F.3d 791, 803 (8th Cir. 2005); *Planned Parenthood Fed'n of Am. v. Ashcroft*, 435 F.3d 1163, 1176 (9th Cir. 2006).

94. *Gonzales*, 550 U.S. at 145.

95. *Id.* at 161 (citing *Ayotte*, 546 U.S. at 328).

96. *Id.*

97. *Id.* at 166.

98. *Id.* at 162.

99. *Id.* at 163.

100. *See id.* at 165–66.

threat requiring protection, and “there is uncertainty over whether the barred procedure is ever necessary to preserve a woman’s health, given the availability of other abortion procedures that are considered to be safe alternatives,”¹⁰¹ the Court held that the Act did not require a health exception.¹⁰² Against the urging of the members of the medical community, the Court upheld the statute.¹⁰³

Gonzales is generally regarded as having undermined the health exception. Describing the opinion as “alarming,” Justice Ginsburg decried that “for the first time since *Roe*, the Court blesses a prohibition with no exception safeguarding a woman’s health.”¹⁰⁴ Commentary after the decision’s issuance sounded that theme. For example: “The major change in the law this opinion brings with it is the new willingness of Congress and the Court to disregard the health of pregnant women and the medical judgment of their physicians.”¹⁰⁵ After *Gonzales*, “the balance of interests shifts, with women’s health no longer paramount but rather societal morality and the state’s interest in life even before the point of viability outside the womb.”¹⁰⁶ “The United States Supreme Court’s recent decision in *Gonzales v. Carhart* was the first time in history the Court determined a physician could be prohibited from performing a medical procedure the physician found necessary to ensure the woman’s health.”¹⁰⁷

101. *Id.* at 166–67.

102. The Act contained a life exception. See 18 U.S.C.A. § 1531(a).

103. See Brief of American Medical Women’s Association, American Public Health Association, et al. as Amici Curiae Supporting Respondents, at 29–30, *Gonzales v. Planned Parenthood Fed’n of Am., Inc.*, 550 U.S. 124 (2007), (No. 05-1382), 2006 WL 2710731. (“Such a ban would be certain to channel at least some women into undergoing riskier abortions. Instead of fundamentally reworking abortion law in this country, this Court should adhere to unbroken years of precedent ensuring that abortion regulations do not undermine the medical community’s commitment and ability to protect women’s health.”).

104. *Gonzales*, 550 U.S. at 170–71 (Ginsburg, J., dissenting). See *id.* at 172 (“In keeping with this comprehension of the right to reproductive choice, the Court has consistently required that laws regulating abortion, at any stage of pregnancy and in all cases, safeguard a woman’s health. See, e. g., *Ayotte*, 546 U.S., at 327–28 (“[O]ur precedents hold . . . that a State may not restrict access to abortions that are necessary, in appropriate medical judgment, for the preservation of the life or health of the [woman].”) (quoting *Casey*, 505 U.S., at 879 (plurality opinion)); *Stenberg*, 530 U.S., at 930 (“Since 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.”). See also *Thornburgh v. Am. Coll. of Obstetricians and Gynecologists*, 476 U.S. 747, 768–769 (1986) (invalidating a post-viability abortion regulation for “fail[ure] to require that [a pregnant woman’s] health be the physician’s paramount consideration”).

105. George J. Annas, *The Supreme Court and Abortion Rights*, 356 NEW ENG. J. MED. 2201 (2007), at 2205. See also Reva B. Siegel, *Roe’s Roots: The Women’s Rights Claims that Engendered*, 90 B.U. L. REV. 1875, 1876 (2010), available at <http://www.bu.edu/law/journals-archive/bulr/documents/siegel.pdf> (describing the opinion as notable for, among other aspects, “its narrowing of the health exception”).

106. R. Alta Charo, *The Partial Death of Abortion Rights*, 356 NEW ENG. J. MED. 2127, 2128 (2007) (stating the tradition has been to permit the medical community to define the meaning of “medically necessary”).

107. Jennifer L. George, *The United States Supreme Court Failed to Follow over Thirty Years of Precedent by Replacing Individualized Medical Judgment with Congressional Findings*, 41 CREIGHTON L. REV. 219, 262 (2008).

But *Gonzales*' substantive import needn't be read as so completely out of step with long-standing precedent. If taken at face value, *Gonzales* can be read as less destructive of the health exception and of the Court's commitment to the health of pregnant people. *Gonzales* does not abandon the health exception. To the contrary, the Court formally adheres to the exception. "The three premises of *Casey* must coexist,"¹⁰⁸ the Court wrote, thus implicitly affirming the continued existence in law of those premises.¹⁰⁹ Stated at the beginning of the *Gonzales* opinion, the second of them is that a state has "power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health."¹¹⁰ Moreover, the Court made much of the fact that *Gonzales* was a "broad, facial attack," capitalizing on the remove provided by that case posture to avoid engaging with the alleged health risks.¹¹¹ Indeed, *Gonzales* formally commits the Court to the posture that a health exception safeguards pregnant peoples' abortion access.¹¹²

Gonzales raises questions with respect to the threshold of risk that must be reached to require that an exception be made. The Court's answer in *Stenberg* was to defer to the doctor's assessment of necessity:

The word "necessary" in *Casey*'s phrase "necessary, in appropriate medical judgment, for the preservation of the life or health of the mother," 505 U.S., at 879 (internal quotation marks omitted), cannot refer to an absolute necessity or to absolute proof. Medical treatments and procedures are often considered appropriate (or inappropriate) in light of estimated comparative health risks (and health benefits) in particular cases. Neither can that phrase require unanimity of medical opinion. Doctors often differ in their estimation of comparative health risks and appropriate treatment. And *Casey*'s words "appropriate

108. *Gonzales*, 550 U.S. at 158.

109. *Id.* at 145 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 846 (1992)) ("First is a recognition of the right of the woman to choose to have an abortion before viability and to obtain it without undue interference from the State. Before viability, the State's interests are not strong enough to support a prohibition of abortion or the imposition of a substantial obstacle to the woman's effective right to elect the procedure. Second is a confirmation of the State's power to restrict abortions after fetal viability, if the law contains exceptions for pregnancies which endanger the woman's life or health. And third is the principle that the 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. These principles do not contradict one another; and we adhere to each.")

110. *Gonzales*, 550 U.S. at 145 (emphasis added) (quoting *Casey*, 505 U.S. at 846).

111. *Id.* at 133; see also *id.* at 189-90 (Stevens, J., concurring) ("The Court envisions that in an as-applied challenge, 'the nature of the medical risk can be better quantified and balanced.' *Ibid.* But it should not escape notice that the record already includes hundreds and hundreds of pages of testimony identifying 'discrete and well-defined instances' in which recourse to an intact D&E would better protect the health of women with particular conditions. Record evidence also documents that medical exigencies, unpredictable in advance, may indicate to a well-trained doctor that intact D&E is the safest procedure.") (internal citations omitted).

112. *Gonzales*, 550 U.S. at 166-67 ("The 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 the availability of other abortion procedures that are considered to be safe alternatives.")

medical judgment” must embody the judicial need to tolerate responsible differences of medical opinion . . .¹¹³

Moreover, “Whether, in the words of the Georgia statute, ‘an abortion is necessary’ is a professional judgment that the Georgia physician will be called upon to make routinely.”¹¹⁴ Necessity, though, is not itself freewheeling. The Court writes about necessity, in order to *preserve*: as stated in *Roe*, abortion must be allowed “when it is necessary to preserve the life or health of the mother.”¹¹⁵ “Preserve” can be usefully contrasted with other words the Court might have used: “return” or “restore,” for example.¹¹⁶ There is an element of prevention inherent in the meaning of preservation: “to keep something as it is. . .” as against any chance.¹¹⁷ Protection also is inherent in the idea of preservation: “to keep safe from injury, harm, or destruction.”¹¹⁸ The health exception, following *Stenberg*, entitles a person to maintain health, and to act for the sake of their health, if confronted with risk.

Despite this precedent, did *Gonzales* elevate the legal standard for the harm that must be threatened before abortion is available to a pregnant person under the health exception? The argument that it did looks to the majority’s quoting of “significant” in its assertion of the legal standard.¹¹⁹ However, three points undermine this conclusion. First, it is hard to accept the idea that a quoted passage from a prior case out of context could transmogrify a long-established legal threshold, particularly without any commentary by the Court indicating that was its intention. Quoting a descriptor from another case, should not, *sub silentio*, displace an entire doctrine.¹²⁰ Indeed, because the Court did not itself accept that the Act would lead to threats to health, but instead tolerated Congress’ conclusion that it would not, *Gonzales* did not formally concede that pregnant people should be made to bear any, including less-than-substantial, risks. Rather, *Gonzales* turned away from that question and encouraged a new, as-applied lawsuit to be brought.

Second, working against the inclusion of the term “significant” as increasing the threshold of threatened harm required, is the fact that risk has two component parts:

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

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

115. *Roe v. Wade*, 410 U.S. 113, 164 (1973).

116. Brief for Appellant at 29, *Roe v. Wade*, 410 U.S. 113 (1973) (No. 70-18), 1971 WL 128054 (“It was only after a tour of hospitals on the continent of Europe, in 1889, that the Mayo brothers could envision ‘the prospect of a surgery of expediency, of operating that would not be just a last desperate throw of the dice with death but a means of restoring health’”) (quoting HELEN CLAPESATTLE, *THE DOCTORS MAYO* 269 (1941)).

117. *Preserve*, CAMBRIDGE DICTIONARY, <https://dictionary.cambridge.org/us/dictionary/english/preserve> (last visited Oct. 2, 2020).

118. *Preserve*, MERRIAM-WEBSTER DICTIONARY, <https://www.merriam-webster.com/dictionary/preserve> (last visited Sept. 28, 2020).

119. See *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007) (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006)).

120. See, e.g., *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 18 (2000) (“This Court does not normally overturn, or so dramatically limit, earlier authority *sub silentio*.”).

probability and gravity.¹²¹ An analog exists in tort law, where the Hand formula combines the magnitude of risk and the gravity of the potential harm in order ostensibly to ascertain, in a much-flawed but theoretically useful calculation, whether an action was reasonably undertaken.¹²² A reasonable person, the supposition goes, will not undertake a risk where the magnitude or likelihood of harm are sufficiently severe. What threshold of risk is the appropriate one in the context of the health exception? Justice Douglas, in his *Vuitch* partial dissent, pressed on this point: “A doctor may well remove an appendix far in advance of rupture in order to prevent a risk that may never materialize. May he act in a similar way under this abortion statute?”¹²³ In other words, what level of risk must the person seeking an abortion be made to endure before the procedure will be made available?

The Court was arguably operating under the probability prong of risk assessment, rather than the gravity prong. Since it found medical uncertainty about whether the banned procedure was ever necessary to avert health risks—it deferred to Congress and accepted that it was not—that probability was nil.¹²⁴ This logic meant that the Court never actually grappled with the gravity prong in concluding that there was no risk.

Finally, cutting against an interpretation of the health exception as protecting against only “significant” health risks, is the fact that the exception explicitly protects health, for its own sake, not health as relevant because threats to it could become threats to life. The Court has consistently held and often repeated that abortion must be permitted where “‘necessary, in appropriate medical judgment, for the preservation of the . . . health of the mother.’”¹²⁵ The health exception is distinct from its cousin exception for the pregnant person’s life. The Court in *Roe* did not extend the statute’s original life exception to encompass health simply as a means to provide a margin of safety to doctors, to protect them from prosecution. Rather, the Court expanded the exception to encompass health for health’s

121. See Brief for Am. Med. Women’s Ass’n, Am. Pub. Health Ass’n, et al., as Amici Curiae Supporting Respondents at 14 n.9, *Gonzales v. Planned Parenthood Fed’n of Am., Inc.*, 550 U.S. 124 (2007), (No. 05-1382), 2006 WL 2710731 (“In medicine, the term ‘risk’ encompasses both probability and gravity. The first study comparing intact D&E to D&E with dismemberment, showed general complication rates were the same, but all serious complications were in the dismemberment group”. Chasen, D&E at 1183 (App. 1063). This evidence of intact D&E’s safety was particularly significant since the intact procedures occurred later in gestation, so researchers had expected to see more complications from that group. Pet. App. 117a; *Carhart* Pet. App. 359a.).

122. MARK GEISTFELD, *TORT LAW: THE ESSENTIALS* (Wolters Kluwer Law & Business; Aspen Publishers, 2008).

123. See *United States v. Vuitch*, 402 U.S. 62, 76 (1971) (Douglas, J., dissenting in part).

124. *Gonzales*, 550 U.S. at 166–67 (“The 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 the availability of other abortion procedures that are considered to be safe alternatives.”).

125. *Id.* at 161 (first quoting *Ayotte*, 546 U.S. at 327–28, then quoting *Casey*, 505 U.S. at 879 (plurality opinion)).

own sake.¹²⁶ To limit risks to those that are “significant” would make death the ultimate benchmark.

All of this jurisprudence and the logic supporting it cuts against a reading of *Gonzales* that recognizes only “significant” risks. To the extent that *Gonzales* is interpreted to ratchet the risk threshold to “significant” before a health exception may be invoked by a pregnant person, it is misunderstood. Because of the Court’s equivocation, a subsequent Court could, consistent with *Gonzales*, affirm that the health exception requires abortion availability whenever there is a threat to health, “significant” or otherwise.

Subsequent Supreme Court cases have not directly addressed the health exception. Lower courts continue to treat it as constitutionally required.¹²⁷

B. THE HEALTH EXCEPTION’S LEGAL FOUNDATION

The health exception was explicitly established by *Roe*, but it recognizes a limit on state power that has roots deeper than that case. The health exception vocalizes a principle of negative liberty — to be free from state-imposed physical harms — that precedes and stands separate and apart from *Roe*.

