

The Geography of Abortion Rights

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Total or near-total abortion bans passed in recent years have garnered tremendous public attention. But another recent wave of more modest-looking abortion restrictions consists of laws regulating the geography of abortion provision through management of spaces, places, and borders. In the 1990s and early 2000s, numerous states adopted laws regulating the physical spaces where abortions can be performed. These laws include mandates that abortions be performed in particular kinds of places, such as ambulatory surgical centers, or that abortion-providing facilities have agreements in place with local hospitals. One consequence of such regulations has been to reduce the availability of abortion services within the geographical borders of a particular state and to require people to travel out of state in order to terminate a pregnancy. Other abortion controversies, too, have foregrounded the significance of state and even national borders, as in the cases of unaccompanied immigrant minors who sought abortions while in the custody of the U.S. government. Thus, an entire subset of abortion restrictions intentionally targets the geography of abortion provision, inevitably impacts the geographical distribution of abortion services, or both. Yet, the geographical dimension of abortion restrictions has gone mainly unappreciated in the legal literature. This Article thus aims to provide an overview of the geography of abortion regulation. It first considers the unique impact and attractiveness of spatial regulations, demonstrating that they rely on the apparent naturalness of geographical features to exploit or aggravate preexisting social inequality, making the resulting disproportionate burdens seem inevitable. Second, this Article considers the jurisprudential implications of this “spatial turn” in three specific areas: the right to travel, the private nondelegation doctrine, and the concept of viability in abortion doctrine.

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INTRODUCTION

Enormous public attention has focused on the total or near-total abortion bans passed by numerous states in recent years.¹ But another recent wave of more modest-looking abortion restrictions consists of laws regulating the geography of abortion provision through the management of spaces, places, and borders. In the 1990s and early 2000s, numerous states adopted laws regulating the physical spaces where abortions can be performed, such as mandates that abortions be performed in ambulatory surgical centers.² These laws contrast with laws regulating the abortion process itself, such as waiting periods and parental consent requirements for minors. Yet, despite their recent importance, the legal literature on abortion rights has failed to delve deeply into the significance of spatial regulations as compared with other types of abortion restrictions.³

1. In 2019, nine states passed laws banning abortions at a point in pregnancy that is well before viability. See K.K. Rebecca Lai, *Abortion Bans: 9 States Have Passed Bills to Limit the Procedure This Year*, N.Y. TIMES (May 29, 2019), <https://www.nytimes.com/interactive/2019/us/abortion-laws-states.html>. Alabama enacted a total ban on abortion; Georgia, Kentucky, Louisiana, Mississippi, and Ohio banned abortion when a fetal heartbeat can be detected (as early as six weeks of pregnancy); Missouri passed a law banning abortion at eight weeks gestation; and Arkansas and Utah banned abortion at eighteen weeks. See *id.*; Elizabeth Nash, Lizamarie Mohammed, Olivia Cappello & Sophia Naide, *State Policy Trends 2019: A Wave of Abortion Bans, but Some States Are Fighting Back*, GUTTMACHER INST. (Dec. 10, 2019), [guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back](https://www.guttmacher.org/article/2019/12/state-policy-trends-2019-wave-abortion-bans-some-states-are-fighting-back) [<https://perma.cc/BC6M-YXWP>]. North Dakota and Iowa had previously passed first-trimester abortion bans. Elizabeth Nash, *A Surge in Bans on Abortion as Early as Six Weeks, Before Most People Know They Are Pregnant*, GUTTMACHER INST. (May 30, 2019), <https://www.guttmacher.org/article/2019/03/surge-bans-abortion-early-six-weeks-most-people-know-they-are-pregnant> [<https://perma.cc/VL56-8LRL>]. None of these bans is currently in effect.

2. Such laws existed previously, but many were adopted in the 1990s and 2000s. See, e.g., Rachel Benson Gold & Elizabeth Nash, *TRAP Laws Gain Political Traction While Abortion Clinics—and the Women They Serve—Pay the Price*, 16 GUTTMACHER POL’Y REV. 7, 8 (2013), https://www.guttmacher.org/sites/default/files/article_files/gpr160207.pdf [<https://perma.cc/4PET-NLC4>]; Mary Ziegler, *Liberty and the Politics of Balance: The Undue-Burden Test After Casey/Hellerstedt*, 52 HARV. C.R.-C.L. L. REV. 421, 451–52 (2017).

3. A handful of articles from the 1990s and early 2000s consider the constitutional issues surrounding hypothetical extraterritorial abortion restrictions. See, e.g., Susan Frelich Appleton, *Gender, Abortion, and Travel After Roe’s End*, 51 ST. LOUIS U. L.J. 655 (2007); Richard H. Fallon, Jr., *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 ST. LOUIS U. L.J. 611 (2007); Seth F. Kreimer, “*But Whoever Treasures Freedom . . .*”: *The Right to Travel and Extraterritorial Abortions*, 91 MICH. L. REV. 907 (1993); Seth F. Kreimer, *The Law of Choice and Choice of Law: Abortion, the Right to Travel, and Extraterritorial Regulation in American Federalism*, 67 N.Y.U. L. REV. 451 (1992) [hereinafter Kreimer, *The Law of Choice*]. This somewhat narrow issue is addressed below in Section V.B. More recently, Professor Glenn Cohen has discussed abortion, among other medical procedures, in his work on circumvention tourism with a primary focus on international rather than domestic travel. See, e.g., I. GLENN COHEN, PATIENTS WITH PASSPORTS: MEDICAL TOURISM, LAW, AND ETHICS 318–21, 347–56 (2015); I. Glenn Cohen, *Circumvention Tourism*, 97 CORNELL L. REV. 1309, 1363–73 (2012). Lisa Pruitt and Marta Vanegas have written incisively about the role of “urbanormativity” and spatial privilege in shaping the judicial understanding of the burdens imposed on women—particularly rural women—by abortion restrictions. See Lisa R. Pruitt & Marta R. Vanegas, *Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 BERKELEY J. GENDER L. & JUST. 76 (2015). “Urbanormativity,” according to Pruitt and Vanegas, is the tendency to presume urban life as the normal or baseline way of life, and its prevalence among judges results in a failure of case law to recognize the impact that abortion restrictions may have on rural women, such as restrictions that increase the travel required to access abortion services by requiring medically unnecessary in-person visits to a provider. *Id.* at 80, 139–42. See generally Lisa R. Pruitt, *Gender, Geography & Rural*

But geography and space are implicated in abortion laws in ways that go beyond the narrow category of restrictions described above.⁴ Most obviously, one (likely intended) consequence of facility regulations has been to reduce the availability of abortion services within the geographical borders of a particular state and to require some people to travel out of state to terminate a pregnancy. As discussed below, state borders play a significant role in courts' evaluations of the constitutionality of these laws. Other abortion controversies, too, such as the case of unaccompanied immigrant minors who sought abortions while in the custody of the U.S. government, have foregrounded the significance of state and even national borders.⁵

Finally, another set of abortion regulations may be understood as spatial regulations, although they are not usually described as such. These are laws that involve delineation of physical spaces within the woman's⁶ body in a way that resembles the process of mapping out a geographical space. In this category are laws that require an ultrasound before an abortion, often accompanied by a description of the fetal anatomy—a delineation of internal anatomical space projected, like a map, on the screen. The federal Partial-Birth Abortion Ban Act of 2003 is another example of a law that regulates the geography of women's bodies by designating internal "anatomical landmarks" as trigger points for state control of the abortion procedure.⁷

This Article attempts a comprehensive overview of the geography of abortion regulation. The bulk of this Article examines the unique impact of spatial regulation, explaining how the effects of spatial regulation are different from those of other forms of abortion regulation. This Article argues that regulating place is a

Justice, 23 BERKELEY J. GENDER L. & JUST. 338 (2008) [hereinafter Pruitt, *Gender, Geography & Rural Justice*] (examining the influence that geographically focused laws have on rural women). And Mae Kuykendall discusses abortion restrictions among other contexts in which the concept of place plays a role in law. See Mae Kuykendall, *Restatement of Place*, 79 BROOK. L. REV. 757, 787–93 (2014); see also B. Jessie Hill, *Dangerous Terrain: Mapping the Female Body in Gonzales v. Carhart*, 19 COLUM. J. GENDER & L. 649 (2010) (discussing the way in which *Gonzales v. Carhart* presents the woman's internal anatomy as a physical terrain). There is, however, significant room for expansion on the topic of geography in relation to abortion rights. In fact, I owe a debt of gratitude to Mae Kuykendall for encouraging me to expand on this topic.

4. Although the terms *space* and *place* are arguably distinguishable, this Article uses them more or less interchangeably. But see Timothy Zick, *Constitutional Displacement*, 86 WASH. U. L. REV. 515, 524–25 (2009) [hereinafter Zick, *Constitutional Displacement*] (distinguishing among geographic terms such as *place*, *geography*, and *territory*); Timothy Zick, *Space, Place, and Speech: The Expressive Topography*, 74 GEO. WASH. L. REV. 439, 442 (2006) (defining different kinds of places and "non-places"). Similarly, *geography* and *geographic* are used to refer to the attributes of a physical space or place, except when the context indicates that *geography* refers to the academic discipline.

5. See *Garza v. Hargan*, 304 F. Supp. 3d 145, 150–53 (D.D.C. 2018), *aff'd in part, vacated in part, remanded sub nom. J.D. v. Azar*, 925 F.3d 1291 (D.C. Cir. 2019).

6. This Article occasionally uses *women* as shorthand for individuals who may seek an abortion because abortion restrictions disproportionately affect women and are often targeted specifically at women. At the same time, it recognizes that individuals of all gender identities, including transgender men and gender nonconforming people, may become pregnant and seek abortions.