126. *Vuitch*, 402 U.S. at 71–72 (addressing the question of vagueness regarding the health exception requirement, finding that it is not unconstitutionally vague). Since its first brush with a requirement for a health exception, the Court has addressed the question of vagueness and dismissed those concerns. *Id.* (“Since that decision, however, the issue has been considered in *Doe v. General Hospital of the District of Columbia*, 313 F. Supp. 1170 (DC 1970). There, the district court judge construed the statute to permit abortions ‘for mental health reasons whether or not the patient had a previous history of mental defects.’ *Id.*, at 1174–75. The same construction was followed by the United States Court of Appeals for the District of Columbia Circuit in further proceedings in the same case. 140 U.S. App. D.C. 149 and 153, 434 F.2d 423 and 427 (1970) (“We see no reason why this interpretation of the statute should not be followed. Certainly this construction accords with the general usage and modern understanding of the word ‘health,’ . . . [V]iewed in this light, the term ‘health’ presents no problem of vagueness. Indeed, whether a particular operation is necessary for a patient’s physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered. We therefore hold that properly construed the District of Columbia abortion law is not unconstitutionally vague[.]”). The absence of more definite gridlines and boundaries did not indicate inadequate guidance or nebulous rules, as numerous anti-abortion scholars have argued. *See, e.g.*, Gail Glidewell, Note, “*Partial Birth*” *Abortion and the Health Exception: Protecting Maternal Health or Risking Abortion on Demand?*, 28 *FORDHAM URB. L.J.* 1089, 1090–91 (2001) (About *Stenberg*: “However, the majority provided few clear guidelines specifying the requirements of such a health exception.”); Michael J. Tierney, *Post-Viability Abortion Bans and the Limits of the Health Exception*, 80 *NOTRE DAME L. REV.* 465, 468–69 (2004) (“Although the Court has clearly stated there must be an exception to post-viability abortion bans when the mother’s health or life is in danger, it is unclear how broad that health exception must be.”). These complaints are misplaced. The Court need not supply a more refined, contoured, or constrained description because the answer is not refined, contoured, or constrained. These critiques masquerade as confusion but are in fact dissatisfaction with the given answer. They beg for definition and boundaries not for the sake of clarification but rather for the sake of substantive change.

127. *See, e.g.*, *W. Ala. Women’s Ctr. v. Williamson*, 900 F.3d 1310, 1330 (11th Cir. 2018), *cert. denied sub nom. Harris v. W. Ala. Women’s Ctr.*, 139 S. Ct. 2606, 204 L. Ed. 2d 1159 (2019); *Planned Parenthood of Ark. & E. Okla. v. Jegley*, No. 4:15-CV-00784-KGB, 2016 WL 6211310, at *1 (E.D. Ark. Mar. 14, 2016), *vacated and remanded sub nom. Planned Parenthood of Ark. & E. Okla. v. Jegley*, 864 F.3d 953 (8th Cir. 2017); *Northland Fam. Planning Clinic, Inc. v. Cox*, 487 F.3d 323, 340 (6th Cir. 2007).

Roe did not explain the legal origins of the health exception.¹²⁸ The Court offers no description as to where, constitutionally or otherwise, the mandate for a health exception comes from, outside of the general right to abortion derivative of the right to privacy grounded, in turn, in substantive due process.¹²⁹ *Casey* describes the abortion right as rooted in two distinct, “long recognized” rights: “privacy and bodily integrity.”¹³⁰ Arguably, *Stenberg* looks to prior cases rather than the Constitution itself.¹³¹ *Gonzales* begrudgingly defers to precedent. Yet, the health exception has been consistently reaffirmed by the Court. This section describes historic and deeply embedded legal concepts that relate to and root the rule.

One source of support for the exception is longstanding precedent that limits state power to impose physically cruel restrictions on those under their jurisdiction — precedent that demonstrates a person’s interest in protecting their own health can overrule other state interests.¹³² In *Jacobson v. Massachusetts*, 197 U. S. 11 (1905), the Supreme Court addressed the extent of the state police power to enforce public health when at odds with personal physical integrity. As a general rule, *Jacobson* asserts, the police power enables states to act, and permitted Massachusetts to order vaccination against smallpox.¹³³ But *Jacobson* also recognized the limit of that state power as applied to an individual:

128. Clarke Forsythe, *The Medical Assumption at the Foundation of Roe v. Wade & Its Implications for Women’s Health*, 71 WASH. & LEE L. REV. 827, 832 (2014) (“Professor Stephen Gilles has analyzed how the Court has never justified or explained its life-or-health exception after viability.”).

129. Monica Eppinger, *The Health Exception*, 17 GEO. J. GENDER & L. 665, 668 (2016) (“Surprisingly, though, despite its centrality to abortion doctrine and significance in legal challenges since *Roe*, the history of the health exception remains obscure.”).

130. *Casey*, 505 U.S. at 926; see also *id.* at 912–14 (Stevens, J., concurring in part and dissenting in part) (“I also accept what is implicit in the Court’s analysis, namely, a reaffirmation of *Roe*’s explanation of why the State’s obligation to protect the life or health of the mother must take precedence over any duty to the unborn. The Court in *Roe* carefully considered, and rejected, the State’s argument ‘that the fetus is a ‘person’ within the language and meaning of the Fourteenth Amendment.’ After analyzing the usage of ‘person’ in the Constitution, the Court concluded that that word ‘has application only postnatally.’ Commenting on the contingent property interests of the unborn that are generally represented by guardians ad litem, the Court noted: ‘Perfection of the interests involved, again, has generally been contingent upon live birth. In short, the unborn have never been recognized in the law as persons in the whole sense.’ Accordingly, an abortion is not ‘the termination of life entitled to Fourteenth Amendment protection.’ From this holding, there was no dissent; indeed, no Member of the Court has ever questioned this fundamental proposition. Thus, as a matter of federal constitutional law, a developing organism that is not yet a ‘person’ does not have what is sometimes described as a ‘right to life.’ This has been and, by the Court’s holding today, remains a fundamental premise of our constitutional law governing reproductive autonomy.” (citations omitted)).

131. See *Stenberg*, 530 U.S. at 929 (holding the statute “violates the Federal Constitution, as interpreted in” *Casey* and *Roe*) (emphasis added).

132. See *Jacobson v. Massachusetts*, 197 U.S. 11, 39 (1905).

133. See *South Bay United Pentecostal Church, et al. v. Gavin Newsom, et al.*, 590 U.S. ____, 140 S. Ct. 1613, 1613–14 (2020) (referencing limits to state power and citing *Jacobson*) (“Where those broad limits are not exceeded . . .”).

It is easy, for instance, to suppose the case of an adult who is embraced by the mere words of the act, but yet to subject whom to vaccination in a particular condition of his health or body would be cruel and inhuman in the last degree. We are not to be understood as holding that the statute was intended to be applied to such a case, or, if it was so intended, that the judiciary would not be competent to interfere and protect the health and life of the individual concerned.¹³⁴

Jacobson, which is cited in *Roe*, *Casey*, *Stenberg*, and *Gonzales*, recognized that the state power had a limit, specifically one that did not permit interference with life or health. A state may have authority to take action that affects a person's physicality, but that permission extends only so far. Where a state exceeds its ambit, courts can "interfere and protect" an individual's "health and life."¹³⁵ This limitation in *Jacobson* sounds in the substance of the health exception.

Jacobson explains the source of this limit only through citation to another general assertion about statutory interpretation: "All laws. . . should receive a sensible construction. General terms should be so limited in their application as not to lead to injustice, oppression, or an absurd consequence. It will always, therefore, be presumed that the legislature intended exceptions to its language which would avoid results of this character."¹³⁶ To allow the state to impose on an individual or make a person suffer a law that is oppressive, cruel, inhumane, or "absurd" would be, the Court asserts, insensible and inconsistent with broader principles of law, even if formally consistent with the specific dictates of a single law.¹³⁷ Something more fundamental than statutory text intercedes to prevent those applications.

What might the Court in *Jacobson* have envisioned as "cruel and inhumane in the last degree," oppressive, or absurd, such that it was a prohibited excess? While *Jacobson* does not define those terms, the concept of cruelty has been well defined in the context of the Eighth Amendment's prohibition on punishment that is "cruel and unusual."¹³⁸ This cruelty is attentive, particularly, to physicality and pain - literal suffering.¹³⁹ Cruelty in the context of the Eighth Amendment is instructive in contexts beyond criminal sanctions.¹⁴⁰

134. *Jacobson*, 197 U.S. at 38–39.

135. *Id.*

136. *Id.* at 39 (quoting *United States v. Kirby*, 74 U.S. 482, 483 (1868)).

137. *Id.* at 38–39.

138. U.S. CONST. amend. VII.

139. See, e.g., *Baze v. Rees*, 553 U.S. 35, 41 (2008).

140. See *Casey*, 505 U.S. at 847 ("[T]he guaranties of due process, though having their roots in Magna Carta's 'per legem terrae' and considered as procedural safeguards 'against executive usurpation and tyranny,' have in this country 'become bulwarks also against arbitrary legislation.' *Poe v. Ullman*, 367 U.S. 497, 541, 81 S. Ct. 1752, 1776, 6 L.Ed.2d 989 (1961) (Harlan, J., dissenting from dismissal on jurisdictional grounds) (quoting *Hurtado v. California*, 110 U.S. 516, 532 (1884)).").

In addition to guarding against cruelty, courts have long made allowances for individuals to safeguard their physical being.¹⁴¹ The *Casey* plurality noted that, “As early as 1891,” the Court recognized that “[n]o right is held more sacred, or is more carefully guarded by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others”¹⁴² In particular, this primacy of bodily self-possession¹⁴³ — control of one’s own person — has barred external impositions of physical risk. When threats to health are involved, other legal principles give way, bend to the omnipresent condition that physical threats do not need to be tolerated. Contract law finds formal agreement absent if a person was compelled to consent, under duress of threat to physical health. Physically harming another person, though generally prohibited, is an affirmative defense in criminal law and is justified if the harm was inflicted in self-defense.¹⁴⁴ And under the theory accepted by courts in

141. *Casey* hinted at this. *See id.* at 857 (“*Roe*, however, may be seen not only as an exemplar of *Griswold* liberty but as a rule (whether or not mistaken) of personal autonomy and bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection. If so, our cases since *Roe* accord with *Roe*’s view that a State’s interest in the protection of life falls short of justifying any plenary override of individual liberty claims.”) (citing *Cruzan v. Director, Mo. Dept. of Health*, 497 U.S. 261, 278 (1990); *cf., e.g., Riggins v. Nevada*, 504 U.S. 127, 135 (1992); *Washington v. Harper*, 494 U.S. 210 (1990); *see also, e.g., Rochin v. California*, 342 U.S. 165 (1952); *Jacobson v. Massachusetts*, 197 U.S. 11, 24–30 (1905)).

142. *Casey*, 505 U.S. at 926 (quoting *Union Pac. R. Co. v. Botsford*, 141 U.S. 250, 251 (1891)).

143. Christyne L. Neff, *Woman, Womb, and Bodily Integrity*, 3 *YALE J.L. & FEMINISM* 327 (1991); *see also* Brief for Constitutional Accountability Center as Amici Curiae Supporting Petitioners at 6, *June Medical Services v. Russo*, 140 S. Ct. 2103 (2020) (No. 18-1323) (“Erasing the stain of slavery—the ultimate violation of personal liberty and bodily integrity—from the Constitution, the Framers affirmed that ‘there are some inherent and inalienable rights, pertaining to every citizen, which cannot be abolished or abridged by State constitutions or laws,’ including the ‘right to live, the right of personal security, personal liberty, and the right to acquire and enjoy property.’ Cong. Globe, 39th Cong., 1st Sess. 1832–33; *see id.* at 1757 Both personal liberty and personal control over one’s person and body—a basic aspect of personal security—were understood by the Framers to be inalienable rights. *See id.* at 1118 (defining ‘personal security’ to include “‘a person’s legal and uninterrupted enjoyment of his life, his limbs, his body, his health, and his reputation.’”)) (internal citation omitted)).

144. *See, e.g.,* Carla Graff, *The Religious Right to Therapeutic Abortions*, 85 *GEO. WASH. L. REV.* 954, 958–69 (2017) (suggesting that the health exception is rooted in an interconnection of religion, abortion, and self-defense rights, “regardless of the current standard established by the Court or possible lack of life or health exceptions provided under state law.”) (arguing that “[t]he right to self-defense . . . is an alternative avenue to maintain the right to health exceptions for abortion.”) (referencing the model penal code); (forty-four state constitutions to establish the embeddedness of the principle of self-defense in American law) (“Because the need for an abortion arises when a woman’s life and health are at risk, the right to abortion coincides with the right to self-defense. The right to self-defense has long been recognized as an essential and inalienable right of natural law.”); *see also* 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); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 *HARV. L. REV.* 1813, 1814–15 (2007); Carter Snead, *Unenumerated Rights and the Limits of Analogy: A Critique of the Right to Medical Self-Defense*, 121 *HARV. L. REV.* F. 1 (2007) (concluding of Volokh’s article that “none of his suggested common law grounds are adequate to justify it. Self-defense is not a fitting analogy to, and thus does not provide support for, this entitlement. The doctrine of necessity (or choice of evils) is a more promising common law analogy, but it is also an unsound foundation. Lacking any roots in the

considering battered women syndrome, the threat of harm needn't be immediate, merely imminent, for self-defense to be justified.¹⁴⁵ Tort law is premised on the idea that physically harming another person requires compensation, and has been theorized to be primarily useful as a mechanism for preventing physical harm.¹⁴⁶ Disparate prohibitions on imposing physical harm on others are the core of legal rules, and equally core is the principle that where physical harm is threatened, a person has recourse against it. This idea is laced into common law,¹⁴⁷ which, in turn, is woven into Constitutional guarantees.¹⁴⁸

To deny a pregnant person access to abortion where their health is threatened would be inconsonant with prohibitions on cruelty and with the space law creates for self-protection. The health exception acknowledges that imposing those threats is not within the ambit of valid state action.

II. MEDICAL RESEARCH VALIDATES THE NECESSITY OF A BROAD HEALTH EXCEPTION

Since the establishment of the health exception, medical research has exposed the pervasive hazards of pregnancy. In 1972, the year before *Roe* and *Doe* were decided and the exception entered doctrine, a research article observed that “relatively little attention has been given to identifying a general category of morbidities that could be called near misses,” that is, instances where a complication of pregnancy is life-threatening but not ultimately fatal.¹⁴⁹ The CDC and the American College of Obstetricians and Gynecology (ACOG) established the Pregnancy Mortality Surveillance System (“PMSS”) in 1986 “to better understand the causes of death and risk factors associated with pregnancy-related deaths.”¹⁵⁰ The findings of these research programs affirm the importance and wide applicability of the health exception.

nation’s history and tradition, the entitlement to medical self-help cannot, therefore, rise to the level of a fundamental constitutional right.”).

145. See Lenore E. Walker, *Battered Women Syndrome and Self-Defense*, 6 NOTRE DAME J. L. ETHICS & PUB. POL’Y 321, 324 (1992), available at: <http://scholarship.law.nd.edu/ndjlepp/vol6/iss2/3>.

146. GEISTFELD, TORT LAW, *supra* note 122.

147. Anita Bernstein, *Common Law Fundamentals of the Right to Abortion*, 63 BUFF. L. REV. 1141, 1144–45 (2015).

148. See Anita L. Allen, *Social Contract Theory in American Case Law*, 51 FLA. L. REV. 1, 33-34 (1999); see also ALFRED H. KELLY ET AL., *THE AMERICAN CONSTITUTION, ITS ORIGINS AND DEVELOPMENT* 118 (6th ed. 1983) (Michael Kanunen ed., 1986) at viii–ix; Andrew C. McLaughlin, *Social Compact and Constitutional Construction*, 5 AM. HIST. REV. 467, 467 (1900) (“Students of American history or political philosophy need not be told that in the Revolutionary period men believed that society originated in compact.”); Bernard Bailyn, *The Ideological Origins of the American Revolution* (1967); Arlin M. Adams & Charles J. Emmerich, *A Heritage of Religious Liberty*, 137 U. PA. L. REV. 1559, 1562 & note 8 (1989).

149. Stacie E. Geller et al., *Defining a Conceptual Framework for Near-Miss Maternal Morbidity*, 57 J. AM. MED. WOMEN’S ASS’N 135 (1972) (proposing “an initial framework and a process for the definition and identification of near-miss morbidity that minimizes loss of information yet has practical utility” and arguing that “[p]recise classification of near-miss morbidity is the first step in analyzing factors that may differentiate survival from death on the continuum from morbidity to mortality.”).

150. Petersen, *supra* note 3.

The most extreme risk of pregnancy and birth is the potential death of the pregnant person.¹⁵¹ Data from the PMSS for 2007–2016 established that overall, for every 100,000 live births in the United States, there are 16.7 pregnancy-related deaths, resulting in approximately 700 deaths per year.¹⁵² Significant racial and ethnic disparities stratify maternal mortality, with Black and indigenous women approximately three times more likely to die of pregnancy-related causes than white women.¹⁵³ Leading causes of pregnancy-related deaths are “[c]ardiovascular conditions (including cardiomyopathy, other cardiovascular conditions, and cerebrovascular accidents), other noncardiovascular medical conditions, and infection. . . .”¹⁵⁴ The U.S.’ maternal mortality rate is among the highest of developed countries.¹⁵⁵ Relatedly, severe maternal morbidity increased 75 percent in the decade between 1998/1999 and 2008/2009.¹⁵⁶ The cause of the U.S.’ high maternal mortality and maternal morbidity rates — in other words, why so many pregnant people die or nearly die in birth — is unclear.¹⁵⁷ Maternal mortality and morbidity, and the racial disparities therein, are a “complex national problem,” the CDC has acknowledged,¹⁵⁸ and the subject of international opprobrium.

151. See generally Ctrs. for Disease Control and Prevention, *Pregnancy-related Deaths: Saving Womens' Lives Before, During, and After Delivery* (May 2019), <https://www.cdc.gov/vitalsigns/maternal-deaths/index.html>.

152. Petersen, *supra* note 3.

153. *Id.*; see also Amy Metcalfe et al., Racial Disparities in Comorbidity and Severe Maternal Morbidity/Mortality in the United States: An Analysis of Temporal Trends, 97 *ACTA OBSTRICIA ET GYNECOLOGICA SCANDINAVICA* 89, 90 (2018) <https://obgyn.onlinelibrary.wiley.com/doi/pdf/10.1111/aogs.13245> (“The Black–White disparity in maternal mortality has increased over time; as of 2010, the maternal mortality rate for Black women was over three times that observed for White women at 38.9 vs. 12.0 deaths/100 000 live births.”); Katy B. Kozhimannil et al., Severe Maternal Morbidity and Mortality Among Indigenous Women in the United States, 135 *OBSTETRICS & GYNECOLOGY* 294, 297 (2020).

154. Petersen, *supra* note 3 (noting that the CDC classified as cause of death: “hemorrhage; infection; amniotic fluid embolism; thrombotic pulmonary or other embolism (i.e., air, septic, or fat); hypertensive disorders of pregnancy (i.e., preeclampsia or eclampsia); anesthesia complications; cerebrovascular accidents; cardiomyopathy; other cardiovascular conditions (e.g., congenital heart disease, ischemic heart disease, cardiac valvular disease, hypertensive heart disease, and congestive heart failure); and other noncardiovascular medical conditions (e.g., endocrine, hematologic, immunologic, and renal).”).

155. U.S. Dept. of Health and Hum. Serv., Health Res. and Serv. Admin., *HRSA Maternal Mortality Summit: Promising Global Practices to Improve Maternal Health Outcomes, Technical Report 2* (2019) (“In 2015, the U.S. ranked 46th among the 181 countries with a maternal mortality rate that is among the highest of developed countries.”).

156. Metcalfe, *supra* note 153 (“As of 2010/2011, 163/10 000 delivery hospitalizations in the USA were complicated by severe maternal morbidity.”).

157. See Michael R. Kramer et al., Changing the conversation: applying a health equity framework to maternal mortality reviews, 221 *AM. J. OBSTETRICS & GYNECOLOGY* 6, 609.e1–609.e9 (2019); see also Philip D. D. Darney et al., Maternal Mortality in the United States Compared With Ethiopia, Nepal, Brazil, and the United Kingdom, 135 *OBSTETRICS & GYNECOLOGY* 1362, 1362–63, 1365 (2020).

158. Petersen, *supra* note 3 (recognizing that “[f]urther identification and evaluation of factors contributing to racial/ethnic disparities are crucial to inform and implement prevention strategies that will effectively reduce disparities in pregnancy-related mortality, including strategies to improve women’s health and access to quality care in the preconception, pregnancy, and postpartum periods.”).

This section investigates contemporary medical findings about the risks of, first, pregnancy; second, birth; and third, the postpartum period. Next, this section addresses the ways in which race and poverty greatly exacerbate the risks at each stage. Finally, this section asserts the pervasiveness of these risks: “[M]aternal morbidity and mortality can occur unpredictably in any obstetric setting.”¹⁵⁹ Viewed in total, this research establishes that every pregnancy and birth entails significant risk for the pregnant person.

A. MEDICAL HAZARDS OF PREGNANCY

Threats to health, in the context of pregnancy, may originate from the pregnancy itself. Alternatively, they may result from exacerbation of an already present health issue, coincide with another health-related occurrence unrelated to the pregnancy, or prevent the pregnant person from caring for themselves as necessary to maintain their health.

Over the course of pregnancy, a pregnant person’s body undergoes anatomic and physiologic changes.¹⁶⁰ These shifts alter health¹⁶¹ and render a pregnant individual “immunocompromised,”¹⁶² resulting in a person’s increased susceptibility to various medical issues.

For example, changes in the immune system during pregnancy and in the peripartum period (the last month of pregnancy through the first weeks after delivery)

159. Kavita Shah Arora et al., *Triggers, bundles, protocols, and checklists—what every maternal care provider needs to know*, 214 AM. J. OBSTETRICS & GYNECOLOGY 444 (2016) (noting “[t]he rise in maternal morbidity and mortality has resulted in national and international attention at optimally organizing systems and teams for pregnancy care” and summarizing evidence-based protocols to “assist primary maternal care providers in their utilization and implementation of these safety tools.”).

160. Meredith L. Birsner & Cynthia Gyamfi-Bannerman, *ACOG Committee Opinion: Physical Activity and Exercise During Pregnancy and the Postpartum Period*, 135 OBSTETRICS & GYNECOLOGY e178 (2020), available at <https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2020/04/physical-activity-and-exercise-during-pregnancy-and-the-postpartum-period> (detailing changes during pregnancy, including weight gain, a shift in the body’s center of gravity that results in “progressive lordosis. These changes lead to an increase in the forces across joints and the spine during weight-bearing exercise. As a result, more than 60% of all pregnant women experience low back pain” Pregnancy also causes hemodynamic changes: “Blood volume, heart rate, stroke volume, and cardiac output normally increase during pregnancy, and systemic vascular resistance decreases.” The weight of the uterus “result[s] in decreased venous return due to aortocaval compression. . . leading to hypotension.” Pregnant people also experience “profound respiratory changes,” including “[m]inute ventilation increases up to 50%, primarily as a result of the increased tidal volume. Because of a physiologic decrease in pulmonary reserve, the ability to exercise anaerobically is impaired, and oxygen availability for aerobic exercise and increased workload consistently lags. The physiologic respiratory alkalosis of pregnancy may not be sufficient to compensate for the developing metabolic acidosis of strenuous exercise.” To lessen their osteoarticular load, and consequent low-back pain, pregnant people are advised to exercise in water, where buoyancy counters the heaviness and to lift less weight to minimize musculoskeletal injury.)

161. See Khiara M. Bridges, *When Pregnancy Is an Injury: Rape, Law, and Culture*, 65 STAN. L. REV. 457, 486–87 (2013). For descriptions of pregnancy, see Brief for The California Committee to Legalize Abortion, et al. as Amici Curiae Supporting Appellants at 9–12, *Roe v. Wade*, 410 U.S. 113 (1973) (Nos. 70–18, 70–40) (citations omitted). See also Darney, *supra* note 157 at 1363; Neff, *supra* note 143, at 348–49.

162. See, e.g., April Rees, et al., *Maternal Immunometabolic Adaptation in Pregnancy*, 204 (1 Supplement) J. OF IMMUNOLOGY 73.4 (2020).

make pregnant people “particularly vulnerable” to sepsis, and because the usual manner of detecting sepsis is complicated by biological shifts consequent to pregnancy, sepsis can progress before being diagnosed.¹⁶³ Furthermore, “[c]hanges in the immune system, heart, and lungs during pregnancy make pregnant women (and women up to two weeks postpartum) more prone to severe illness from flu, including illness resulting in hospitalization.”¹⁶⁴ In addition, weight gain in pregnancy and the positioning of that weight load can increase strain to a pregnant person’s musculoskeletal system, leading to sciatica and spinal issues, including disc compression and herniation, which sometimes requires surgery to fix.¹⁶⁵

Beyond these specific health risks, there are a broad array of medical conditions that may arise from pregnancy. The doctor who contested the Nebraska statute in *Stenberg* described some of the conditions he encountered in his abortion practice: “women with severe renal failure, severe brittle diabetes, and women whose lives [we]re in jeopardy.”¹⁶⁶

These risks may not be equal for everyone. Multiple and disparate facets of a person’s body, health, and medical history can increase risks if a person becomes pregnant. If a person has given birth before, the mode of that birth—vaginal or cesarean section—has implications for risk,¹⁶⁷ as does the location and positioning of the developing placenta within the pregnant person’s body.¹⁶⁸ Certain autoimmune disorders increase risk. For example, more than “20% of pregnancies in patients with systemic lupus erythematosus (SLE) and/or antiphospholipid antibodies (APL) result in an adverse pregnancy outcome (APO) related to abnormal

163. Colleen D. Acosta et al., *The Continuum of Maternal Sepsis Severity: Incidence and Risk Factors in a Population-based Cohort Study*, 8 PLOS ONE 1, 1 (2013).

164. *Flu and Pregnant Women*, CTRS. FOR DISEASE CONTROL & PREVENTION (Sept. 22, 2020), https://www.cdc.gov/flu/highrisk/pregnant.htm?CDC_AA_refVal=https%3A%2F%2F

165. See Guinn Dunn, et al., *Trajectories of Lower Back, Upper Back, and Pelvic Girdle Pain During Pregnancy and Early Postpartum in Primiparous Women*, 15 WOMEN’S HEALTH 1, 2 (2019).