7. See 18 U.S.C. § 1531 (2018). See *infra* Section IV.A for a discussion of the Act's "anatomical landmarks."

way of subtly drawing lines of social exclusion and inclusion, reinscribing social inequality along the dimensions of gender and socioeconomic status, while at the same time concealing this operation. This facet of spatial regulation has made it particularly attractive to advocates and legislators seeking to restrict access to abortion. In addition, borders—whether geographical or anatomical—have the capacity to create and reinforce politics of inclusion and exclusion not so much because of whom they include or exclude but because the ability to manipulate those borders is itself a key mechanism of control. Whether borders are being strengthened or made more permeable, the key fact is not the function of the border (exclusion versus inclusion) but rather its deployment for political and moral ends.⁸

This Article also considers the implications of this “spatial turn” for the development of abortion jurisprudence (and perhaps other areas of constitutional jurisprudence as well). It suggests three ways in which the spatial perspective on abortion regulation might affect constitutional doctrine. First, placing substantive due process jurisprudence pertaining to spatial regulation side-by-side with right-to-travel and equal protection jurisprudence suggests a deep connection between the substantive due process jurisprudence of reproductive liberty and the constitutional concept of equal citizenship. Importantly, it suggests that states may have a constitutional obligation to ensure a certain, non-negligible level of abortion access for their residents. Second, a fresh understanding of spatial regulation might seed a new understanding of state action. Because physical space is taken for granted, state action that creates, manipulates, and reinforces borders is often rendered invisible. This misleading effect, which makes governmental decisions appear to be attributable only to private actors, could be counteracted by reviving the doctrine of “private nondelegation.”⁹ That doctrine forbids private entities from exercising unreviewable and standardless power over individuals’ constitutional rights. Third and finally, this Article suggests that a healthy degree of skepticism is appropriate with respect to claims about supposedly fixed or objective borders, even in the medical realm. Thus, judges should be skeptical of claims that scientific advances have undermined the premises supporting the Supreme Court’s reliance on viability as the appropriate borderline for when abortion can be prohibited.

This Article proceeds as follows. Part I lays out the central theoretical premises of this Article, examining how borders and travel are related to sovereignty and to women’s liberty. Having demonstrated that liberty and legal borders are deeply intertwined, this Article then describes the nature and implications of three

8. See Ayelet Shachar, *The Shifting Border: Legal Cartographies of Migration and Mobility*, in *THE SHIFTING BORDER: LEGAL CARTOGRAPHIES OF MIGRATION AND MOBILITY* 3, 8–9 (Antony Simon Laden, Peter Niesen & David Owen eds., 2020) (describing the selective opening and closing of borders to include or exclude).

9. This Article uses the term *private nondelegation* to distinguish this line of doctrine from the “nondelegation” doctrine that limits the functions that legislatures can delegate to Executive Branch actors and agencies, exemplified by the case *A. L. A. Schechter Poultry Corp. v. United States*, 295 U.S. 495 (1935).

different forms of spatial regulation in each of the next three parts. Part II discusses the regulation of abortion in connection with state and national borders. It argues that such borders play an essential role in defining citizenship and that the presumed inevitability of borders both reinforces and conceals the state's intent to remove from women one of the key attributes of citizenship. Moving to the level of the individual clinic, Part III discusses the current state of abortion-facility regulation in the United States. Through an exposition of the jurisprudence that has developed around such regulation, Part III argues that abortion-facility regulation has the effect of contributing to the unequal citizenship of women by isolating abortion, both physically and legally, from health care generally. Then, turning to abortion's "internal" geography, Part IV considers how abortion laws focused on women's physical anatomy function as spatial regulation, deploying the manipulation of borders as a means of sovereignty and control. Finally, Part V brings together the prior three parts by highlighting the themes that unite all three forms of spatial regulation and by suggesting some ways in which constitutional law might take account of the more problematic aspects of spatial abortion regulation.

A final introductory note: at the time of this writing, the constitutional status of the right to abortion appears as precarious as it has ever been in the years since *Roe v. Wade*¹⁰ was decided. A Supreme Court decision in the near future could well, in one sense, render the analysis here moot, insofar as no woman will have a federal constitutional right to abortion. Therefore, notions of state action and equal protection deriving from that right may soon appear irrelevant because spatial regulations may be replaced by total abortion bans. From another perspective, however, a post-*Roe* world might be only a starker version of the world that already exists. Before *Roe*, some women had the ability to end unwanted pregnancies and others did not.¹¹ A woman's access to procreative liberty varied then, as now, depending on geography, as well as on social class and, consequently, on race and ethnicity.¹² This geographical and social inequality will likely persist, as will the constitutional questions surrounding the scope of state power, even if *Roe* does not. The United States may end up with a patchwork in which some states outlaw abortion in nearly all circumstances, whereas others guarantee liberal access. Indeed, the importance of geography will only intensify as states consider exercising their power extraterritorially.¹³ The possibility of constitutional change thus generates a more pressing need for a new set of arguments with which to challenge restrictions on women's reproductive freedom, such as those presented here.

10. 410 U.S. 113 (1973).

11. See, e.g., LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1876–1973, at 16 (1997).

12. See, e.g., *id.* Alternately, it is possible that federal legislation will be adopted to protect access to abortion nationwide. See, e.g., Women's Health Protection Act of 2019, S. 1645, 116th Cong.

13. See generally Appleton, *supra* note 3 (analyzing constitutional questions posed by extraterritorial criminal abortion bans); Fallon, Jr., *supra* note 3 (same); *infra* text accompanying notes 256–64.

I. SPATIAL REGULATION AND THE MEANING OF REPRODUCTIVE LIBERTY

Control over borders is an essential attribute of sovereignty. According to traditional views of sovereignty, the government determines who is entitled to the benefits and protections of membership in a given political community through controlling physical ingress and egress.¹⁴ It engages in acts of inclusion and exclusion.¹⁵ In theory at least, political borders mark the point at which certain legal protections come into effect, as well as the scope of state sovereignty or power over individuals. For example, the Fourteenth Amendment provides that “[a]ll persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside.”¹⁶ The Fourteenth Amendment’s operation thus depends on geographical facts in its references to the location of birth and of residence, as well as to being within the “jurisdiction” of the United States. State and national borders mark the dividing line between those who are “in”—that is, entitled to the rights, privileges, and immunities of citizenship—and those who are “out.”¹⁷ Regulation affecting borders is therefore not only a quintessential exercise of sovereignty but also one fraught with the possibility of creating and enforcing inequality.

Moreover, although they often rely on natural features such as rivers and mountains, state and national borders are fundamentally artificial—they are creations of law.¹⁸ Perhaps recognizing this artificiality, modern legal doctrine has rejected territory as the primary basis of legal power or jurisdiction, favoring residence or citizenship instead.¹⁹ A focus on residence or citizenship entails a more consensual basis for the state exercise of power over individuals: if individuals willingly choose to live in a particular state and partake of its benefits, they should also expect to be subject to the burden of that state’s rules.

The legal conception of borders thus comprises two contradictory but often coexisting conceptions, as explained in Richard Ford’s groundbreaking scholarship on geography and racial segregation.²⁰ In one conception, which basically aligns with the territorial conception of jurisdiction, political geography is seen as “opaque” in that, like the rivers and mountains themselves, it is “inert, primordial,

14. This is the classical, “Westphalian” understanding of the state, in which legal rights and remedies “are connected to, or limited by, territorial location.” Kal Raustiala, *The Geography of Justice*, 73 *FORDHAM L. REV.* 2501, 2503, 2508–11 (2005). As Kal Raustiala has shown, this understanding has considerable staying power, despite no longer reflecting legal realities and lacking a rational conceptual foundation. *Id.* at 2513–28.

15. Zick, *Constitutional Displacement*, *supra* note 4, at 526–27 (“Sovereigns use territory to control access to the critical prize of membership or citizenship. . . . To enforce the spatiality of citizenship and membership, sovereigns must possess the authority to control territorial borders—to repel and expel.”).

16. U.S. CONST. amend. XIV, § 1.

17. See *Zadvydas v. Davis*, 533 U.S. 678, 693 (2001).

18. See Judith Resnik, “*Within Its Jurisdiction*”: *Moving Boundaries, People, and the Law of Migration*, 160 *PROC. AM. PHIL. SOC’Y* 117, 117 (2016).

19. For helpful and concise discussions of this shift, see Cohen, *supra* note 3, at 1329–35, and Fallon, Jr., *supra* note 3, at 629–32.

20. Richard Thompson Ford, *The Boundaries of Race: Political Geography in Legal Analysis*, 107 *HARV. L. REV.* 1841, 1859 (1994).

natural, and therefore having a natural or prepolitical meaning.”²¹ In the other conception, perhaps represented by the consensual view of jurisdiction, space and geography are “transparent”—that is, “irrelevant, both superseded in importance by the modern technologies of transportation and communication, and insignificant and without consequences of its own.”²² Interestingly, both conceptions take responsibility away from the state for the effects of laws that rely on geographical facts, concealing and ignoring the extent to which decisions by individuals with political power in turn shape those geographies, with predictable and often intended effects on individuals within them.

As an aspect or benefit of citizenship, reproductive liberty is inherently implicated in the regulation of borders. Specifically, the regulation of geography is closely related to reproductive liberty in two ways. First, to the extent that the right to procreative control is understood to be a fundamental right—a basic appurtenance of citizenship—state laws creating a patchwork of abortion access raise the prospect of unequal federal citizenship based on geography.²³ The ability to access medical services is a privilege or immunity of state citizenship; therefore, no citizen of a state can be prevented from traveling to another state to access abortion.²⁴ Yet, the ability of states to regulate the geography of abortion provision in a way that severely constrains patients’ access in some states and forces them to cross state borders to access medical services leads to spatial inequality with respect to a fundamental constitutional liberty.

Second, in the most basic sense, “liberty” is the liberty of movement. It is the freedom from bodily constraints and geographical barriers that prevent free motion. Indeed, according to Blackstone, “personal liberty consists in the power of loco-motion, of changing situation, or removing one’s person to whatsoever place one’s own inclination may direct; without imprisonment or restraint, unless by due course of law.”²⁵ Perhaps due to its long pedigree, no less an originalist than Justice Clarence Thomas has embraced this definition, arguing that the term “liberty” in the Fourteenth Amendment fundamentally connotes nothing more

21. *Id.*

22. *Id.*

23. *See, e.g.,* Jackson Women’s Health Org. v. Currier, 940 F. Supp. 2d 416, 422 (S.D. Miss. 2013) (noting that the logic that states can avoid their responsibility to ensure abortion access “by merely saying that abortions are available elsewhere” would lead to “a patchwork system where constitutional rights are available in some states but not others”), *aff’d as modified*, 760 F.3d 448 (5th Cir. 2014); *cf. Shapiro v. Thompson*, 394 U.S. 618, 627 (1969) (holding that minimum residency requirements for public welfare benefits “create two classes of needy resident families” and violate equal protection with respect to the right to travel).

24. The Supreme Court held in *Doe v. Bolton* that the right to seek abortion services is an aspect of the “privileges and immunities” of state citizenship not because reproductive liberty is a fundamental right but because access to medical care is a privilege of state citizenship. 410 U.S. 179, 200 (1973) (holding that a state residency requirement for abortions violates the Privileges and Immunities Clause of Article IV of the U.S. Constitution).