166. Brief for Respondent at 14, *Stenberg v. Carhart*, 530 U.S. 914 (2000) (No. 99-830).

167. Eric Jauniaux & Amar Bhide, *Prenatal Ultrasound Diagnosis and Outcome of Placenta Previa Accreta after Cesarean Delivery: a Systematic Review and Meta-Analysis*, 217 AM. J. OBSTETRICS & GYNECOLOGY 1, 27–36 (2017), available at <http://www.sciencedirect.com/science/article/pii/S0002937817303824> (“The fourteen cohort studies included 3889 pregnancies presenting with placenta previa or low-lying placenta and 1 or more prior cesarean deliveries screened for placenta accreta. There were 328 cases of placenta previa accreta (8.4%), of which 298 (90.9%) were diagnosed prenatally by ultrasound. The incidence of placenta previa accreta was 4.1% in women with 1 prior cesarean and 13.3% in women with ≥2 previous cesarean deliveries.”); Simona Labor & Simon Maguire, *The Pain of Labour*, 2 REVS. IN PAIN 15, 18 (2008) (“Immediate serious complications of epidural analgesia include: massive misplaced injection intravascularly, intrathecally, or subdurally, high or total spinal block (rare), hypotension, and local anaesthetic induced convulsions and cardiac arrest (rare). Delayed complications include post dural puncture headache, transient backache, urinary retention, epidural haematoma, abscess or meningitis (rare) and permanent neurological deficit (rare). The majority of neurological injuries in this setting are not as a result of neuraxial analgesia but are intrinsic to labour and delivery.”).

168. Jauniaux & Bhide, *supra* note 167, at 27. (“The objective of the study was to evaluate the accuracy of ultrasound imaging in the prenatal diagnosis of placenta accreta and the impact of the depth of villous invasion on management in women presenting with placenta previa or low-lying placenta and with 1 or more prior cesarean deliveries.”).

placentation.”¹⁶⁹ Obesity prefigures increased likelihood of cesarean birth, as well as complications from pregnancy including preeclampsia, gestational hypertension, and gestational diabetes.¹⁷⁰ The extent of obesity also influences the degree of risk; pregnant people who were “morbidly obese” (BMI of 35 or greater) faced higher risks of developing the mentioned obstetric complications than those who were “obese” (BMI of 30 to 34.9).¹⁷¹ High blood pressure entails hazards.¹⁷² Insulin-production and processing capacities shape how a person copes with pregnancy.¹⁷³ Age, too, can be complicating. A pregnant person had “significantly increased adjusted odds” of developing sepsis if they were 35 years old or above, than if they were between 25 and 34 years old,¹⁷⁴ and pregnancy-related mortality ratios also “increased with maternal age.”¹⁷⁵ If a person has experienced psychiatric illness, “prior or current,” the risk of postpartum hemorrhage, defined as blood loss greater than 1000 ml during the first two hours after birth,¹⁷⁶ increases.¹⁷⁷ If a person has taken a particular type of commonly prescribed antidepressant, a selective serotonin reuptake inhibitor (SSRI), the odds of postpartum hemorrhage top nine percent.¹⁷⁸

These clinical factors also sometimes coexist, as with diabetes and obesity, or compound each other. For example, pregnant people who have had a

169. Mimi Y. Kim, et al., Angiogenic factor imbalance early in pregnancy predicts adverse outcomes in patients with lupus and antiphospholipid antibodies: results of the PROMISSE study, 214 AM. J. OBSTETRICS & GYNECOLOGY 1, 108.e1-108.e14 (2016).

170. Joshua L. Weiss et al., Obesity, obstetric complications and cesarean delivery rate—a population-based screening study, 190 AM. J. OBSTETRICS & GYNECOLOGY, 4, 1091–1097 (2004).

171. *Id.*

172. Laurence E. Shields et al., Early Standardized Treatment of Critical Blood Pressure Elevations is Associated with a Reduction in Eclampsia and Severe Maternal Morbidity, 216 AM. J. OBSTETRICS & GYNECOLOGY 4, 415.e1-415.e5 (2017) (affirming that maternal morbidity could be “improved using a standardized approach for treatment of critically elevated blood pressures,” particularly “early intervention with intravenous blood pressure medication” and that “[h]ypertensive disorders of pregnancy result in significant maternal morbidity and mortality.”).

173. See International Association of Diabetes and Pregnancy Study Groups Consensus Panel, International Association of Diabetes and Pregnancy Study Groups Recommendations on the Diagnosis and Classification of Hyperglycemia in Pregnancy, *Diabetes Care* (Mar. 2010); 33(3): 676–682, <https://doi.org/10.2337/dc09-1848>.

174. Acosta, *supra* note 163 (investigating “the incidence and risk factors associated with uncomplicated maternal sepsis and progression to severe sepsis” based on “hospital discharge and vital statistics records data for 1,622,474 live births in California during 2005–2007”) (finding that “1598 mothers developed sepsis; incidence of all sepsis was 10 per 10,000 live births” and that “791 women progressed to severe sepsis; incidence of severe sepsis was 4.9 per 10,000 live births”).

175. Petersen, *supra* note 3; see also Donna L. Hoyert et al., *Maternal Mortality in the United States: Changes in Coding, Publication, and Data Release, 2018*, 69 NAT’L VITAL STAT. REP. 2, 3 (2020) (listing mortality data for 1999–2002 from the National Vital Statistics System) (maternal mortality rate: age under 25, 6.5; age 25–39, 10.4; age 40–44, 33.2; age 45–54, 107.6).

176. Alkistis Skalkidou et al., SSRI Use During Pregnancy and Risk for Postpartum Haemorrhage: a National Register-Based Cohort Study in Sweden, 127 BRITISH J. OBSTETRICS AND GYNAECOLOGY 11, 1366 (2020).

177. *Id.* (“Postpartum haemorrhage prevalence was ...7.6% among women with prior or current psychiatric illness”).

178. *Id.* (“Postpartum haemorrhage prevalence was ... 9.1% among women treated with SSRI.”)

“previous cesarean delivery, presenting with a placenta previa, have become the largest group with the highest risk for placenta previa accreta.”¹⁷⁹ Similarly, preeclampsia, which is a condition associated with the development of significantly elevated blood pressure that carries the risk of progressing to eclampsia, in which seizures are present,¹⁸⁰ and postpartum hemorrhage are “significantly associated with progression to severe sepsis,”¹⁸¹ and “[f]or every cumulative factor, risk of uncomplicated sepsis increased by 25% . . . and risk of progression to severe sepsis/septic shock increased by 57%.”¹⁸² Preeclampsia has no successful mechanisms for early detection and “affects approximately 3% of all pregnancies and is a major cause of maternal and perinatal morbidity and death.”¹⁸³

The likelihood of risks manifesting is sometimes foreseeable, but some obstetric events occur without warning or possibility of prevention or early detection. For example, seven percent of “healthy women” experience obstetric hemorrhage,¹⁸⁴ which is “the leading cause of severe maternal morbidity and of preventable maternal mortality in the United States.”¹⁸⁵

In addition to presenting new risks, pregnancy can interfere with otherwise uncomplicated aspects of safeguarding one’s health. Doctors advise that pregnant people defer elective surgery.¹⁸⁶ Prescription medications of various types — some antidepressants¹⁸⁷ among them — are either strongly advised against or

179. Jauniaux, *supra* note 167, at 27–36. See Frances M. Anderson-Bagga & Angelica Sze, *Placenta Previa*, STATPEARLS., <https://www.ncbi.nlm.nih.gov/books/NBK539818/> (last updated June 27, 2020) (defining placenta previa as “the complete or partial covering of the internal os of the cervix with the placenta.”).

180. *Planned Parenthood v. Casey*, 947 F.2d 682, 700 (3d Cir. 1991) (“Preeclampsia is a combination of symptoms related to an immunological disorder. When diagnosed as having preeclampsia, the patient develops hypertension, she can have destruction of the liver, hemorrhage into the liver, she can have destruction of the kidneys and she may go on to have clampsia, which is a seizure disorder of the brain.” Trial Testimony of Dr. Bolognese, Witness for the Clinics (“Bolognese Testimony”), App. at 614. Both Dr. Bolognese for the clinics and the doctor who testified for the Commonwealth agreed that preeclampsia requires an abortion. Trial Testimony of Dr. Bowes, Witness for the Commonwealth (“Bowes Testimony”), App. at 889.”).

181. Acosta, *supra* note 163.

182. *Id.* at 5.

183. Neil O’Gorman et al., *Competing Risks Model in Screening for Preeclampsia by Maternal Factors and Biomarkers at 11-13 Weeks Gestation*, 214 AM. J. OBSTETRICS & GYNECOLOGY, 103.e1, 103.e1(2016).

184. Skalkidou, *supra* note 176 (“Postpartum haemorrhage prevalence was 7.0% among healthy women, 7.6% among women with prior or current psychiatric illness and 9.1% among women treated with SSRI. The unadjusted odds for PPH among women with prior or current psychiatric illness and women on SSRI treatment were increased by 9 and 34%, respectively”).

185. Elliott K. Main et al., *Reduction of Severe Maternal Morbidity from Hemorrhage Using a State Perinatal Quality Collaborative*, 216 AM. J. OBSTETRICS & GYNECOLOGY 3, 298.e1 (2017).

186. Mauricio V. Ramirez & Catalina G. Valencia, *Anesthesia for Nonobstetric Surgery in Pregnancy*, 63 CLINICAL OBSTETRICS & GYNECOLOGY 2, 351 (2020).

187. Donna Stewart & Simone Vigod, *Antenatal Use of Antidepressants and Risk of Teratogenicity and Adverse Pregnancy Outcomes: Selective Serotonin Reuptake Inhibitors (SSRIs)*, UPTODATE (Nov. 17, 2018), (available at <https://www.uptodate.com/contents/antenatal-use-of-antidepressants-and-risk-of-teratogenicity->

foreclosed from prescription throughout the term of the pregnancy.¹⁸⁸ Some over the counter medicines and select foods¹⁸⁹ should also be avoided,¹⁹⁰ and treatment for other medical illness or ailment, including but certainly not limited to cancer, can be complicated or slowed.¹⁹¹

B. MEDICAL HAZARDS OF BIRTH

Birth itself also threatens health. Whether vaginal or cesarean, birth is a hazardous experience, representing an assault to health, that involves monumental pain and physical trauma, and recovering from birth can involve physical and psychological impositions and risks.

During birth, a pregnant person confronts various hazards.¹⁹² Labor is “dynamic,”¹⁹³ sometimes short, but more often long.¹⁹⁴ The first stage is defined

and-adverse-pregnancy-outcomes-selective-serotonin-reuptake-inhibitors-ssris?search=pregnancy%20risk%20factors&source=search_result&selectedTitle=30~150&usage_type=default&display_rank=30).

188. See Michael Sladden & Karen Harman, *What Is the Chance of a Normal Pregnancy in a Woman Whose Fetus Has Been Exposed to Isotretinoin?*, ARCHIVES OF DERMATOLOGY, Sept. 2007, at 1187–88, doi:10.1001/archderm.143.9.1187; Allen Mitchell, et al., *Medication Use During Pregnancy, with Particular Focus on Prescription Drugs: 1976-2008*, AM. J. OBSTETRICS & GYNECOLOGY, July 2011, at 51.e1-51.51e8, doi:10.1016/j.ajog.2011.02.029; Phoebe Thorpe, et al., *Medications in the First Trimester of Pregnancy: Most Common Exposures and Critical Gaps in Understanding Fetal Risk*, PHARMACOEPIDEMIOLOGY & DRUG SAFETY, July 2013, at 1013-1018, doi:10.1002/pds.3495; ACOG Practice Bulletin No. 92: *Use of Psychiatric Medications During Pregnancy and Lactation*, OBSTETRICS & GYNECOLOGY, Apr. 2008, at 1001–20.

189. *Foods to Avoid in Pregnancy: Your Pregnancy and Baby Guide*, NAT’L HEALTH SERV. (Apr. 16, 2020), <https://www.nhs.uk/conditions/pregnancy-and-baby/foods-to-avoid-pregnant/>.

190. See, e.g., *Update on Seafood Consumption During Pregnancy*, Am. Coll. of Obstetricians & Gynecologists (Jan. 2017), <https://www.acog.org/clinical/clinical-guidance/practice-advisory/articles/2017/01/update-on-seafood-consumption-during-pregnancy> (suggesting that pregnant people limit seafood intake to certain amounts and kinds and noting that “it is important that pregnant women avoid all raw and undercooked seafood, eggs, and meat”).

191. Maya Manian, *Lessons from Personhood’s Defeat: Abortion Restrictions and Side Effects on Women’s Health*, 74 OHIO ST. L. J. 75, 77 (2013) (“Esperanza needed chemotherapy, but the doctors refused to provide the treatment due to fear of prosecution for causing the death of the fetus. By the time the government intervened and ordered chemotherapy be provided, it was too late—the cancer had progressed and Esperanza eventually died.”).

192. Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law As A Tool to Improve Health Care*, 94 NEB. L. REV. 799, 808–13 (2016) (Citations excluded) (“Cesarean surgery is the most common operating room procedure in the U.S., reflecting the near record-high rate of 32.7% of all babies born by cesarean in 2013. This widely reported statistic exceeds the World Health Organization’s projection that medically necessary cesareans should represent only 10-15% of all births in an industrialized nation. But medical intervention into birth extends far beyond cesareans. In 2005, 49% of all hospital procedures performed on individuals aged 18-44 were obstetric procedures. Six of the fifteen most commonly performed hospital procedures for the entire population are associated with childbirth, and six of the ten most common procedures billed to Medicaid and private insurers in 2005 were related to maternity care. Although “more intensive and invasive care is appropriate for about one mother in six,” based on the definition of low-risk pregnancy identified in the federal *Healthy People 2010* initiative, research suggests that rates of invasive medical procedures during childbirth significantly exceed this target; a landmark study of women’s birth experiences reported that 41% of women underwent an attempt by their health care provider to induce labor artificially, 31% had their labors artificially accelerated with synthetic oxytocin, and 36% had their water broken by their care provider to induce or augment labor. Respondents reported widespread use of pain medications during

by cervical dilation,¹⁹⁵ the second by pushing and delivery.¹⁹⁶ Following delivery of the infant is delivery of the placenta, the third stage of labor; placental separation is often prefigured by a “gush of blood.”¹⁹⁷ The two hours immediately postpartum are considered the fourth and final stage of labor.¹⁹⁸

In the process of vaginal birth, the pregnant person's vaginal skin thins and stretches, but more often than not, it also tears, fabric stretched past its limit.¹⁹⁹ Until 1996, evidence indicated that rather than waiting for the skin to tear, the best practice was for doctors to make space by slicing the

childbirth, with 67% receiving an epidural or spinal analgesia and 16% receiving a narcotic analgesia. Further, 25% of women received an episiotomy, a surgical incision to widen the vaginal opening. Researchers have identified a phenomenon where procedures that interfere with the physiologic process of birth can also incur a “cascade of secondary interventions” that are used to monitor and treat side effects of the original interventions. . . . and interventions, both to prevent and to cure disease,” they were also “on the lookout for trouble in birth.”).

193. M. James Lozada et al., *Obstetric Analgesia & Anesthesia*, CRITICAL CARE OBSTETRICS 315, 315 (Jeffrey P. Phelan et al. eds., 2018).

194. See Edgardo Abalos et al., *Duration of Spontaneous Labour in 'Low-Risk' Women with 'Normal' Perinatal Outcomes: A Systematic Review*,” 223 EUR. J. OBSTETRICS & GYNECOLOGY & REPRODUCTIVE BIOLOGY 123, 129 (2018) (“When beginning at 4cm cervical dilatation (commonly associated with active labour onset), the median duration of active first stage was approximately 4–8h in nulliparous with upper limits of up to 20h, and 4h (up to 13h) when active phase onset was defined by cervical dilatation of 5cm. In parous women, when beginning at 4cm cervical dilatation, the median duration was approximately 2–5h with an upper limit of up to 14h, and 3h (up to 11h) when starting point is defined at 5cm. In nulliparous, the second stage was often completed within 1h but could take close to 4h in women with epidural analgesia. Likewise, the second stage in parous women was usually completed in less than half an hour but could take up to 2h in women with epidural analgesia.”).

195. See Ass'n of Professors of Gynecology & Obstetrics, *Topic 11: Intrapartum Care*, YOUTUBE (Sept. 1, 2015), <https://www.youtube.com/watch?v=p-T0nibAY74> (defining labor as “painful uterine contractions” and “cervical dilation”).

196. See *id.* In 2014, medical research guidance shifted to a “long-accepted obstetric paradigm” and condoned second-stage labor of longer than three hours (up to four). Am. Coll. of Obstetricians & Gynecologists & Soc'y for Maternal-Fetal Med., *Obstetric Care Consensus: Safe Prevention of the Primary Cesarean Delivery*, 210 AM. J. OBSTETRICS & GYNECOLOGY 179, 185 (2014). See also Kenneth J. Leveno, David B. Nelson & Donald D. McIntire, *Second-Stage Labor: How Long Is Too Long?*, 214 AM. J. OBSTETRICS & GYNECOLOGY 484, 484 (2016) (noting that “The management of labor has come under increased scrutiny due to the rapid escalation of cesarean delivery in the United States.”) (“[W]e review the evidence on infant safety, vis-à-vis length of the second stage of labor . . . [and] conclude that the currently available evidence fails to support the Obstetric Care Consensus position that longer second-stage labor is safe for the unborn infant.”).

197. See Ass'n of Professors of Gynecology & Obstetrics, *supra* note 195.

198. Stages of Labor, SUTTER HEALTH, <https://www.sutterhealth.org/health/labor-delivery/labor-stages> (last visited Oct. 5, 2020).

199. *Practice Bulletin No. 165: Prevention and Management of Obstetric Lacerations at Vaginal Delivery*, 128 AM. C. OF OBSTETRICIANS & GYNECOLOGISTS 1, 1 (2016) (“Although laceration rates vary based on patient characteristics, birth settings, and obstetric care provider practices, 53–79% of women will sustain some type of laceration at vaginal delivery, with most being first-degree and second-degree lacerations.”) (citations omitted); see also Ass'n of Professors of Gynecology and Obstetrics, APGO Basic Sciences - Topic 23: Pelvic Anatomy, YOUTUBE (Nov. 12, 2018), <https://www.youtube.com/watch?v=z71sBzXZBpI> (To complete vaginal delivery, there “[s]hould be at least 11cm to ensure delivery of the fetal head.”).

pregnant person's flesh and sewing it closed afterward.²⁰⁰ This procedure is called an episiotomy. However, medical research has since established that episiotomies made matters worse during birth²⁰¹ and in the months afterward.²⁰² Episiotomies are now employed less frequently but not infrequently.²⁰³ Over 24 percent of births in the United States involved this practice in 2004.²⁰⁴ In addition, 3.5 percent of births involved anal sphincter laceration.²⁰⁵ Indeed, “[m]odern-day childbirth is, to an unprecedented degree, a procedure-intensive medical event.”²⁰⁶ As the second stage of labor continues and cesarean section is not desired or medically indicated, then birth can be assisted: “Operative deliveries are accomplished by applying direct traction to the fetal skull with forceps” or with a vacuum extractor.²⁰⁷ Roughly 3.3 percent of births in the United States are operative deliveries.²⁰⁸

Cesarean delivery is a major surgery that is common in the United States, despite association with increased maternal mortality and “significant downstream health consequences.”²⁰⁹ A study of all births in the United States in the decade beginning in 2005 found an overall cesarean delivery rate of 31.6 percent,²¹⁰ a

200. See Christophe Clesse et al., *Socio-historical Evolution of the Episiotomy Practice: A Literature Review*, 59 *WOMEN & HEALTH* 760, 760 (2019).

201. Michael C. Klein et al., *Relationship of episiotomy to perineal trauma and morbidity, sexual dysfunction, and pelvic floor relaxation*, 171 *AM. J. OBSTETRICS & GYNECOLOGY* 3, 591 (1994) (“Median episiotomy was causally related to third- and fourth-degree tears”; “[s]pontaneous perineal tears were less painful than episiotomy.”).

202. *Id.* (“Perineal and pelvic floor morbidity was greatest among women receiving median episiotomy versus those remaining intact or sustaining spontaneous perineal tears.”); see also *Practice Bulletin*, *supra* note 199.

203. See generally Klein, *supra* note 201, at 591 (“Episiotomy use should be restricted to specified fetal-maternal indications.”).

204. Elizabeth A. Frankman et al., *Episiotomy in the United States: Has Anything Changed?*, 200 *AM. J. OBSTETRICS & GYNECOLOGY*, 461, 573.e1–573.e7 (2009) (“The rate of episiotomy with all vaginal deliveries decreased from 60.9% in 1979 to 24.5% in 2004”).

205. *Id.* (“Anal sphincter laceration with spontaneous vaginal delivery declined from 5% in 1979 to 3.5% in 2004. Rates of anal sphincter laceration with operative delivery increased from 7.7% in 1979 to 15.3% in 2004”).

206. Elizabeth Kukura, *Giving Birth Under the ACA: Analyzing the Use of Law as a Tool to Improve Health Care*, 94 *Neb. L. Rev.* 799, 808–13 (2016).

207. Ass’n of Professors of Gynecology and Obstetrics, *APGO Basic Sciences - Topic 23: Pelvic Anatomy*, YOUTUBE (Nov. 12, 2018), <https://www.youtube.com/watch?v=z71sBzXZBpI>.

208. *Id.*; Am. Coll. of Obstetricians & Gynecologists, *Practice Bulletin: Operative Vaginal Birth* (April 2020), <https://www.acog.org/clinical/clinical-guidance/practice-bulletin/articles/2020/04/operative-vaginal-birth>.

209. Mark P. Hehir et al., *Cesarean Delivery in the United States 2005 Through 2014: A Population-Based Analysis Using the Robson 10-Group Classification System*, 219 *AM. J. OBSTETRICS & GYNECOLOGY* 105, 105 (2018).

210. *Id.* (“Group-3 births (singleton, term, cephalic multiparas in spontaneous labor) were most common, while group-5 births (those with a previous cesarean) accounted for the most cesarean deliveries increasing from 27% of all cesareans in 2005 through 2006 to >34% in 2013 through 2014. Breech pregnancies (groups 6 and 7) had cesarean rates >90%. Primiparous and multiparous women who had a prelabor cesarean (groups 2b and 4b) accounted for over one quarter of all cesarean deliveries in the 27,044,217 births included in the study.”).

prerate twice that recommended by the World Health Organization²¹¹ and generally recognized to be “too high.”²¹² In particular, cesarean delivery is overused on poor populations of color.²¹³ One study observed that “[w]omen with cumulative advantages (white women with a college education) have the lowest odds of having a cesarean delivery, all else being equal.”²¹⁴ In a cesarean delivery, described rudimentarily, a doctor slices open the pregnant person’s abdomen and creates a wide enough space through which to pull the baby.²¹⁵ The slice cuts through skin, fat, muscle, and the placenta, and can be more than seven inches long.²¹⁶ The procedure lasts roughly forty-five minutes, most of which are spent suturing the pregnant person’s abdomen.²¹⁷

211. Louise Marie Roth & Megan M. Henley, *Unequal Motherhood: Racial-Ethnic and Socioeconomic Disparities in Cesarean Sections in the United States*, 59 SOCIAL PROBLEMS 207, 207 (2012) (“[T]he World Health Organization (WHO) recommends a cesarean rate of 10 to 15 percent: below 10 percent the benefits of the surgery outweigh the risks to mothers and infants, but cesarean rates above 15 percent of births increase maternal and neonatal mortality and morbidity related to the surgery itself (WHO 1985, 2009).”).

212. Steven L. Clark et al., “*Doing Something*” *About the Cesarean Delivery Rate*, 219 AM. J. OBSTETRICS & GYNECOLOGY 267, 267 (2018) (Arguing that “[t]he US cesarean delivery rate is the result of 3 forces largely beyond the control of the practicing clinician: patient expectations and misconceptions regarding the safety of labor, the medical-legal system, and limitations in technology” and stating that, “[w]hether too high or too low, the current US cesarean delivery rate is the expected result of the unique demographic, geographic, and social forces driving it and is unlikely to change significantly given the limitations of current technology to otherwise satisfy the demands of these forces”). See also Kukura, *supra* note 206, at 808 (“Cesarean surgery is the most common operating room procedure in the U.S., reflecting the near record-high rate of 32.7% of all babies born by cesarean in 2013. This widely reported statistic exceeds the World Health Organization’s projection that medically necessary cesareans should represent only 10-15% of all births in an industrialized nation.”).

213. Roth, *supra* note 211, at 222 (“...after accounting for risks and complications, non-Hispanic blacks, Latinas, and Native Americans are more likely to have primary cesareans than non-Hispanic white women, while Asian mothers are less likely”).

214. *Id.*

215. See, e.g., T.R. Vejnović et al., *New Technique for Caesarean Section*, 72(9) GEBURTSHILFE FRAUENHEILKD, 840, 841 (2012) (describing the operative technique) (“The skin incision in the classic C-section technique is done as a horizontal Pfannenstiel incision 2 cm above the pubic symphysis; subcutaneous adipose tissue and the abdominal fascia are also sharply dissected using a scalpel and the aponeurosis of the transverse abdominal muscles is detached from the straight abdominal muscles. The rectus abdominis muscles are then pushed apart. This is followed by cranio-caudal incision of the peritoneum. The peritoneum is severed from the front uterine wall and pushed away caudally. In the classic C-section method the uterine wall is completely dissected using a scalpel, and the incision is then extended manually in a slight horizontal curve. The child is delivered manually after opening the amniotic sac. After determining the neonatal pH-value, the placenta is removed by hand. Curettage of the uterus is done if there is any suspicion that remnants of the placenta have been retained. Depending on the extent of cervical dilation, manual cervical dilatation or dilatation using Hegar pins is done to a width of around 3 cm. The uterus is closed using continuous or interrupted sutures. The peritoneum and the musculature are sutured with continuous or interrupted sutures. The fascia is closed as usual with a continuous suture. Finally the skin incision is closed with intracutaneous continuous sutures”). See also *Uterine Incisions Used During C-sections*, MAYO CLINIC, <https://www.mayoclinic.org/tests-procedures/c-section/multimedia/uterine-incisions-used-during-c-sections/img-20006738> (last visited Oct. 5, 2020).

216. See, e.g., Laura Nicholls-Dempsey et al., *Cesarean Section Incision Length and Post-Operative Pain*, 133 OBSTETRICS & GYNECOLOGY 200S (2019).

217. *Id.*; see also Ass’n of Professors of Gynecology and Obstetrics, *supra* note 195.

No matter the means or duration of birth, the process almost inevitably involves immense pain.²¹⁸ “Labor results in severe pain for most women. During stage one of labor, pain results from the contractions of the uterus and dilation of the cervix, resulting in visceral pain at the levels of T10 to L1,” vertebrae in the mid and lower back.²¹⁹ “As labor progresses, the fetal head distends the lower birth canal and paraneum, resulting in somatic pain transmitted through S2 to S4,” vertebrae near the sacrum.²²⁰ In most medical contexts, pain is considered a health ailment that falls within the ambit of healthcare.²²¹ Options for pain relief include an epidural block: the “most effective form of intrapartum pain relief in the [U]nited [S]tates. Local anesthetics or narcotics are infused through a catheter into the epidural space.”²²² Intravenous opioids or opioid agonists and antagonists may be used but are systemically administered, “so [the] primary mechanism of pain relief is via sedation.”²²³

Efforts undertaken to reduce pain may also come with consequent risks.²²⁴ In order to administer the epidural, a needle is inserted as a spinal tap would be, between vertebrae in the pregnant person’s lower back.²²⁵ That insertion may cause headaches, bleeding, and rarely, a steep drop in blood pressure.²²⁶ Additionally, epidurals may lengthen the duration of labor because they function by numbing the lower portion of the body — thus inhibiting maximum pushing.²²⁷

The extent of labor pain relates “to multiple physiological and psychological factors in a complex manner.”²²⁸ It may worsen if the pregnant person is anxious

218. See Ass’n of Professors of Gynecology and Obstetrics, *supra* note 195 (Defining labor as “painful uterine contractions” and “cervical dilation”); *Safe Prevention of the Primary Cesarean Delivery*, OBSTETRIC CARE CONSENSUS (Soc’y for Maternal-Fetal Med./The Am. C. of Obstetricians and Gynecologists), NO. 1 Mar. 2014 at 1 (documenting ACOG guidelines for vaginal birth after cesarean delivery in this context).

219. See Ass’n of Professors of Gynecology and Obstetrics, *supra* note 195.

220. *Id.*

221. See Black’s Law Dictionary (11th ed. 2019), health, Bryan A. Garner (“health (bef. 12c) 1. The quality, state, or condition of being sound or whole in body, mind, or soul; esp., freedom from pain or sickness.”).

222. See Ass’n of Professors of Gynecology and Obstetrics, *supra* note 195.

223. See *id.*

224. See Simona Labor & Simon Maguire, *The Pain of Labour*, 2(2) REVIEWS PAIN 15, 15–19 (Dec. 2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4589939/>.

225. *Id.* (“Epidural analgesia is thought to be the most effective method of providing pain relief in labour and involves injecting local anaesthetic close to the nerves that transmit pain. It also gives the option of providing regional anaesthesia for obstetric interventions such as forceps delivery and caesarean sections, and obese and other parturients who are at risk of obstetric interventions particularly benefit from an early epidural.”) (“Labour epidurals are associated with an increase in the duration of the second stage and an increased risk of instrumental vaginal delivery. They are also associated with an increased need for stimulation of labour contractions and may cause reduction in maternal blood pressure, and fever.”).

226. See *Epidurals for Labor Fact Sheet*, JOHNS HOPKINS MED., <https://anesthesiology.hopkinsmedicine.org/wp-content/uploads/2019/04/Epidural-Handout-11-20-2018.pdf> (last visited Sep. 25, 2020).

227. See Ass’n of Professors of Gynecology and Obstetrics, *supra* note 195 (noting the second stage of labor may be “shorter if there is no epidural.”).

228. Caroline Junge et al., *Labor Pain in Women with and without Severe Fear of Childbirth: A Population-Based, Longitudinal Study*. 45 BIRTH 469, 477 (2018).

or fearful about birth, or depressed.²²⁹ It may lessen if the birthing person is numbed locally via epidural, or anaesthetized generally in emergency situations,²³⁰ or, most commonly, injected with opiates.²³¹ It may persist if opioids or epidurals are withheld or delivered ineffectively, as is more common if the pregnant person is Black or Hispanic.²³² More homespun, non-pharmacological techniques — massage, inflatable wading pools filled with water,²³³ consistent presence, and emotional support from a doula²³⁴ — also may alleviate pain.²³⁵ Methods that do mitigate pain “may not relieve anxiety or suffering.”²³⁶

Through labor, pain “evolves.”²³⁷ Early labor pain is typically “dull,” and centered “in the lower abdomen, sacrum and back.”²³⁸ Opioids may not effectively combat this pain.²³⁹ As labor progresses, dull pressure

229. *Id.*

230. Lozada, *supra* note 193 (“General anesthesia is used in obstetric practice when regional anesthesia is contraindicated or when a maternal or fetal emergency requires a rapid, reliable anesthetic.”).

231. *See id.* (“Opioids are the most widely used systemic medications for labor anesthesia due to their low cost, ease of use, and lack of need for specialized equipment or personnel.”).

232. *See* George Rust et al., *Racial and Ethnic Disparities in the Provision of Epidural Analgesia in Georgia Medicaid Beneficiaries During Labor and Delivery*, 191(2) AM. J. OBSTETRICS & GYNECOLOGY 456-62 (2004); *see also* Nevet Badreldin, *Racial Disparities in Postpartum Pain Management*, 134(6) HEALTH DISPARITIES: ORIGINAL RESEARCH 1147-1153 (2019).

233. Alison S. Bryant & Ann E. Borders, Am. Coll. of Obstetricians & Gynecologists, *ACOG Committee Opinion: Approaches to Limit Intervention During Labor and Birth*, 133 OBSTETRICS & GYNECOLOGY 164-73 (2020); *see also* Elizabeth R. Cluett, Ethel Burns, & Anna Cuthbert, *Immersion in water during labour and birth*, THE COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2018), CD000111.pub4.

234. *See* Ellen D. Hodnett et al., *Continuous Support for Women During Childbirth*, THE COCHRANE DATABASE OF SYSTEMATIC REVIEWS (2017); *see also* Bryant, *supra* note 233; Tamar Kabakian-Khasholian & Anayda Portela, *Companion of Choice at Birth: Factors Affecting Implementation*, BMC PREGNANCY CHILDBIRTH 17, 265 (2017) (reviewing literature on emotional support in birth and discussing implementation challenges to having labor companion); World Health Organization, *WHO Recommendations for Augmentation of Labour*, (2014); World Health Organization, *WHO Recommendations on Health Promotion Interventions for Maternal and Newborn Health* (2015).

235. *See* Bryant, *supra* note 233 (noting that “Data about the relative effectiveness of nonpharmacologic techniques are limited” because “few have been studied extensively enough to determine clear or relative effectiveness.”).

236. *Id.*

237. Lozada, *supra* note 193. For descriptions of birth pain: Maressa Brown, *14 Moms on What Labor Really Feels Like*, WHAT TO EXPECT (NOV. 9, 2018), <https://www.whattoexpect.com/pregnancy/labor-and-delivery/what-labor-really-feels-like/>; *see also* Emma McGowan, *25 Women Share What It Feels Like To Give Birth*, BUSTLE (May 20, 2015), <https://www.bustle.com/articles/84782-what-does-labor-feel-like-25-women-talk-about-what-it-really-feels-like-to-give>; Kate Kelly, *What Does Labor Feel Like?*, PARENTS (July 16, 2020), <https://www.parents.com/pregnancy/giving-birth/labor-and-delivery/new-moms-describe-what-labor-is-really-like/>; Nell Frizell, *What does childbirth feel like? You asked Google – here’s the answer*, THE GUARDIAN (JULY 18, 2018), <https://www.theguardian.com/commentisfree/2018/jul/18/what-does-childbirth-feel-like-google>; Molly Thomson, *11 women got real about what it really feels like to give birth*, INSIDER (Feb. 1, 2018, 11:11 AM), <https://www.insider.com/what-does-birth-feel-like-2018-1#scraping-away-at-your-insides-with-a-hot-butter-knife-4>.

238. Simona Labor & Simon Maguire, *The Pain of Labour*, 2(2) REVS. PAIN 15, 16 (2008), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4589939/>.

239. *Id.*

transforms to “sharp[ness].”²⁴⁰ The location of pain shifts to “the vagina, rectum and perineum” and is “more resistant to opioid drugs.”²⁴¹ Pain is something medical professionals do not even aspire to fully eradicate. Instead, it is “managed” — as in, “Effective management of labor pain requires an understanding of the dynamic labor process”²⁴² and “Pain assessment is crucial for in-labour pain management.”²⁴³ The maximum pain intensity reported during a pregnant person’s first labor and labor in a subsequent pregnancy is “not clinically different.”²⁴⁴ ACOG has recommended that rather than ask how much pain the laboring person feels, the question be reframed as “coping.” The coping scale asks, “On a scale of 1 to 10, how well are you coping with labor right now?”²⁴⁵ The reason for the reframing is that the formerly-relied upon numeric pain scale (“1-10”) was “insufficient to assess the complex and multifactorial experience of labor.”²⁴⁶ “[A]s a consistent finding, labour pain is ranked high on the pain rating scale when compared to other painful life experiences.”²⁴⁷

C. MEDICAL HAZARDS POST-PARTUM

Postpartum recovery also necessarily involves additional health harms.²⁴⁸ Cesarean sections are major surgery and require over a month to heal fully. The site of incision is vulnerable to infection, and the abdomen is a wound needing to heal.²⁴⁹ Psychological repercussions can include postpartum depression, which

240. *Id.*

241. *Id.*

242. Lozada, *supra* note 193.

243. Yongfang Deng et al., *Are There Differences in Pain Intensity Between Two Consecutive Vaginal Childbirths? A Retrospective Cohort Study*, 105 INT’L J. NURSING STUD. 1, 1 (2020).

244. *Id.* (“Even though women’s self-rated pain intensity is the standard for pain relief or analgesic administration, multiparas appear to receive worse in-labour pain management than primiparas do. . . . Healthcare providers tend to think that multiparas endure the pain and report less pain because they have experienced childbirth . . . From a clinical point of view, in-labour pain is not clinically different for women when comparing their first and second labours. Health care professionals may underestimate in-labour pain in primiparas when comparing them with nulliparas. More studies are warranted to explore options for achieving better pain management for women with more childbirths.”).

245. Am. Coll. of Obstetricians and Gynecology, *ACOG Committee Opinion: Approaches to Limit Intervention During Labor and Birth*, 133 OBSTETRICS & GYNECOLOGY no. 2, 164, 168 (2019).

246. *Id.*

247. Simona Labor & Simon Maguire, *The Pain of Labour*, 2 REVS. IN PAIN no. 2, 15, 15 (2008).

248. *See also* Nev. Dep’t of Hum. Res. v. Hibbs, 538 U.S. 721, 731 (2003) (“Many States offered women extended ‘maternity’ leave that far exceeded the typical 4– to 8–week period of physical disability due to pregnancy and childbirth. . . .”).

249. AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS & SOC’Y FOR MATERNAL FETAL MED., OBSTETRIC CARE CONSENSUS NO. 1, SAFE PREVENTION OF THE PRIMARY CESAREAN DELIVERY 2, tbl.1 (2014), <https://www.acog.org/-/media/project/acog/acogorg/clinical/files/obstetric-care-consensus/articles/2014/03/safe-prevention-of-the-primary-cesarean-delivery.pdf>; *see also* R. Douglas Wilson et al., *Guidelines for Antenatal and Preoperative Care in Cesarean Delivery: Enhanced Recovery After Surgery Society Recommendations (Part 1)*, 219 AM. J. OBSTETRICS & GYNECOLOGY 523, 523 (2018) (<http://www.sciencedirect.com/science/article/pii/S0002937818307634>) (providing an “Enhanced Recovery After Surgery (ERAS) Guideline for perioperative care in cesarean delivery [including] best practice, evidenced-based, recommendations for preoperative, intraoperative, and postoperative phases with, primarily, a maternal focus”).

affects up to fifteen percent of people who give birth.²⁵⁰ Federal law mandates that insurance cover hospital stays for at least ninety-six hours following a cesarean section and forty-eight hours after vaginal birth.²⁵¹

These harms are not acute risks, like preeclampsia; they are the matter of fact occurrences inevitable in every birth. The physiological byproducts of pregnancy and birth are themselves health harms, and their psychological toll, if the pregnancy is not wanted or otherwise tenable, is exacerbated.²⁵²

Furthermore, pregnancy-related risks may present long after one has given birth. “Complications of pregnancy, childbirth, and the postpartum period may lead to death or cause a continuum of morbidities that affect a woman’s health for short or long-term periods during and after pregnancy, and even throughout her life.”²⁵³ Maternal mortality is measured with contested timelines (some metrics measure through 42 days after birth,²⁵⁴ others through one year²⁵⁵), but any cut off is limited in order to enable standardized counting, not because the harms of birth elapse cleanly after a set amount of time postpartum. To the contrary, health risks persist postpartum and extend past the time window of measured counts.²⁵⁶ Though “[m]ost studies have focused on identification of risk factors shortly after pregnancy” and “[l]ess is known on the prevalence of risk factors or actual signs” of, for example, cardiovascular disease later in life, some long-term risks associated with pregnancy have been identified.²⁵⁷ For one, people who experience a hypertensive disorder in pregnancy, particularly early-onset preeclampsia, “are at increased risk

250. Teri Pearlstein et al., *Postpartum Depression*, 200 AM. J. OBSTETRICS & GYNECOLOGY 357, 357 (2009).

251. Newborns’ and Mothers’ Health Protection Act, 29 U.S.C. § 1185 (1996).

252. Compare Lesley Leeds & Isabel Hargreaves, *The Psychological Consequences of Childbirth*, 26 J. OF REPROD. AND INFANT PSYCH. 108, 117-120 (noting that mothers who experienced difficulties during childbirth, resulting in unexpected obstetric procedures, experienced PTSD symptoms with greater frequency) with Caitlin Gerds et al., *Side Effects, Physical Health Consequences, and Mortality Associated with Abortion and Birth after an Unwanted Pregnancy*, 26 WOMEN’S HEALTH 55, 57-59 (2016) (discussing the increased physical toll on the mother of an unwanted pregnancy or abortion).

253. Rachel C. Vanderkruik et al., *Framing Maternal Morbidity: WHO Scoping exercise*, 13 BMC PREGNANCY & CHILDBIRTH 213, 213 (2013).