25. 1 WILLIAM BLACKSTONE, COMMENTARIES 130, *quoted in* The Civil Rights Cases, 109 U.S. 3, 39 (1883) (Harlan, J., dissenting).

than “freedom from physical restraint.”²⁶ But this concept of liberty—although considerably less expansive than the modern notion of liberty as encompassing the right to privacy and decisionmaking autonomy²⁷—is not necessarily a crabbed or archaic one. A concept of liberty grounded in freedom of movement may also support a broad conception of reproductive liberty as intimately related to women’s right to travel, to cross state borders while retaining the appurtenances of citizenship, and even to societal mobility. At the same time, the conception of liberty includes its mirror image—a right not to travel. In the same section discussing the liberty of locomotion, Blackstone also spoke of a fundamental right “to abide in [one’s] own country so long as [one] pleases; and not to be driven from it unless by the sentence of the law.”²⁸

Indeed, the liberty of movement, broadly understood, is an essential aspect of reproductive liberty. Liberty of bodily movement is arguably the most fundamental attribute of citizenship, just as a fundamental attribute of slavery is the inability to leave captivity, to choose where one will enter or stay.²⁹ In the *Civil Rights Cases*, Justice Joseph Bradley noted that the lack of physical mobility was one of the central features of American slavery.³⁰ Moreover, physical mobility brings with it the ability to avail oneself of the privileges and immunities of other states’ laws; *Dred Scott v. Sandford* involved the question of whether an American slave became free by traveling to territory in which slavery was not recognized, thus garnering the benefits of that legal regime.³¹ This question was situated within a broader political, legal, and moral battle over the power of states to exercise extraterritorial power and impose their views on slavery—whether pro or con—on citizens of other states that might disagree.³² Of course, the Supreme Court’s denial of Scott’s citizenship meant that he could not benefit from the anti-slavery regime of other states; it thus denied him, among many other things, a meaningful right to travel and to move about freely at will.

Although obviously a constraint of a different magnitude and kind, involuntary parenthood also constrains women’s physical liberty in numerous ways.³³ Pregnancy may in

26. *Obergefell v. Hodges*, 576 U.S. 644, 725 (2015) (Thomas, J., dissenting); see also Raoul Berger, *Liberty and the Constitution*, 29 GA. L. REV. 585, 587–88 (1995) (discussing historical conceptions of “liberty”); Charles Warren, *The New “Liberty” Under the Fourteenth Amendment*, 39 HARV. L. REV. 431, 444–45 (1926) (same).

27. See *Roe v. Wade*, 410 U.S. 113, 153 (1973).

28. 1 BLACKSTONE, *supra* note 25, at 133.

29. For example, historian William Linn Westermann noted that the ancient Greek definition of freedom, as distinguished from slavery, relied on four elements: (1) “legal status as a protected member of the community”; (2) “immunity from arbitrary seizure or arrest”; (3) “occupational mobility”; and (4) “spatial mobility,” or the freedom to move about at will. William Linn Westermann, *Between Slavery and Freedom*, 50 AM. HIST. REV. 213, 216 (1945).

30. 109 U.S. at 22.

31. 60 U.S. (19 How.) 393, 400 (1857).

32. See generally Kreimer, *The Law of Choice*, *supra* note 3, at 467–68 (explaining how states attempted unsuccessfully to impose their laws pertaining to slavery on conduct outside their borders).

33. Indeed, although it is impossible to compare slavery to any other constraint on individual liberty in terms of its severity and enduring trauma, one scholar has likened involuntary parenthood to involuntary servitude. Andrew Koppelman, *Forced Labor: A Thirteenth Amendment Defense of Abortion*, 84 NW. U. L. REV. 480, 483–84 (1990). In addition, forced childbearing was an essential

some cases literally constrain women's physical movement, but more importantly, parenthood may limit women's social and economic mobility—which also often involves geographic mobility.³⁴ At the same time, the need to access abortion may force women to engage in unwanted travel, perhaps even out of state, as the Supreme Court recognized in *Whole Woman's Health v. Hellerstedt* when striking down the Texas law that would have closed nearly all of Texas's abortion clinics and left broad swaths of the state with no abortion access at all.³⁵ Although this travel enables women to exercise control over their reproductive decisions by accessing abortion services in other states, it is not freely chosen in the sense that it is required by legal rules that limit abortion access within wide geographic regions.

In several other respects, the constitutional right to travel is intertwined with both liberty and racial, gender, and socioeconomic equality. In *Shapiro v. Thompson*, the Supreme Court struck down minimum residency requirements for indigent people to access public benefits, noting that “the nature of our Federal Union and our constitutional concepts of personal liberty unite to require that all citizens be free to travel throughout the length and breadth of our land uninhibited by statutes, rules, or regulations which unreasonably burden or restrict this movement.”³⁶ In *Saenz v. Roe*, the Court vindicated the rights of several women who were fleeing to California to escape abusive relationships in their home states to avail themselves of public benefits under California law on the same terms as other citizens of the state.³⁷ In these cases, claimants asserted a right to equality in the form of a claim of equal citizenship that was intimately connected to the right to travel—that is, a right to avail themselves of certain fundamental privileges regardless of their states of residence. In *Loving v. Virginia*, on the other hand, the Lovings were banished from their home state of Virginia for violating its law banning interracial marriage; their lengthy court battle was essentially a fight to return home and not to be forced to travel.³⁸

This basic framework, connecting the Fourteenth Amendment's guarantees of liberty and equality to the right to travel and to freedom of movement more generally, represents both a lost history and a way forward in challenging spatial regulation of abortion. As Parts II through IV demonstrate, governments control women's bodies and subject them to second-class citizenship through the control of borders and physical spaces. This form of state control often goes

aspect of enslavement. See generally DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 22–55 (2d ed. 2017) (describing the ways in which enslaved Black women were denied autonomy over their reproduction).

34. See, e.g., Diana Greene Foster, M. Antonia Biggs, Lauren Ralph, Caitlin Gerdtts, Sarah Roberts & M. Maria Glymour, *Socioeconomic Outcomes of Women Who Receive and Women Who Are Denied Wanted Abortions in the United States*, 108 AM. J. PUB. HEALTH 407, 412–13 (2018).

35. 136 S. Ct. 2292, 2318 (2016).

36. 394 U.S. 618, 627–29 (1969). Of course, liberty of movement across state borders is also an essential aspect of American federalism.

37. 526 U.S. 489, 494, 498 (1999). Susan Frelich Appleton points out this fact about the plaintiffs in *Gender, Abortion, and Travel After Roe's End*, *supra* note 3, at 674.

38. 388 U.S. 1, 3 (1967). For a depiction of the Lovings' legal odyssey and the extent to which they viewed it as a vindication of their right to return to their home, see *THE LOVING STORY* (HBO 2011).

unrecognized, because spatial regulation has a tendency to appear more neutral, or less the result of official mandates, than it actually is. For this reason, as Part V argues, a new conception of liberty and equal citizenship is urgently needed.

II. BORDER CONTROL: ZONING OUT ABORTION AND CREATING REPRODUCTIVE REFUGEES

As explained in Section II.A, abortion restrictions may interact with state or national borders. First, facility regulations that close abortion clinics on a massive scale have threatened to leave entire states without an abortion provider. These laws appear to be the result of intentional efforts to make some states “abortion-free.” Second, laws have been proposed or passed that regulate the ability of women under the age of eighteen to access abortion outside the borders of their state. Finally, the federal government has taken steps to regulate the access of undocumented minors to abortion in the United States after crossing the southern border. As discussed in Section II.B, all of these instances of abortion-related “border control” demonstrate the effectiveness of spatial regulation in concealing the role of the state in enforcing or aggravating various forms of inequality, thus highlighting the intimate relationship among sovereignty, liberty, and equal citizenship.

A. THE RELATIONSHIP BETWEEN SPATIAL ABORTION RESTRICTIONS AND STATE AND NATIONAL BORDERS

As noted above, the ability to police borders is a fundamental attribute of sovereignty, just as the ability to travel and cross borders freely is a fundamental attribute of liberty, or self-sovereignty. For this reason, it should come as no surprise that state and national borders take on special significance in the struggle over the control of women’s reproductive autonomy. This significance has manifested in various ways.

First, some abortion restrictions have a statewide impact. In some states, including Mississippi, Missouri, and Kentucky, restrictions have come to the verge of shutting down all abortion clinics in the entire state—a result that, in each state, seemed to be the very purpose of the regulations. Indeed, in Mississippi, elected officials clearly expressed their specific intent to this effect. Governor Phil Bryant, on vowing to sign a bill requiring abortion providers to have admitting privileges at a local hospital, stated, “I will continue to work to make Mississippi abortion-free.”³⁹ The lieutenant governor of that state similarly quipped, shortly after the law’s passage, that it “should effectively close the only abortion clinic in Mississippi.”⁴⁰ Individual legislators made comments to the same effect.⁴¹ When Texas passed S.B. 5 (later enacted as H.B. 2)—an abortion

39. Complaint ¶ 19, *Jackson Women’s Health Org. v. Currier*, 940 F. Supp. 2d 416 (S.D. Miss. 2013) (No. 3:12-cv-00436-DPJ-FKB) (quoting Phil West, *Mississippi Senate Passes Abortion Regulation Bill*, COM. APPEAL (Apr. 4, 2012)).

40. *Id.* ¶ 18 (quoting Joe Sutton & Tom Watkins, *Mississippi Legislature Tightens Restrictions on Abortion Providers*, CNN (Apr. 5, 2012, 5:25 AM), <https://www.cnn.com/2012/04/04/politics/mississippi-abortion/index.html> [<https://perma.cc/4DYB-U3KT>]).

41. *Id.* ¶¶ 21–22.

restriction subsequently struck down in *Whole Woman's Health v. Hellerstedt*⁴²—the state's lieutenant governor posted the following tweet, which made visible the geographic impact of the law on abortion availability⁴³:



David Dewhurst ✓

@DavidHDewhurst

 Follow

We fought to pass SB5 thru the Senate last night, & this is why! #StandWithTXChildren #txlege



**KEEP
ABORTION
SAFE &
LEGAL**

**If SB5 passes, it would
essentially ban abortion statewide:**

- Abortion providers that may be forced to close
- One of only 5 providers that will be able to provide safe and legal abortion

StandwithTXWomen.org

The graphic features a map of Texas with several small white dots indicating the locations of abortion providers. The text is in a bold, sans-serif font, and the overall background is a dark gray.