254. *Id.* at 214-15 (describing the “scoping exercise conducted by the World Health Organization’s Department of Reproductive of Health and Research (WHO/RHR)” to better define maternal morbidity (flagging “discrepancies in 1) the timeframe within which a maternal morbidity occurs, 2) the severity of conditions considered to be a maternal morbidity, 3) the way in which maternal morbidities are classified, and 4) the ways in which maternal morbidities are identified” in English-language research literature on maternal mortality published in the 20 years prior to 2011).

255. Petersen, *supra* note 3, at 762 (The CDC’s Pregnancy Mortality Surveillance System (PMSS) considers a death “pregnancy-related if it occurred during or within 1 year of pregnancy and was caused by a pregnancy complication, a chain of events initiated by pregnancy, or aggravation of an unrelated condition by the physiologic effects of pregnancy.”).

256. See, e.g., Anouk Bokslag et al., *Effect of Early-Onset Preeclampsia on Cardiovascular Risk in the Fifth Decade of Life*, 216 AM. J. OBSTETRICS & GYNECOLOGY 523.e1, 523.e1 (2017).

257. *Id.*; see also Jennifer B. Wasserman et al., *Soft Tissue Mobilization Techniques Are Effective in Treating Chronic Pain Following Cesarean Section: A Multicenter Randomized Clinical Trial*, 42 J. WOMEN’S HEALTH PHYSICAL THERAPY 111, 111 (2018) (discussing chronic pain at the site of cesarean section).

of developing cardiovascular disease later in life” and “have a more than 2-fold increased risk of dying from cardiovascular diseases.”²⁵⁸ “After childbirth, most American women are not scheduled for follow-up care for six weeks, and this visit is poorly attended. Many new mothers feel unprepared for the common health issues they encounter and are uncertain of whom to contact.”²⁵⁹

Moreover, maternal mortality metrics also exclude some health risks associated with and derivative from pregnancy or postpartum hazards, like suicide or drug overdose connected to postpartum depression,²⁶⁰ and homicide, a consequence of intimate partner violence which has been documented to escalate during pregnancy and after.²⁶¹ These biological and clinical risks are now known, but many still may not be.

D. RACE AND POVERTY INCREASE RISKS

Biological and clinical risks are exacerbated by systemic inequalities for minorities and low-income individuals. Maternal hazards in the United States are disproportionately confronted by indigenous people and people of color.²⁶² Black and indigenous women are most likely, and white women least likely, to die as a consequence of pregnancy and to experience severe maternal morbidity.²⁶³ This

258. Bokslag, *supra* note 256 (concluding that “A large proportion of women who experienced early-onset preeclampsia had major cardiovascular risk factors in the fifth decade of life, compared with healthy controls.”).

259. Kristin P. Tully et al., *The Fourth Trimester: A Critical Transition Period with Unmet Maternal Health Needs*, 217 AM. J. OBSTETRICS & GYNECOLOGY 1, 37-41 (2017) (identifying as central issues from birth to twelve weeks postpartum i.e. the “Fourth Trimester”: “(1) the intense focus on women’s health prenatally is unbalanced by infrequent and late postpartum care; (2) medical practice guidelines often do not align with women’s experiences and constraints; (3) validation of women as experts of their infants and elevating their strengths as mothers is necessary to achieve health goals; and (4) mothers need comprehensive care, which is difficult to provide because of numerous system constraints.”).

260. Petersen, *supra* note 3.

261. See *Intimate Partner Violence*, Committee Op. 518, AM. COLL. OF OBSTETRICIANS AND GYNECOLOGISTS (Feb. 2012), <https://www.acog.org/clinical/clinical-guidance/committeeopinion/articles/2012/02/intimate-partner-violence>.

262. S. Res. 459, 115th Cong. (2018) (“Whereas according to the Centers for Disease Control and Prevention, Black mothers in the United States die at 3 to 4 times the rate of White mothers; Whereas Black women in the United States suffer from life-threatening pregnancy complications twice as often as White women; Whereas United States maternal mortality rates are the highest in the developed world and are increasing rapidly; Whereas the United States has the highest maternal mortality rate among affluent countries because of the disproportionate death rate of Black mothers; Whereas the premature delivery rate among Black women is 49 percent higher than the rate among all other women; Whereas Black women are twice as likely to suffer from severe maternal morbidity than White women; Whereas high rates of maternal mortality among Black women span across income and education levels, as well as socioeconomic status; Whereas racial disparities exist across income and education levels; Whereas structural racism, gender oppression, and social determinants of health inequities experienced by Black women in the United States significantly contribute to the disproportionately high rates of maternal mortality and morbidity among Black women; Whereas race and racism play an integral role in maternal health outcomes, care, and policy. . .”).

263. Petersen, *supra* note 3 (“The black:white disparity ratio in the PRMR for the states in the lowest, middle, and highest tertiles was 3.0, 3.3, and 2.8, respectively.”) (“Non-Hispanic black (black) and non-Hispanic American Indian/Alaska Native (AI/AN) women experienced higher PRMRs (40.8 and 29.7, respectively) than did all other racial/ethnic groups. . . The PRMR for black and AI/AN women aged

racial disparity holds regardless of education level,²⁶⁴ geography,²⁶⁵ and age.²⁶⁶ Reasons why pregnant people of color are likely to confront worse outcomes in pregnancy and birth are multiple and complex²⁶⁷ and may be explained largely by documented worse medical care during pregnancy due to social determinants of health including racism,²⁶⁸ implicit bias,²⁶⁹ residential segregation,²⁷⁰ and relatedly, lower quality of care at hospitals serving patients of color.²⁷¹ This lower quality of care also leads to discounting of patient-reported pain²⁷² and symptoms

≥30 years was approximately four to five times that for their white counterparts.”) (“The PRMR for black and AI/AN women aged ≥30 years was approximately four to five times that of their white counterparts. Even in states with the lowest PRMRs, and among groups with higher levels of education, significant disparities persisted. . .”).

264. *Id.* (“Racial/ethnic disparities were present at all education levels. The PRMR among black women with a completed college education or higher was 1.6 times that of white women with less than a high school diploma. Among women with a college education or higher, the PRMR for black women was 5.2 times that of their white counterparts.”).

265. See *Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths*, CDC ONLINE NEWSROOM, (Sept. 5, 2019), <https://www.cdc.gov/media/releases/2019/p0905-racial-ethnic-disparities-pregnancy-deaths.html>; *Pregnancy-Associated Mortality*, NEW YORK CITY DEP’T OF HEALTH AND MENTAL HYGIENE 20, 9, <https://www1.nyc.gov/assets/doh/downloads/pdf/ms/pregnancy-associated-mortality-report.pdf>.

266. Petersen, *supra* note 3.

267. *Id.* (“Multiple factors contribute to pregnancy-related mortality and to racial/ethnic disparities. Previous analyses found that for each pregnancy-related death, an average of three to four contributing factors were identified at multiple levels, including community, health facility, patient/family, provider, and system. Thirteen state maternal mortality review committees reported 60% of pregnancy-related deaths were preventable, and there were no significant differences in preventability by race/ethnicity. Differences in proportionate causes of death among black and AI/AN women might reflect differences in access to care, quality of care, and prevalence of chronic diseases.”).

268. Katie Allan, *Maternal Mortality: Beyond Overmedicalized Solutions*, 2 AM J. OBSTETRICS & GYNECOLOGY MFM 1, 2 (2020) (“Maternal health is also shaped by racism within and without medical institutions, which puts added stressors—from microaggressions to fear of being killed in one’s own home—on black and brown bodies.”).

269. Elizabeth Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*, 61 CLINICAL OBSTETRICS & GYNECOLOGY 387, 387-99 (2018) (Discussing disparities in quality of care and the increased likelihood that Black women will have inappropriate or delayed diagnosis or treatment and noting that that education on “shared decision-making, cultural competency and implicit bias” is needed to address disparities in care); see also Petersen, *supra* note 3.

270. Zinzi D. Bailey, et al., *Structural Racism and Health Inequities in the USA: Evidence and Interventions*, 389 THE LANCET 1453, 1454 (2017) (“Residential segregation also systematically shapes health-care access, utilisation, and quality at the neighbourhood, health-care system, provider, and individual levels.”).

271. Petersen, *supra* note 3 (“Quality of care likely has a role in pregnancy-related deaths and associated racial disparities.”); see also Teresa Janevic et al., *Neighborhood Racial and Economic Polarization, Hospital of Delivery, and Severe Maternal Morbidity*, 39 HEALTH AFFAIRS, 768, 768 (2020) (arguing that “evidence of the underlying macro-level determinants that influence SMM is lacking”).

272. Sarahn Wheeler & Allison Bryant, *Racial and Ethnic Disparities in Health and Health Care*, 44 OBSTETRICS & GYNECOLOGY CLINICS OF N. AM. 1, 4 (2017) (noting that “Several studies have documented that providers are less likely to give analgesics to Black patients seeking treatment in an emergency department compared with whites”).

that, if heeded, could prevent worse outcomes.²⁷³ Most pregnancy-related deaths are preventable.²⁷⁴ But whether a hazard is theoretically preventable is irrelevant for a pregnant person confronting a potentially mortal risk and for whom prevention will not occur. What matters, for the person, and the health exception, is the fact of it.

Race and poverty are highly correlated, meaning that people of color are not only at risk because of racial bias leading to worse care, but also because of increased economic barriers to maintaining health and obtaining high quality care.²⁷⁵ Black women are more likely to have comorbidities, and those comorbidities are more likely to be inadequately managed. PMSS data indicate that “excess mortality in Black women is due to higher case fatality rates, as opposed to higher incidence rates of severe maternal morbidity,”²⁷⁶ meaning that with better or more attentive or resourced medical care, some Black women may not have died. Indeed, quality of healthcare can be determinative.²⁷⁷ An individual’s ability to detect and manage a pre-existing condition—or multiple—is influenced by whether that person is insured and has regular access to a quality obstetric healthcare provider, financial resources, and time.²⁷⁸ Many pregnant people do not have access to those basic prerequisites to a safe pregnancy and birth.

Poverty is associated with worse health, generally,²⁷⁹ and pregnancy is an intensive and taxing physical experience.²⁸⁰ Pregnant people also had significantly increased adjusted odds of developing sepsis if they had public or no insurance or

273. Petersen, *supra* note 3, at 764 (“A national study of five specific pregnancy complications found a similar prevalence of complications among black and white women, but a significantly higher case-fatality rate among black women.”), 763 (“Cardiomyopathy, thrombotic pulmonary embolism, and hypertensive disorders of pregnancy contributed to a significantly higher proportion of pregnancy-related deaths among black women than among white women. Hemorrhage and hypertensive disorders of pregnancy contributed to a higher proportion of pregnancy-related deaths among AI/AN women than among white women.”).

274. *Id.*; see, e.g., Acosta, *supra* note 163 (“In countries with developed healthcare systems, sepsis remains a leading cause of preventable maternal morbidity and mortality.”).

275. See Linda M. Burton et al., *Poverty*, PATHWAYS (SPECIAL ISSUE) 9 (2017), https://inequality.stanford.edu/sites/default/files/Pathways_SOTU_2017_poverty.pdf; *Ethnic and Racial Minorities & Socioeconomic Status*, AM. PSYCHOL. ASS’N (July 2017), <https://www.apa.org/pi/ses/resources/publications/minorities>; see also *Poverty Rate by Race/Ethnicity*, KAISER FAM. FOUND. (2018), <https://www.kff.org/other/state-indicator/poverty-rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D>.

276. Metcalfe, *supra* note 153, at 89.

277. See Elizabeth A Howell, *Reducing Disparities in Severe Maternal Morbidity and Mortality*. 61 CLINICAL OBSTETRICS & GYNECOLOGY 2, 388 (June 2018).

278. Mimi Y. Kim et al., *Angiogenic Factor Imbalance Early in Pregnancy Predicts Adverse Outcomes in Patients with Lupus and Antiphospholipid Antibodies: Results of the PROMISSE Study*, 214 AM. J. OBSTETRICS & GYNECOLOGY, 108.e1, 108.e.1 (2016) (“Timely risk stratification of patients is important for effective clinical care and optimal allocation of health care resources.”).

279. Samuel L. Dickman et al., *Inequality and the Health-care System in the USA*, 389 THE LANCET 1431, 1431–41 (2017); see generally Adam Wagstaff, *Poverty and Health Sector Inequalities*, World Health Organization, 97, 97-105 (2002), <https://www.scielo.org/article/bwho/2002.v80n2/97-105/en/>.

280. See generally Wagstaff, *supra* note 279.

a high school education or less²⁸¹—indicia of poverty.

Risks are intractable in a medical system where preventative measures and treatment, though perhaps theoretically available, are too expensive or too far away to obtain. A study of pregnancy in Appalachia found that nationally, pregnant women in rural areas

die of pregnancy-related causes at a greater rate than urban women. It is unknown how rurality specifically influences pregnancy-related death, but rural women more often embody multiple risk factors associated with negative maternal outcomes. Established risk factors, including high rates of chronic illness and substance abuse, place rural women at risk for severe maternal morbidity and pregnancy-related mortality. These women may also lack the resources to mitigate these risks, including access to high-risk obstetric care.²⁸²

Indigenous women in rural areas also are at a particularly high risk of severe maternal morbidity and mortality and have high risk of preexisting conditions including diabetes.²⁸³

Health risks posing potentially extreme harm abound in pregnancy, particularly for people who are clinically and systemically vulnerable. Research has established these biological and clinical risks, and their intersections with systemic forces of inequity, but this knowledge is comparatively new and evolving. More risks may still be, and almost certainly are, unstudied.