42. See 136 S. Ct. 2292, 2320 (2016).

43. David Dewhurst (@DavidHDewhurst), TWITTER (June 19, 2013, 10:41 AM), <https://twitter.com/davidhdewhurst/status/347363442497302528?lang=en> [<https://perma.cc/RR2W-XMRW>].

In the case of Kentucky, although there were no such direct remarks, a pattern of arbitrary enforcement of the state's abortion regulations strongly suggested a desire to shut down the state's last remaining abortion clinic.⁴⁴

Thus, in some cases, states have attempted to force any women seeking abortion access to leave the state, creating "a patchwork system where constitutional rights are available in some states but not in others,"⁴⁵ and making women into "reproductive refugees."⁴⁶ But courts have so far held that a regulation that would force the closure of a state's last abortion clinic constitutes an unconstitutional undue burden, at least when a sufficient health- or safety-related justification is lacking.⁴⁷

Second, some restrictions operate on the interstate level. Regulations have been passed or proposed that regulate extraterritorial access to abortion. For example, the Child Custody Protection Act (CCPA), which has been introduced eight times since 1998, would criminalize taking a minor across state lines for an abortion to avoid a parental-notice or parental-consent requirement in the minor's home state.⁴⁸ The Child Interstate Abortion Notification Act (CIANA), which has been introduced five times since 2006, would add a requirement that abortion providers notify the parents of all minors seeking abortions unless the minor has *not* traveled from another state *and* the abortion is provided in one of the twelve states that lack a parental involvement requirement.⁴⁹

44. *EMW Women's Surgical Ctr., P.S.C. v. Glisson*, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *2–3 (W.D. Ky. Sept. 28, 2018) (describing how, despite a facility regulation being in place for nineteen years without any problems, the state began suddenly declining to renew a clinic's license for various technical reasons), *rev'd in part, vacated in part sub nom.* *EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 978 F.3d 418 (6th Cir. 2020).

45. *Jackson Women's Health Org. v. Currier*, 760 F.3d 448, 455 (5th Cir. 2014) (quoting the district court's opinion).

46. Brief of Amici Curiae Law Professors Melissa Murray, I. Glenn Cohen & B. Jessie Hill in Support of Petitioners at 18–21, *Whole Woman's Health*, 136 S. Ct. 2292 (No. 15-274).

47. See *Jackson Women's Health Org.*, 760 F.3d at 459; *cf. Friedlander*, 978 F.3d at 443. In *Friedlander*, the Sixth Circuit upheld a Kentucky law that the clinics claimed would leave the entire state without an abortion provider because the panel did not find sufficient evidence that this would occur. *Friedlander*, 978 F.3d at 443 ("Because the plaintiffs have failed to show that [the Kentucky law] would prevent Planned Parenthood from performing abortions in its Louisville facility, they have failed to show that the challenged provisions would leave Kentucky without a licensed abortion facility.")

48. S. 32, 113th Cong. (2013); see S. 167, 112th Cong. (2011); S. 1179, 111th Cong. (2009); S. 2543, 110th Cong. (2008); S. 403, 109th Cong. (2006); H.R. 476, 107th Cong. (2002); H.R. 1218, 106th Cong. (1999); S. 661, 106th Cong. (1999); H.R. 3682, 105th Cong. (1998).

49. Both laws contain exceptions for minors who have already received judicial permission to bypass the parental-involvement requirement (a judicial bypass) and for medical emergencies. S. 369, 113th Cong. (2013); see H.R. 732, 113th Cong. (2013); H.R. 2299, 112th Cong. (2011); S. 1241, 112th Cong. (2011); H.R. 634, 111th Cong. (2009); H.R. 1063, 110th Cong. (2007); S. 403; H.R. 748, 109th Cong. (2005). For a discussion and defense of the CCPA and CIANA, see Teresa Stanton Collett, *Transporting Minors for Immoral Purposes: The Case for the Child Custody Protection Act & the Child Interstate Abortion Notification Act*, 16 HEALTH MATRIX 107 (2006). For a list of the states that currently have parental-involvement requirements, see NARAL PRO-CHOICE AM. & NARAL PRO-CHOICE AM. FOUND., WHO DECIDES?: THE STATUS OF WOMEN'S REPRODUCTIVE RIGHTS IN THE UNITED STATES 24 (26th ed. 2017), <https://www.prochoiceamerica.org/wp-content/uploads/2017/01/WhoDecides2017-DigitalEdition3.pdf> [<https://perma.cc/HY94-DMBX>].

Although neither of these federal laws has yet been enacted, several states have laws aimed at restricting minors' travel for abortion. For example, a 2005 Missouri law creates a civil cause of action for helping a minor obtain an abortion without parental or judicial consent, which would presumably affect adults assisting minors with interstate travel.⁵⁰ Other states restrict the venue where minors can apply for a judicial bypass—for example, to their county of residence or an adjoining county.⁵¹ Read literally, such laws would mean that out-of-state minors generally cannot seek a judicial bypass and therefore cannot get an abortion in the state without parental consent.⁵²

Finally, abortion restrictions have interacted even with national borders. In September 2017, an unaccompanied seventeen-year-old girl crossed the southern U.S. border into Texas, where she was taken into U.S. custody and placed in a shelter run by the Office of Refugee Resettlement (ORR).⁵³ There, the minor, described in the pleadings and cases as J.D. (for Jane Doe), learned she was pregnant, and she wished to terminate the pregnancy.⁵⁴ She successfully followed the procedures prescribed by Texas law for obtaining an abortion without notifying her parents and, with the help of a guardian ad litem, was able to arrange for private financing and transportation for the procedure.⁵⁵ Before she could obtain an abortion, however, ORR officials blocked J.D.'s travel to the clinic, telling her she could receive the procedure only if she left ORR custody by being placed with a sponsor; alternatively, if she did not want to be forced by U.S. officials to carry her pregnancy to term, she could agree to “voluntarily self-deport to her home country,” where abortion is not, however, legal.⁵⁶ Thus, although as a “person” present within the United States J.D. unquestionably possessed a constitutional right to terminate her pregnancy while in the United States,⁵⁷ the federal

50. MO. ANN. STAT. § 188.250 (West 2020); *see* IND. CODE ANN. § 16-34-2-4.2(c) (West 2020). Missouri's law has been upheld against challenges on the First Amendment, Due Process Clause, Commerce Clause, and right-to-travel grounds. *Planned Parenthood of Kan. v. Nixon*, 220 S.W.3d 732, 745 (Mo. 2007) (en banc) (holding the law constitutional). *But see* *Planned Parenthood of Ind. & Ky., Inc. v. Comm'r, Ind. Dep't of Health*, 258 F. Supp. 3d 929, 952 (S.D. Ind. 2017) (issuing a preliminary injunction against a similar law in Indiana), *aff'd*, 937 F.3d 973 (7th Cir. 2019), *cert. granted, judgment vacated sub nom.* *Box v. Planned Parenthood of Ind. & Ky., Inc.*, 141 S. Ct. 187 (2020).

51. *See, e.g.*, FLA. STAT. ANN. § 390.01114(6)(a) (West 2020); IND. CODE § 35-1-58.5-2.5(b) (repealed).

52. However, some courts have construed such venue restrictions not to limit the places where out-of-state minors can seek abortions, to avoid constitutional questions. *See* *Ind. Planned Parenthood Affiliates Ass'n v. Pearson*, 716 F.2d 1127, 1142 (7th Cir. 1983); *Womancare of Orlando, Inc. v. Agwunobi*, 448 F. Supp. 2d 1293, 1306 (N.D. Fla. 2005).

53. *Garza v. Hargan*, 304 F. Supp. 3d 145, 151 (D.D.C. 2018), *aff'd in part, vacated in part, remanded sub nom.* *J.D. v. Azar*, 925 F.3d 1291 (D.C. Cir. 2019).

54. *Id.*

55. *Id.*

56. *Id.*

57. *See* U.S. CONST. amend. V. Neither the courts nor the U.S. Government disputed that J.D. possessed this constitutional right. *See* *Garza v. Hargan*, 874 F.3d 735, 737 (D.C. Cir. 2017) (Millet, J., concurring); *Garza*, 304 F. Supp. 3d at 162 n.5.

government was able to assert arbitrary authority over her reproductive choices and bodily integrity simply by virtue of her geographic situation—her physical presence within ORR custody—which itself was a result of her having crossed a national border. The government’s position was an assertion of complete authority—“an absolute veto”—over J.D.’s pregnancy, which could be avoided only by leaving the sovereign space controlled by the United States.⁵⁸ And it was arbitrary in the sense that it was not legally justified, nor was it claimed to be—it was simply a manifestation of the beliefs and preferences of ORR officials.⁵⁹ Even worse, J.D. was not the only minor to be handled in this manner—her treatment reflected a general policy of the ORR with respect to unaccompanied minors, which led to a class action suit to enjoin the practice.⁶⁰

B. IMPLICATIONS OF ABORTION RESTRICTIONS AFFECTING STATE AND NATIONAL BORDERS

Abortion restrictions that interact with state and national borders have two major features. First, the legal mobilization of state and national borders in the context of abortion restrictions reinforces various forms of inequality while concealing the role of the state in creating and aggravating that inequality. Second, abortion restrictions that have statewide, national, or international effects tend to reinforce the importance of borders in defining citizenship and controlling access to its attributes.

As to the first feature, abortion restrictions that interact with state and national borders invisibly reinforce inequality in several ways. A patchwork in which women in some states completely lack access to abortion creates a form of geographic inequality. Moreover, the inequality plays out along the dimensions of sex, race, and socioeconomic status.⁶¹ Some affected individuals may face intersecting forms of disadvantage—like J.D., whose racial and national identity (resulting in her crossing the southern U.S. border) and whose status as a minor made her particularly vulnerable to the raw exercise of sovereignty by the U.S. government not only over its own borders but also over her body. Another stark instance of intersecting disadvantage created at least in part by spatial abortion regulation is demonstrated by the plight of undocumented immigrant women in the Rio Grande Valley in Texas who largely lack access to abortion care because they cannot travel outside that region within Texas to an abortion provider

58. *Garza*, 304 F. Supp. 3d at 162.

59. *See id.* at 163.

60. *Id.* at 150–51. That class action was settled in September 2020, with the government agreeing not to obstruct minors in ORR custody from seeking abortions. Exhibit A to Joint Stipulation of Dismissal Without Prejudice at 4, *J.D. v. Azar*, No. 1:17-cv-02122-TSC (D.D.C. Sept. 29, 2020), ECF No. 168-1.

61. Regarding the sex equality dimension, in considering the possibility of extraterritorial abortion regulation by states in a world without *Roe*, Susan Frelich Appleton speaks of “a gendered right to travel.” Appleton, *supra* note 3, at 683. Regarding racial and socioeconomic inequality, see JENNA JERMAN, RACHEL K. JONES & TSUYOSHI ONDA, GUTTMACHER INST., CHARACTERISTICS OF U.S. ABORTION PATIENTS IN 2014 AND CHANGES SINCE 2008, at 5–7 (2016), https://www.guttmacher.org/sites/default/files/report_pdf/characteristics-us-abortion-patients-2014.pdf [<https://perma.cc/WC36-RSF9>] (finding that women seeking abortions are disproportionately poor and that they are disproportionately Black and Latina).

without encountering a Border Patrol checkpoint.⁶² Only one clinic remained in the sprawling, nearly 5,000-square-mile Rio Grande Valley region at the time of the Supreme Court's 2016 decision in *Whole Woman's Health*.⁶³ Had the Supreme Court allowed that final clinic to close, people living in that region would have been forced to cross a national border (into Mexico) or a state border (into New Mexico) to access abortion services.

Moreover, even outside the border zone context, restrictions that increase travel burdens self-evidently fall harder on those women who are already financially insecure, because they can little afford the cost of travel itself—not to mention additional costs such as child care and lost wages. Thus, geographic disadvantage often overlaps with other forms of disadvantage and discrimination, such as racial and ethnic discrimination.

Such abortion restrictions have a second significant impact as well. They reinforce the importance of borders—state or national—in defining citizenship and controlling access to the benefits and protections thereof, even as states downplay the importance of those same borders, casting them as arbitrary and irrelevant. Thus, on the one hand, the state sometimes seeks to *avoid* boundary crossings, as in the case of the proposed CCPA and CIANA, as well as state laws that restrict travel and venue for minors seeking abortions. Extraterritorial criminalization of abortion—a possibility that can be contemplated in a post-*Roe* world—would similarly be aimed at keeping pregnant individuals from traveling outside the state for abortions.⁶⁴

On the other hand, states sometimes seek to encourage or even force border crossings. For example, the federal government told J.D. that she could not exercise her right to access abortion within the boundaries of the United States but could choose to “self-deport.”⁶⁵ Or, assuming a kind of “not in my backyard” posture, states have occasionally asserted as a defense to an undue-burden claim based on a dramatic reduction in abortion access that women can simply travel to adjoining states to access abortion, and that the clinics in those other states may even be closer to them than the in-state clinic or clinics in danger of closing.⁶⁶ This argument suggests that state borders are meaningless and arbitrary—that people can cross them at will, and that borders have no special significance for

62. See Madeline M. Gomez, *Intersections at the Border: Immigration Enforcement, Reproductive Oppression, and the Policing of Latina Bodies in the Rio Grande Valley*, 30 COLUM. J. GENDER & L. 84, 107–08 (2015); Kate Huddleston, Note, *Border Checkpoints and Substantive Due Process: Abortion Rights in the Border Zone*, 125 YALE L.J. 1744, 1748 (2016).

63. *Whole Woman's Health v. Cole*, 790 F.3d 563, 592–98 (5th Cir.), modified, 790 F.3d 598 (5th Cir. 2015), *rev'd and remanded sub nom.* *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292 (2016).

64. See *supra* text accompanying note 13.

65. See *supra* note 56 and accompanying text.

66. This claim was made in *Planned Parenthood of Wisconsin, Inc. v. Schimel*, 806 F.3d 908, 918 (7th Cir. 2015); *Whole Woman's Health*, 790 F.3d at 596; *Jackson Women's Health Organization v. Currier*, 760 F.3d 448, 455 (5th Cir. 2014); and *EMW Women's Surgical Center, P.S.C. v. Glisson*, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *25 (W.D. Ky. Sept. 28, 2018) (“Contending that the regulations do not impose an unconstitutional burden on a woman’s access to abortion, Defendants point to the availability of abortion facilities in other states.”).

the exercise of constitutional rights (while at the same time states claim that their abortion-facility regulations are vital to protecting the health and safety of the citizens within their borders).⁶⁷

Similarly, in a challenge to Utah's 24-hour waiting period for abortion, the district court breezily dismissed the notion that the State of Utah is different from the State of Pennsylvania in any legally relevant way—a necessary showing for the plaintiffs because the Supreme Court had upheld Pennsylvania's similar law.⁶⁸ The court acknowledged that Utah is larger than Pennsylvania and has far fewer urban areas but rejected as a “red herring” the argument that “the waiting period's burden is greater on rural women in Utah because they have farther to travel to get [an abortion],” reasoning that “[t]his travel burden is not a factor of state law.”⁶⁹ Instead of recognizing the role of Utah law in burdening Utah women's access to abortion, the court treated such geographical facts as merely natural, inevitable, and irrelevant to the law's constitutionality. This mode of thinking appears to relieve the state of any responsibility for the law's effects in Utah.

Generally, however, courts have rejected this approach, insisting that “state lines do matter.”⁷⁰ The court in *Jackson Women's Health Organization v. Currier (JWHO)*, for example, rejected Mississippi's attempt to enforce a facility regulation that would shut down the state's last remaining abortion clinic, emphasizing the importance of state borders to the state's obligation to ensure that citizens can exercise their constitutional rights.⁷¹ At the same time, the dissenting judge in that case questioned whether “the Clinic's closure would result directly from [the challenged law], as opposed to the independent decisions of local hospitals—non-state actors.”⁷²

There is an apparent contradiction here. State policies regulating abortion with respect to state and national borders alternately endeavor to keep people who seek abortions within the state, and to kick them out. Those policies thus simultaneously reinforce and minimize the importance of those borders, highlighting that the *ability to control* the borders and their implications is more important than whether borders are used to include or to exclude. The border itself is nothing other than a tool of control. As noted above, a fundamental and ancient characteristic of sovereignty is the ability to exercise power over individuals within a set of borders.⁷³ In the immigration context, Ayelet Shachar has referred to “the

67. A related argument showing the arbitrary nature of state borders in abortion regulations is that laws that apply only in a single state, such as heightened informed consent requirements, may have “spillover” effects into other states, such as encouraging doctors to adopt those informed consent requirements even where they are not statutorily required to do so, to avoid civil lawsuits from patients. See Katherine Shaw & Alex Stein, *Abortion, Informed Consent, and Regulatory Spillover*, 92 IND. L.J. 1, 6 (2016).

68. *Utah Women's Clinic, Inc. v. Leavitt*, 844 F. Supp. 1482, 1490 (D. Utah 1994).

69. *Id.* at 1491 n.11.

70. *Jackson Women's Health Org.*, 760 F.3d at 455.

71. *Id.* at 457–58.

72. *Id.* at 461 (Garza, J., dissenting).

73. See *Pennoyer v. Neff*, 95 U.S. 714, 722 (1878) (“[E]very State possesses exclusive jurisdiction and sovereignty over persons and property within its territory.”), *overruled in part by Shaffer v. Heitner*, 433 U.S. 186 (1977).

shifting border” of regulation, meaning that the line triggering enforcement of legal rules is movable and manipulable—“selectively utilized by . . . regulators to regain control over their crucial realm of responsibility, to determine who[m] to permit to enter, who[m] to remove, and who[m] to keep at bay.”⁷⁴ As geographer Mathew Coleman explains, what is really at issue is “social control” rather than “territorial control.”⁷⁵ Borders in abortion regulation, like in immigration law, function more as a means of drawing distinctions among people on the bases of race, ethnicity, poverty, and other social characteristics, than as juridical boundaries. The manipulation of borders in this manner thus demonstrates the deep interconnection among sovereignty, liberty, and equal citizenship.

III. REGULATION OF THE SPACES WHERE ABORTIONS TAKE PLACE: ENFORCING THE PHYSICAL AND DOCTRINAL ISOLATION OF ABORTION

Facility regulations, the focus of this Part, are an obvious example of regulating the spaces where abortions are performed. Section III.A begins with an overview of facility regulations. Facility regulations focus primarily on freestanding abortion clinics, which are the places where the majority of abortions are performed in the United States.⁷⁶ They usually have the widely recognized and expected effect of making abortion more expensive and more difficult to provide and receive, and as a result, advocates have challenged them as imposing an undue burden on abortion access. As discussed below in Section III.B, they also have less obvious effects that make them a particularly attractive form of legislation for lawmakers seeking to restrict access to abortion; they reinforce gender and other forms of inequality and advance a moral agenda while concealing the active role played by state officials in doing so.

A. THE LAW AND POLICY OF ABORTION-FACILITY REGULATION

Facility regulations have a lengthy pedigree, but in recent years, states that are hostile to abortion have adopted them with a newfound zeal. *Roe v. Wade* had left open the possibility that laws regulating the places where abortions are performed would be found constitutional.⁷⁷ And indeed, abortion opponents began introducing such laws as early as the 1970s.⁷⁸ But they did not appear to gain steam until

74. Ayelet Shachar, *The Shifting Border of Immigration Regulation*, 30 MICH. J. INT'L L. 809, 811 (2009); see also *id.* at 813 (noting a trend of “greater latitude for national legislatures and regulatory agencies to develop new enforcement policies that manipulate the border—bleeding it into the interior or extending it beyond the territory’s exterior—whenever such maneuvers are beneficial to deter access by irregular migrants deemed inadmissible or deportable”).

75. Mathew Coleman, *Immigrant Il-Legality: Geopolitical and Legal Borders in the US, 1882–Present*, 17 GEOPOLITICS 402, 403 (2012).

76. See Rachel K. Jones & Jenna Jerman, *Abortion Incidence and Service Availability in the United States, 2014*, 49 PERSP. ON SEXUAL & REPROD. HEALTH 17, 20 (2017).

77. 410 U.S. 113, 163 (1973) (suggesting that states may regulate “the facility in which the procedure is to be performed, that is, whether it must be a hospital or may be a clinic or some other place of less-than-hospital status; . . . the licensing of the facility; and the like”).

78. See, e.g., Ziegler, *supra* note 2, at 441. For example, states adopted laws in the 1970s and 1980s requiring certain abortions to be performed in hospitals and regulating the staffing and structural features

the 1990s and 2000s, perhaps due to those groups' perception that *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁷⁹ in 1992, had further opened the door to them.⁸⁰ In *Casey*, the Supreme Court held that abortion restrictions would no longer be subject to strict scrutiny and instead would pass muster if they did not constitute an "undue burden" on abortion access.⁸¹ Under the undue burden standard, it seemed that nearly any abortion regulation short of a flat-out ban could potentially pass constitutional muster, so long as it was not obviously aimed at stopping abortions.⁸² *Casey* thus introduced a notably amorphous legal standard that seemed to invite envelope-pushing by states seeking to restrict abortion and, as discussed throughout this Article, that allowed state actors seeking to restrict abortion access to hide their purpose behind neutral-seeming laws.