E. INCREASING COMMONALITY OF THREATS TO HEALTH IN PREGNANCY AND BIRTH

Data reveal the increasing prevalence of risk within the pregnancy-capable population. “The rate of both preexisting comorbidities and pregnancy-associated disease is increasing in pregnant women in the USA and varies substantially by race.”²⁸⁴ As to obesity, “The age-adjusted prevalence of obesity among US women increased from 15.8% in 1960 to 40.4% in 2014. In 2014, half of pregnant

281. Acosta, *supra* note 163.

282. Anna Hansen & Mairead Moloney, *Pregnancy-Related Mortality and Severe Maternal Morbidity in Rural Appalachia: Established Risks and the Need to Know More*, 36 J. OF RURAL HEALTH 3, 3 (2020) (answering a call “by the Centers for Disease Control and Prevention (CDC) and the American College of Obstetrics and Gynecology . . . for researchers to further elucidate medical and social determinants of pregnancy-related death and severe maternal morbidity”); *see also* Katy B Kozhimannil et al., *Rural-Urban Differences In Severe Maternal Morbidity And Mortality In The US, 2007-15*, 38 HEALTH AFFS. 2077 (2019), <https://pubmed.ncbi.nlm.nih.gov/31794322/>.

283. Katy B Kozhimannil et al., *Severe Maternal Morbidity and Mortality AMong Indigenous Women in the United States*, 135 OBSTETRICS & GYNECOLOGY 294 (2020), <https://pubmed.ncbi.nlm.nih.gov/31923072/>; *see* Britt Voaklander et al., *Prevalence of diabetes in pregnancy among Indigenous women in Australia, Canada, New Zealand, and the USA: a systematic review and meta-analysis*, 8 The Lancet 681 (2020), <https://www.sciencedirect.com/science/article/pii/S2214109X20300462>.

284. Metcalfe, *supra* note 153 at 89.

women were either overweight (25.6%) or obese (24.8%).”²⁸⁵ “Between 2005-2006 and 2013-2014, the prevalence of chronic conditions increased across all segments of the childbearing population. Widening disparities were identified over time with key areas of concern including disproportionate, progressive increases in the burden of chronic conditions among women from rural and low-income communities and those with deliveries funded by Medicaid.”²⁸⁶ According to the CDC, 9.3 percent of reproductive-age women in the United States have hypertension.²⁸⁷ “[T]he number of women presenting at delivery with 1 or more chronic conditions rose from 66.9 per 1000 delivery hospitalizations in 2005–2006 to 91.8 per 1000 delivery hospitalizations in 2013–2014.”²⁸⁸ Demographic shifts toward

“[d]eliveries by women of advanced maternal age, with preexisting chronic diseases, or multiple gestation pregnancies have increased, as has the use of cesarean delivery. The increased prevalence of preexisting chronic disease in the obstetric population is particularly concerning, as preexisting disease has been independently associated with increased risk of maternal morbidity and mortality, even after adjustment for other demographic shifts.”²⁸⁹

In short, “[b]oth [the] maternal mortality rate and severe maternal morbidity rate have risen significantly in the United States,” and threats to health that do not approximate threats to life are increasingly common, too.²⁹⁰ Pregnancy and birth are, simply, inherently a risk to health.

285. Sarka Lisonkova et al., *Association Between Prepregnancy Body Mass Index and Severe Maternal Morbidity*, 318 JAMA 1777, 1778 (2017) (citing Cheryl D. Fryar et al., *Prevalence of Overweight, Obesity, and Extreme Obesity Among Adults: United States, 1960–1962 Through 2011–2012*, (Sep. 2014); Katherine M. Flegal et al., *Trends in Obesity Among Adults in the U.S., 2005 to 2014*, 315 JAMA 2284–2291 (2016); Amy M. Branum et al., *Prepregnancy Body Mass Index by Maternal Characteristics and State: Data From the Birth Certificate, 2014*, 65 NAT’L VITAL STAT. REP., no. 6, (2016).

286. Linsay K. Admon et al., *Disparities in Chronic Conditions Among Women Hospitalized for Delivery in the United States, 2005-2014*, 130 OBSTETRICS & GYNECOLOGY 1319, 1319 (2017).

287. Olumayowa Azeez et al., *Hypertension and Diabetes in Non-Pregnant Women of Reproductive Age in the United States*, 16 PREVENTING CHRONIC DISEASE, Oct. 2019, at 3; see also Ruben Barakat et al., Abstract, *Exercise During Pregnancy Protects Against Hypertension and Macrosomia: Randomized Clinical Trial*, AM. J. OBSTETRICS & GYNECOLOGY (Dec. 16, 2015), [https://www.ajog.org/article/S0002-9378\(15\)02479-5/fulltext](https://www.ajog.org/article/S0002-9378(15)02479-5/fulltext) (“The prevalence of all pregnancies with some form of hypertension can be up to 10%, with the rates of diagnosis varying according to the country and population studied and the criteria used to establish the diagnosis.”).

288. Shulman, *supra* note 5, at 1305 (“The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing state-based surveillance system of maternal behaviors, attitudes, and experiences before, during, and shortly after pregnancy. PRAMS is conducted by the Centers for Disease Control and Prevention’s Division of Reproductive Health in collaboration with state health departments. . .PRAMS provides state-based data for key maternal and child health indicators that can be tracked over time. Stratification by maternal characteristics allows for examinations of disparities over a wide range of health indicators. (Am J Public Health. Published online ahead of print August 23, 2018: e1–e9. doi:10.2105/AJPH.2018.304563)”).

289. Metcalfe, *supra* note 153, at 90.

290. Elliott K. Main et al., *Measuring Severe Maternal Morbidity: Validation of Potential Measures*, 214 AM. J. OBSTETRICS & GYNECOLOGY 5, 643.e1–643.e10 (2016) (validating the Centers for Disease

III. LEGAL SIGNIFICANCE OF MEDICAL EVIDENCE

Situated in the legal framework governing abortion, this medical evidence indicates that every pregnancy qualifies for the health exception. Though the Court has consistently presumed that threats to health that would justify use of the health exception were rare,²⁹¹ that presumption is false. While emergencies are rare,²⁹² the full set of threats is not so narrow and appears to be growing. Moreover, if almost all pregnancies lead to birth,²⁹³ and birth itself is a threat to health, then almost all pregnancies entail risk. These risks may arise unexpectedly and may have rapidly escalating consequences. Broad segments of the U.S. population are at heightened risk for harm, both as a result of direct clinical variables and as a consequence of systemically imposed hazards, derivative of racism and class. The health exception guards against both threats because the touchstone is the pregnant person's wellbeing. The health exception governs abortion access in medical reality, and abortion limitations must be understood through the prism of health risk.

The medical realities of pregnancy and birth open up the potential for wide application of the health exception, a consequence that is not a weakness of the doctrine; rather, it simply reflects the fact that pregnancy and birth are hazardous, and the Constitution allows individuals in hazardous scenarios to act in their own interest.

The Supreme Court considered the potential expansiveness of a health exception in *Eisenstadt v. Baird*, 405 U.S. 438 (1972). In that case, a Connecticut law allowed condoms to be sold in order to prevent venereal disease but not pregnancy.²⁹⁴ The Court found the presence of a health exception was not itself a problem; rather, the exception revealed the illogic of the attempts to otherwise limit access to contraception.²⁹⁵ So too with the health exception in abortion

Control and Prevention's International Classification of Diseases, 9th revision, criteria for defining severe maternal morbidity with the use of administrative data sources and recognizing the criteria could "serve as a reasonable administrative metric for measuring severe maternal morbidity at population levels").

291. *See* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 850–51 (1992) ("The underlying constitutional issue is whether the State can resolve these philosophic questions in such a definitive way that a woman lacks all choice in the matter, except perhaps in those rare circumstances in which the pregnancy is itself a danger to her own life or health, or is the result of rape or incest.").

292. *Ayotte* is accurate in its assertion that "[i]n some very small percentage of cases, pregnant minors, like adult women, need immediate abortions to avert serious and often irreversible damage to their health." *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 328 (2006).

293. But for miscarriage, *see* Kevin Lang & Ana Nuevo-Chiquero, *Trends in Self-Reported Spontaneous Abortions: 1970-2000*, 49 *DEMOGRAPHY* 989-1009 (2012).

294. Neil S. Siegel & Reva B. Siegel, *Contraception as a Sex Equality Right*, 124 *YALE L.J. FORUM* 349, 353 (2015).

295. *Eisenstadt v. Baird*, 405 U.S. 438, 448–49 (1972) (citations omitted) ("What Mr. Justice Goldberg said in *Griswold v. Connecticut*, *supra*, 381 U.S., at 498 (concurring opinion), concerning the effect of Connecticut's prohibition on the use of contraceptives in discouraging extramarital sexual relations, is equally applicable here. 'The rationality of this justification is dubious, particularly in light of the admitted widespread availability to all persons in the State of Connecticut, unmarried as well as married, of birth-control devices for the prevention of disease, as distinguished from the prevention of

jurisprudence. The Court's presumed rarity of the health exception is ancillary to the logic of it. No matter how common or uncommon use of the health exception is, the arguments grounding it are unaffected. There is nothing scale-dependent about the health exception; it is an individual right.

The universal applicability of the health exception has implications for abortion regulation generally. Because the health exception effectively applies through the entirety of pregnancy, abortion bans, including those post-viability, could, in every instance, be objected to under a full medically informed understanding of the health exception. As a consequence, those bans would not be outcome determinative. Abortion would be available, viability-defining legislation notwithstanding.

Although this article's vision of the health exception as broadly protective and applicable is both supported by medical research and jurisprudence, it is, nevertheless, not currently the way the exception operates in the world. Like other constitutional directives affirming the right to abortion and safeguarding access to it, the health exception has been subjected to legislative limitation.²⁹⁶ And because of what is generally perceived to be the ambiguity of *Gonzales*' holding, since that decision, undertaking affirmative litigation premised on the health exception, or providing abortion care under the exception's safeguard, has seemed a precarious undertaking.²⁹⁷ Still, the medical support underlying the health exception is strong, and equity implications in virtually all categories of social concern—race, class, and geography—only further affirm its validity and essential import.

conception.' See also *id.*, at 505—507 (White, J., concurring in judgment). Like Connecticut's laws, ss 21 and 21A do not at all regulate the distribution of contraceptives when they are to be used to prevent, not pregnancy, but the spread of disease. . .").

296. For example, states have attempted to define mental health out of the health exception entirely. See, e.g., OHIO REV. CODE ANN. § 2919.16(K) (West 1997); FLA. STAT. ANN. § 390.0111(1)(A) (West 2016). Similarly, abortion opponents frequently question whether the exception encompasses mental health. See, e.g., Michael J. Tierney, *Post-Viability Abortion Bans and the Limits of the Health Exception*, 80 NOTRE DAME L. REV. 465 (2004) ("From *Roe v. Wade* in 1973 to *Planned Parenthood v. Casey* in 1992 to *Stenberg v. Carhart* in 2000, the Supreme Court has consistently held that the states have more power to regulate abortions subsequent to viability than prior to viability. Once the child is potentially able to live outside the womb, a state may even ban abortions so long as it provides an exception for situations in which an abortion protects a mother's life or health. But what does it mean to have a health exception? Some circuits interpret this health exception so broadly as to include mental health. Recent Supreme Court cases imply, however, that mental health is not a constitutionally mandated component of the health exception."). Perhaps mental health is vulnerable to argument because mental health has been perceived by some as hazier than physical health: there is more room for debate as to diagnosis, and no readily available way to disprove a person who claims to be, for example, depressed or even suicidal, especially if one is inclined to disbelieve women or even the notion of mental health. The treatment of mental health as distinct from physical health and deserving of fewer protections under the health exception undermines decades of public health education and research recognizing that mental health is a facet of, not distinct from, health. But disbelief or disagreement does not equate with doctrinal confusion or, in turn, with medical validity.

297. See discussion of *Gonzales*, *supra*, Section I.A.6.

Though *Gonzales* is typically regarded as having raised the threshold of risk, a subsequent Court could, consistent with *Gonzales*, affirm that the health exception as requiring abortion availability whenever there is a threat to health, “significant” or not. In fact, the “significant” descriptor may be more semantically than substantively important to safeguarding the health of pregnant people because risks in pregnancy and at birth would satisfy a heightened threshold of risk, in every instance.

CONCLUSION

The health exception's essential consequence has been to assert the right of a pregnant person over and above any possible state interest in potential life. Through the health exception the Court has affirmatively prioritized the pregnant person's health, acknowledged the risks of pregnancy and birth, and held that it would exceed the state's power to impose them.²⁹⁸ Medicine has borne out those risks and established them to be present, always. The state cannot, consistent with the Constitution or foundational legal principles limiting state power, force a person to experience those harms. Some people might choose to go forward with pregnancy despite these risks. This article does not speak to them because the state would not be imposing those hazards; they would be opting in.

The contours of the health exception and the legal principle underlying it clarify that the exception is a strong safeguard of a pregnant person's health against state efforts to compromise it. *Casey* recognized “the urgent claims of the woman to retain the ultimate control over . . . her body” as a claim “implicit in the meaning of liberty.”²⁹⁹ That liberty may be compromised after viability, the Court has held, but not so much that the pregnant person is made to suffer risks to health or life. Pregnancy and birth pose those risks, always.

Through the health exception, the Court protected access to abortion post-viability, thereby recognizing that abortion is healthcare and affirming the primacy of the pregnant person's own health. Unrestricted abortion access, throughout pregnancy, is the health exception's logical mandate.

298. See *Roe v. Wade*, 410 U.S. 113, 164–65 (1973) (“[S]ubsequent 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.”).

299. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 869–70 (1992).