Justified as protecting the health and safety of patients, facility regulations are also, in part, a result of anti-abortion activists' turn toward "woman-protective" arguments.⁸³ Such arguments fed into a broader incremental strategy for undermining *Roe v. Wade*'s constitutional protection for abortion; first, by winning public support for the anti-abortion cause; and second, by exploiting the ambiguities of *Planned Parenthood of Southeastern Pennsylvania v. Casey*.⁸⁴ This approach may have been especially attractive because of the failure of other anti-abortion strategies, such as foregrounding fetal rights.⁸⁵ Thus, a confluence of historical and political factors, gathering over at least two decades, led advocacy groups to push for—and anti-abortion legislators in many states to adopt—an array of laws that targeted abortion clinics rather than the abortion procedure itself.

Some regulations, known as TRAP laws (for Targeted Regulation of Abortion Providers), impose particularly onerous restrictions only on abortion providers and not on facilities providing comparable health care services.⁸⁶ Such laws may include requirements that providers of abortion outside the hospital setting must

of freestanding abortion clinics. *See, e.g., City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 421–25 (1983), *overruled by Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); *Birth Control Ctrs., Inc. v. Reizen*, 743 F.2d 352, 361–67 (6th Cir. 1984).

79. 505 U.S. 833.

80. Ziegler, *supra* note 2, at 442–49.

81. 505 U.S. at 878 (plurality opinion).

82. Laws that were clearly aimed at stopping abortions would violate *Casey*'s "purpose" prong, forbidding laws that have the purpose of imposing an undue burden on abortion access. *Id.* at 877.

83. *See* Ziegler, *supra* note 2, at 447. "Woman-protective" arguments, in this context, are arguments in support of laws denying women reproductive autonomy on the ground that they are for the women's own good. For example, in *Gonzales v. Carhart*, the Court partly justified a ban on a particular abortion method by arguing that women would regret their abortions if they later learned the details of how they were performed; thus, the method had to be banned for the good of the women. 550 U.S. 124, 159–60 (2007).

84. *See* Ziegler, *supra* note 2, at 441–42, 447; Mary Ziegler, *Substantial Uncertainty: Whole Woman's Health v. Hellerstedt and the Future of Abortion Law*, 2016 SUP. CT. REV. 77, 97–101. *See generally* Reva B. Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1707–32 (2008) (discussing the shift toward incrementalism and a focus on "woman-protective" legislation in the context of "partial-birth" abortion bans). As I discuss below, *infra* Part IV, such bans can be considered a species of spatial regulation.

85. *See* Siegel, *supra* note 84, at 1706.

86. *See, e.g., Mandeel Silverman, RU-486: A Dramatic New Choice or Forum for Continued Abortion Controversy?*, 57 N.Y.U. ANN. SURV. AM. L. 247, 280 (2000).

have admitting privileges at a hospital or an agreement or affiliation with a hospital or provider with admitting privileges.⁸⁷ Or they may take the form of physical plant specifications pertaining to corridor width and the size of procedure rooms.⁸⁸ Some of these laws even apply to facilities where only nonsurgical abortions—early abortions completed with the use of medications only—are offered.⁸⁹

Though ostensibly aimed at ensuring the safety of the abortion procedure, such regulations often have minimal safety benefits, which are largely outweighed by their significant burden on abortion access.⁹⁰ For example, “admitting privileges” laws require abortion-providing doctors to acquire the authority, granted by a hospital, to admit patients at that hospital and to treat them there.⁹¹ A hospital often treats the grant of admitting privileges as equivalent to making a doctor a member of its staff.⁹² Though sometimes claimed to indicate clinical competence, admitting privileges can be—and often are—denied for reasons unrelated to competence.⁹³ Nor do admitting privileges affect the quality of care a patient receives at the hospital.⁹⁴ Admitting privileges requirements thus lack any meaningful health or safety justification.

At the same time, TRAP requirements such as a physician performing abortions in a clinic maintain hospital admitting privileges may impose a significant burden on abortion access, and meeting these requirements is impossible for many abortion providers.⁹⁵ Because abortions are provided primarily in nonhospital settings, an abortion provider is unlikely to have a relationship with a hospital unless she also treats other kinds of patients.⁹⁶ Moreover, some hospitals require a certain number of patient admissions for a physician to receive and maintain privileges; because abortion is a safe, minor surgical procedure typically performed in an outpatient setting, it rarely results in hospital admission (which would be required only in the case of a relatively serious complication).⁹⁷ Finally, hospitals may decline to extend admitting privileges to a physician for any reason—including reasons unrelated to clinical competence—and many do so either because their religious affiliation does not permit them to affiliate with an abortion provider or simply because they wish to avoid the controversy associated

87. See, e.g., Gold & Nash, *supra* note 2.

88. See, e.g., *id.* at 11.

89. Eighteen states currently apply such requirements in facilities where medication-only abortions are performed. See *Targeted Regulation of Abortion Providers*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers#> [<https://perma.cc/9XLD-FESJ>] (last updated Feb. 1, 2021).

90. See *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2310–11 (2016).

91. *Id.* at 2130–12; *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 909 (7th Cir. 2015).

92. See *Whole Woman’s Health*, 136 S. Ct. at 2312; *Schimel*, 806 F.3d at 909.

93. See *Whole Woman’s Health*, 136 S. Ct. at 2312–13.

94. See *id.* at 2311–12.

95. June Med. Servs., L. L. C. v. Russo, 140 S. Ct. 2103, 2123 (2020) (plurality opinion); *Whole Woman’s Health*, 136 S. Ct. at 2312.

96. *Schimel*, 806 F.3d at 916.

97. *Whole Woman’s Health*, 136 S. Ct. at 2312–13; *Schimel*, 806 F.3d at 916–17.

with doing so.⁹⁸ If providers are unable to obtain privileges, then clinics will close, restricting abortion access.

Litigation concerning facility regulations has been particularly active in recent years as courts have worked to apply the “undue burden” framework in this context. In 2016, the U.S. Supreme Court in *Whole Woman’s Health v. Hellerstedt* considered the constitutionality of two different abortion-facility regulations adopted by the state of Texas: a requirement that abortion providers have admitting privileges at a local hospital and a requirement that abortion clinics conform to expensive physical plant requirements so as to qualify as ambulatory surgical centers (ASCs).⁹⁹ In articulating the legal standard that it would apply, the Court in *Whole Woman’s Health* claimed that “*Casey* . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer,” necessitating a balancing of burdens against benefits to determine whether the burden on abortion access is “undue”—that is, unjustified by its benefits.¹⁰⁰

The Court reviewed the extensive evidence presented in the trial court regarding the safety benefits of each law, which it found to be minimal or nonexistent.¹⁰¹ The Court then weighed these benefits against the law’s burden on abortion access, which in this case meant the closure of about thirty-two of Texas’s forty abortion clinics, requiring women in some parts of the state to travel over 400 miles roundtrip to obtain an abortion.¹⁰² Given the negligible safety benefits as compared to the significant burdens on abortion access, the Court held that the Texas regulations amounted to an unconstitutional “undue burden” on abortion under the framework set forth in *Planned Parenthood of Southeastern Pennsylvania v. Casey*.¹⁰³ Crucially, *Whole Woman’s Health* explained that courts must consider the actual, on-the-ground burdens imposed by a particular abortion restriction, such as the expense and inconvenience of travel and the negative impact on quality of care, and weigh them against any benefits that the law would bring.¹⁰⁴ As Linda Greenhouse and Reva Siegel explain, although under

98. *Whole Woman’s Health*, 136 S. Ct. at 2312–13; *EMW Women’s Surgical Ctr., P.S.C. v. Glisson*, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *4 (W.D. Ky. Sept. 28, 2018) (noting that the termination of a hospital’s transfer agreement with Planned Parenthood was partly due to “public controversy,” as well as the expressed view of the Archdiocese of Louisville), *rev’d in part, vacated in part sub nom.* *EMW Women’s Surgical Ctr., P.S.C. v. Friedlander*, 978 F.3d 418 (6th Cir. 2020). See generally *Mauer v. Highland Park Hosp. Found.*, 232 N.E.2d 776, 778 (Ill. App. Ct. 1967) (“It is a well-settled rule that a private hospital has the right to refuse to appoint a physician or surgeon to its medical staff, and this refusal is not subject to judicial review; the decision of the hospital authorities in such matters is final.” (citing *State ex rel. Sams v. Ohio Valley Gen. Hosp. Ass’n*, 140 S.E.2d 457, 462 (W. Va. 1965); *Schulman v. Wash. Hosp. Ctr.*, 222 F. Supp. 59, 63 (D.D.C. 1963); *Khoury v. Cmty. Mem’l Hosp., Inc.*, 123 S.E.2d 533, 539 (Va. 1962); *Manczur v. Southside Hosp.*, 183 N.Y.S.2d 960, 961 (1959); *Levin v. Sinai Hosp. of Balt. City*, 46 A.2d 298, 301 (Md. 1946))).

99. *Whole Woman’s Health*, 136 S. Ct. at 2310–14.

100. *Id.* at 2309–10.

101. *Id.* at 2310–12, 2315–16; see *supra* text accompanying notes 90–94.

102. *Whole Woman’s Health*, 136 S. Ct. at 2301–02.

103. *Id.* at 2300.

104. See *id.* at 2309–10.

prior doctrine states could “impose almost any obstacle to abortion short of criminalization, in *Whole Woman’s Health* the Court assess[e]d the impact of an abortion restriction in constitutional terms sensitive to women’s experience in making and carrying out a decision to end a pregnancy.”¹⁰⁵ If the actual, record-supported benefits of the law were outweighed by such real-life costs, the Court explained, the law’s burden would be “undue.”¹⁰⁶ The Court in *Whole Woman’s Health* also demonstrated attentiveness to the particular burdens faced by poor and rural women and to the problems of requiring women to seek care in overcrowded clinics due to increased demand for services.¹⁰⁷

As litigation over facility regulations continued to play out in lower courts under the *Whole Woman’s Health* balancing test, a differently composed Supreme Court had an opportunity to reconsider that test just four years later. In *June Medical Services L. L. C. v. Russo*, the Supreme Court struck down a Louisiana law requiring admitting privileges for abortion providers—a law that was “substantially identical” to the Texas law that it held unconstitutional in *Whole Woman’s Health*.¹⁰⁸ The law, if allowed to have gone into effect, would have closed two of Louisiana’s three abortion clinics and left it with only one abortion-providing physician in the state.¹⁰⁹ However, because Justice Kennedy, who provided the fifth vote in the *Whole Woman’s Health* majority, had been replaced by the more conservative Justice Kavanaugh, only four Justices from that original coalition remained on the Court. Chief Justice Roberts, who had dissented in *Whole Woman’s Health*, nonetheless joined Justices Breyer, Ginsburg, Kagan, and Sotomayor in striking down the Louisiana law. In his separate concurrence to the four-Justice plurality opinion, Roberts asserted that “[t]he Louisiana law impose[d] a burden on access to abortion just as severe as that imposed by the Texas law, for the same reasons,” and therefore *stare decisis* required the Court to declare it unconstitutional.¹¹⁰ At the same time, he placed the *Whole Woman’s Health* balancing test into doubt, insisting that “[n]othing about *Casey* suggested that a weighing of costs and benefits of an abortion regulation was a job for the courts.”¹¹¹ Instead, Chief Justice Roberts insisted, courts should only look at the burden side of the equation—that is, they should only strike down a law if the burden it placed on abortion access was sufficiently substantial.¹¹²

105. Linda Greenhouse & Reva B. Siegel, *The Difference a Whole Woman Makes: Protection for the Abortion Right After Whole Woman’s Health*, 126 *YALE L.J.F.* 149, 162 (2016).

106. *Whole Woman’s Health*, 136 S. Ct. at 2313, 2318; see also Greenhouse & Siegel, *supra* note 105, at 161 (“In identifying the burdens imposed by the Texas law, the Court describes how enforcing the law would transform women’s experience of abortion, and treats these changes in the conditions of access as constitutionally cognizable harms to women.”).

107. *Whole Woman’s Health*, 136 S. Ct. at 2302, 2318.

108. 140 S. Ct. 2103, 2113 (2020) (plurality opinion).

109. *Id.* at 2129.

110. *Id.* at 2134 (Roberts, C.J., concurring).

111. *Id.* at 2136.

112. *Id.* at 2138–39.

In the context of facility regulations, the decision whether to engage in balancing of benefits and burdens can be dispositive. If the court focuses only on how substantially a law burdens abortion access, without comparing that burden to the benefits the law was supposed to advance, then courts will be more likely to uphold restrictions that have little to no actual medical benefits. For example, a law requiring women to listen to a lengthy and medically inaccurate script before obtaining an abortion may have no health or safety benefits, but it would likely also impose a less severe burden than the laws at issue in *Whole Woman's Health* and *June Medical Services*, which threatened to shutter the majority of clinics in the state. Considering only the substantiality of a law's burdens, without weighing them against benefits, might therefore lead a court to uphold it. Thus, courts considering facility regulations must determine to what extent the framework set out in Chief Justice Roberts's separate opinion is the narrowest and therefore the controlling position.¹¹³ In the wake of *June Medical*, lower courts evaluating facility regulations have split on the proper test to apply, with some holding that the balancing test from *Whole Woman's Health* survives, and others treating as binding law Chief Justice Roberts's single-justice concurrence focusing only on burdens to the exclusion of benefits.¹¹⁴

Not all facility regulations take the form of admitting privileges requirements. Some have directly attempted to control the places where abortion clinics may stand. An Alabama law passed in 2017 limited the places within the state where abortion clinics were permitted, prohibiting them from existing within 2,000 feet of a public elementary school.¹¹⁵ Deploying the *Whole Woman's Health* balancing test, a federal district court held that law to constitute an undue burden.¹¹⁶ Although supposedly adopted to "minimiz[e] disturbance in the educational environment" (from protestors outside the clinics) and to "support[] a parent's right to

113. See *Marks v. United States*, 430 U.S. 188, 193 (1977) ("When a fragmented Court decides a case and no single rationale explaining the result enjoys the assent of five Justices, 'the holding of the Court may be viewed as that position taken by those Members who concurred in the judgments on the narrowest grounds . . .'" (quoting *Gregg v. Georgia*, 428 U.S. 153, 169 n.15 (1976) (opinion of Stewart, Powell, & Stevens, JJ.))).

114. Compare *Hopkins v. Jegley*, 968 F.3d 912, 915–16 (8th Cir. 2020) (per curiam) (asserting that *June Medical Services* had eliminated the balancing test and required consideration only of the burdens on abortion access imposed by a law), with *Whole Woman's Health v. Paxton*, 972 F.3d 649, 652 (5th Cir. 2020) (holding that *Whole Woman's Health* "remains binding law in this Circuit").

115. ALA. CODE § 22-21-35 (2020), *invalidated by* *W. Ala. Women's Ctr. v. Miller*, 299 F. Supp. 3d 1244 (M.D. Ala. 2017). Similarly, a city in Tennessee passed a zoning restriction that had the effect of preventing any abortion clinic from locating within the city limits. *FemHealth USA, Inc. v. City of Mount Juliet*, No. 3:19-cv-01141, 2020 WL 2098234, at *3 (M.D. Tenn. May 1, 2020). The case was settled after a district court held that the provision was likely unconstitutional. Andy Humbles, *Mt. Juliet to Pay \$225K in Abortion Lawsuit Settlement; 'A Bitter Pill to Swallow,' City Attorney Says*, TENNESSEAN (Sept. 15, 2020, 10:51 AM), <https://www.tennessean.com/story/news/local/wilson/mt-juliet/2020/09/15/mt-juliet-pay-225-k-abortion-settlement-carafem-clinic/5802117002> [<https://perma.cc/6RKZ-F5RN>]. Such laws may be part of a still relatively marginal movement to create "sanctuary cities" where abortion is not permitted. See, e.g., Dionne Searcey, *The Wall Some Texans Want to Build Against Abortion*, N.Y. TIMES (Mar. 3, 2020), <https://www.nytimes.com/2020/03/03/us/politics/texas-abortion-sanctuary-cities.html>.

116. *Miller*, 299 F. Supp. 3d at 1249, 1252.

control his or her children's exposure to the subject of abortion," the court found that these interests were insufficient to justify the law's burdens.¹¹⁷ There was no evidence of any disruption to the nearby schools and minimal evidence of injury to parents' interests, and the law would force the closure of two clinics in two major Alabama cities, which provided seventy percent of abortions in the state.¹¹⁸ This would greatly increase delays and travel distances for many women in the state, and abortion after fifteen weeks of pregnancy would become completely unavailable in Alabama.¹¹⁹

Less obviously, laws regulating particular abortion methods can be considered to be facility regulations because their most significant impact is restricting one type of physical space where abortions are performed—namely, freestanding clinics. Several states have adopted laws banning a particular method of abortion, known as dilation and evacuation, or D&E.¹²⁰ This procedure is not only the most common method of second-trimester abortion but also the only procedure that is performed in a freestanding clinical setting after approximately thirteen to sixteen weeks of pregnancy.¹²¹ Although other methods of abortion at this stage of pregnancy do exist, those procedures cannot be performed in a clinical setting, as opposed to a hospital.¹²² And because hospitals do not perform a significant number of abortions as compared to clinics,¹²³ a law outlawing a particular method of abortion like D&E can in reality function as a total ban on abortions after a particular stage of pregnancy. Because D&E is the only practicable method of abortion in clinics after a particular stage of pregnancy, and only freestanding clinics provide abortions in most states (for all intents and purposes), the only abortions available after a particular point in pregnancy are D&E abortions. Thus, even regulation of the methods of abortion are, ultimately, also facility regulations.

Similarly, some states have imposed spatial limitations on telemedicine for the medication-only method of abortion.¹²⁴ Currently, nineteen states require the provider of abortion medication to be in the physical presence of the woman receiving the drug, although many of those states have more relaxed standards for telemedicine outside the abortion context.¹²⁵ Indeed, the COVID-19 pandemic

117. *Id.* at 1253–54.

118. *Id.* at 1254–58, 1264.

119. *Id.* at 1261–64.

120. *See Bans on Specific Abortion Methods Used After the First Trimester*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/bans-specific-abortion-methods-used-after-first-trimester> [<https://perma.cc/6JNG-TBLB>] (last updated Feb. 1, 2021).

121. *See* *EMW Women's Surgical Ctr., P.S.C. v. Friedlander*, 960 F.3d 785, 790–91 (6th Cir. 2020); *Whole Woman's Health v. Paxton*, 280 F. Supp. 3d 938, 948 (W.D. Tex. 2017), *aff'd*, No. 17-51060, 2020 WL 6042428 (5th Cir. Oct. 13, 2020), *opinion modified and superseded*, 978 F.3d 896 (5th Cir. 2020).

122. *See, e.g.,* *W. Ala. Women's Ctr. v. Williamson*, 900 F.3d 1310, 1321 (11th Cir. 2018).

123. *See, e.g., id.* (stating that "99.6% of abortions in Alabama occur in outpatient clinics"); Stanley K. Henshaw, *The Accessibility of Abortion Services in the United States*, 23 FAM. PLAN. PERSP. 246, 246 (1991).

124. *See, e.g.,* IOWA ADMIN. CODE r. 653-13.10 (2020); W. VA. CODE ANN. § 30-14-12d (West 2020).

125. *State Laws and Policies: Medication Abortion*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/medication-abortion> [<https://perma.cc/N4YK-CK9T>] (last updated Feb. 1, 2021); *see also, e.g.,* *Planned Parenthood of the Heartland, Inc. v. Iowa Bd. of Med.*, 865 N.W.2d 252, 269 (Iowa 2015).

caused several states to relax restrictions on telemedicine, although that relaxation did not always apply to abortion.¹²⁶ Only one such law has thus far been held unconstitutional outside the context of the COVID-19 pandemic.¹²⁷ As in the other cases discussed above, the court in that case weighed the negligible-to-non-existent health and safety benefits of the law against the severe reduction in abortion access caused by potentially extreme travel distances in the state.¹²⁸

B. IMPLICATIONS OF FACILITY REGULATIONS

Facility regulations have similar effects to other spatial regulations in that they create or reinforce existing inequalities while concealing the role of the state. This Section begins by providing some context around the spatial distribution of abortion services in the United States, according to which the overwhelming majority of abortions are provided in freestanding clinics rather than hospitals. Then, it explains how this geographical distribution of services, combined with laws regulating abortion facilities, isolates abortion services from other health care services, aggravates various forms of inequalities (while making those inequalities appear natural and inevitable rather than state-imposed), and in particular hides the explicitly moral agenda of state actors.

To understand the current impact of facility regulations on abortion availability and on abortion jurisprudence more generally, it is important to understand how abortion services are distributed in the United States and why they are distributed in this way. Approximately ninety-five percent of abortions are performed in freestanding clinics; only five percent are performed in hospitals or physicians' offices.¹²⁹ This geographical fact is not a mere historical accident; rather, it arose from an intentional decision by abortion-rights activists in the era leading up to *Roe* to prioritize provision of abortion services in nonhospital settings, with the goal of making abortion services more accessible and less expensive.¹³⁰ Clinics,

126. For example, Ohio's governor adopted an emergency order loosening restrictions on telemedicine during the pandemic, but that order did not affect existing legislation requiring two in-person visits for abortion patients. Ohio Exec. Order No. 2020-05D (Mar. 19, 2020), <https://coronavirus.ohio.gov/static/publicorders/Executive-Order-2020-05D.pdf> [<https://perma.cc/DUM7-QEAA>]; see OHIO REV. CODE ANN. § 2317.56(B)(1) (West 2020) (requiring an in-person meeting with a physician twenty-four hours before an abortion procedure); OHIO ADMIN. CODE 5160-1-21 (2020) (now expired) (modifying several legal requirements to allow telehealth in a state of emergency, but not modifying Ohio Rev. Code § 2317.56).

127. *Planned Parenthood of the Heartland*, 865 N.W.2d at 269; see also *State Laws and Policies: Medical Abortion*, *supra* note 125 (indicating that nineteen states currently ban telemedicine for abortion but that only one such law—the one in *Planned Parenthood of the Heartland*—has ever been enjoined). In *American College of Obstetricians & Gynecologists v. FDA*, a Maryland district court blocked enforcement of certain restrictions on the provision of medication abortion drugs by mail for the duration of the pandemic. 472 F. Supp. 3d 183, 233 (D. Md. 2020).

128. *Planned Parenthood of the Heartland*, 865 N.W.2d at 265–69.

129. Jones & Jerman, *supra* note 76. Most nonhospital abortions are performed in specialized abortion clinics (fifty-nine percent), but a substantial proportion (thirty-six percent) are performed in clinics that may also provide other services, such as family planning. *Id.*

130. David J. Garrow, *Abortion Before and After Roe v. Wade: An Historical Perspective*, 62 ALB. L. REV. 833, 838 (1999). The freestanding clinic model is also discussed in DAVID J. GARROW, LIBERTY AND SEXUALITY: THE RIGHT TO PRIVACY AND THE MAKING OF *ROE V. WADE* 456–57 (1994). For a

which were visibly identified as women's health care providers, could provide abortions much less expensively than hospitals—much in the same way that free-standing birth control clinics increased access to contraception for lower-income women who were not able to obtain it discreetly from private physicians.¹³¹

Still, there was an initial expectation among abortion advocates that hospitals would continue to provide abortions and fill any gaps that clinics could not.¹³² This expectation turned out to be incorrect. In the year *Roe* was decided, about eighteen percent (1,064 of 6,000) of general, short-term hospitals in the United States offered abortions,¹³³ by 1985, that percentage had only increased to twenty-one percent.¹³⁴ More strikingly, whereas about half of all abortions were performed in hospitals in 1973, by 1982 that figure was only eighteen percent.¹³⁵ As noted above, the percentage of abortions performed in hospitals today is almost negligible.¹³⁶

There are likely several reasons for the change. Many insurers do not provide coverage for abortion, and abortion cannot be subsidized by federal Medicaid funds, with some exceptions for life endangerment, rape, or incest.¹³⁷ However, it appears that hospital policies, driven by hostility on the part of hospital personnel, together with hospital boards' concerns about being seen as "abortion mills," drove hospitals to simply outsource this service in most circumstances.¹³⁸ Indeed, one study from 1980 found that physicians' negative attitudes toward abortion were the primary driver of hospital policies in this area.¹³⁹

general discussion of how abortion services were distributed in the years immediately before and after *Roe*, see GERALD N. ROSENBERG, *THE HOLLOW HOPE: CAN COURTS BRING ABOUT SOCIAL CHANGE?* 189–201 (2d ed. 2008).

131. Garrow, *supra* note 130, at 834–35, 838.

132. FAYE D. GINSBURG, *CONTESTED LIVES: THE ABORTION DEBATE IN AN AMERICAN COMMUNITY* 55 (updated ed. 1998) ("Implicit in the [Supreme] Court's 1973 decisions is the assumption that doctors and health institutions—except those with religious objections—would respond to women's need for safe termination of pregnancies in a manner that reflects society's delegation to doctors of virtual monopoly control over the delivery of health services." (alteration in original) (quoting FREDERICK S. JAFFE, BARBARA L. LINDHEIM & PHILIP R. LEE, *ABORTION POLITICS: PRIVATE MORALITY AND PUBLIC POLICY* 31 (1981))).

133. Stanley K. Henshaw, Jacqueline Darroch Forrest & Ellen Blaine, *Abortion Services in the United States, 1981 and 1982*, 16 *FAM. PLAN. PERSP.* 119, 123 (1984).

134. Stanley K. Henshaw, Jacqueline Darroch Forrest & Jennifer Van Vort, *Abortion Services in the United States, 1984 and 1985*, 19 *FAM. PLAN. PERSP.* 63, 68 (1987). If Catholic providers are excluded, the figure is still only twenty-three percent. *Id.*

135. Henshaw et al., *supra* note 133.

136. See *supra* note 129 and accompanying text; see also Henshaw, *supra* note 123 ("In the United States, abortion services have been concentrated in clinics, initially because hospitals in many areas chose not to perform abortions when the procedure became legal in the early 1970s, and more recently because hospitals have been moving away from offering minor surgery in general.").

137. *State Laws and Policies: Restricting Insurance Coverage of Abortion*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/restricting-insurance-coverage-abortion> [https://perma.cc/5VJ4-X92Q] (last updated Feb. 1, 2021).

138. Cf. GARROW, *supra* note 130, at 550 (describing Justice Blackmun's concerns about "abortion mills").

139. See Constance A. Nathanson & Marshall H. Becker, *Obstetricians' Attitudes and Hospital Abortion Services*, 12 *FAM. PLAN. PERSP.* 26, 26 (1980); see also ROSENBERG, *supra* note 130, at 189–95 (describing hospitals' opposition to performing abortions as "perhaps the strongest barrier" to legal abortion access).

These decisions about the provision of abortion services have had several significant long-term doctrinal and on-the-ground effects. For one thing, it has led to the spatial and doctrinal isolation of abortion from health care more generally. Just as one abortion-rights proponent, Dr. Robert Hall, predicted in the early 1970s, the relegation of abortion provision to clinics essentially let “organized medicine” off the hook from providing those services.¹⁴⁰ This led to the increased isolation of abortion providers, many of whose practices primarily or exclusively consisted of abortion provision.¹⁴¹ It also made it easier to reduce abortion availability just by regulating the sorts of freestanding clinics where most abortions were performed because they are easily singled out in statutory and regulatory frameworks.¹⁴²

As noted above in Part II, in many states, facility regulations have severely affected the accessibility of abortion services. Onerous facility regulations can reduce the availability of abortion services because they can be too expensive or logistically impossible to comply with, especially because they require clinics to, in essence, gain the approval or at least the acquiescence of private parties (hospitals or nonabortion-providing physicians) to stay in operation.¹⁴³

Importantly, these effects are not evenly distributed. Hospitals are more likely to be located in urban areas, as are abortion clinics.¹⁴⁴ This state of affairs makes it more difficult for clinics to operate in rural settings and for rural women, many of whom are also poor, to access abortion.¹⁴⁵ Indeed, one recent study documents “substantial and persistent spatial disparities in access to abortion” in the United States, such that many women—those in urban areas—live relatively short distances from an abortion provider, but a substantial minority—rural women—may

140. Garrow, *supra* note 130, at 839–40.

141. *See id.* This point may be driven home by a comparative observation. In Canada, where legislative hostility to abortion is not as high as in the United States, hospital abortions are more common. *See generally* Wendy V. Norman, Edith R. Guilbert, Christopher Okpaleke, Althea S. Hayden, E. Steven Lichtenberg, Maureen Paul, Katharine O’Connell White & Heidi E. Jones, *Abortion Health Services in Canada: Results of a 2012 National Survey*, 62 CANADIAN FAM. PHYSICIAN e209 (2016).

142. *See, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 245.001-025 (West 2019) (setting minimum standards for “abortion facilities”).

143. *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2301–03 (2016) (repeating the district court’s findings that the cost of complying with the Texas surgical-center requirement for existing abortion clinics would be approximately \$1 million to \$1.5 million or more; that some clinics would be altogether unable to comply due to the constraints of the physical size of their locations; and that constructing a new, compliant clinic would likely cost \$3 million or more).

144. *See, e.g.*, Comm. on Health Care for Underserved Women, *Committee Opinion No. 586: Health Disparities in Rural Women*, 123 OBSTETRICS & GYNECOLOGY 384, 385 (2014); William F. Rayburn, Michael E. Richards & Erika C. Elwell, *Drive Times to Hospitals with Perinatal Care in the United States*, 119 OBSTETRICS & GYNECOLOGY 611, 612 (2012) (“Any level of hospitals was most accessible in metropolitan settings.”).

145. *See* Pruitt, *Gender, Geography & Rural Justice*, *supra* note 3, at 360–61. At the same time, this uneven geographical distribution of abortion services has led some to suggest that abortion providers “target” urban poor and minority neighborhoods. *See, e.g.*, Susan W. Enouen, *Investigation: Planned Parenthood Speeds Targeting of Minorities*, LIFE ISSUES INST. (Feb. 14, 2017), <https://www.lifeissues.org/2017/02/investigation-planned-parenthood-speeds-targeting-minorities> [https://perma.cc/DE89-VSPY].

live over 50 or even 100 miles from any provider.¹⁴⁶ Moreover, this spatial inequality aggravates other forms of inequality, such as socioeconomic inequality, which makes travel substantially more difficult for poor women, who are less likely to be able to afford child care, time off work, and other expenses such as overnight lodging that may be necessitated by state laws requiring two trips to an abortion provider.¹⁴⁷ For such women, accessing abortion might be not only difficult and burdensome but also ultimately impossible.

More broadly, facility regulations exploit the geographical circumstances—which, in the wake of *Whole Woman's Health*, courts have considered in determining the regulations' constitutionality—that differ from state to state and within a particular state.¹⁴⁸ For example, the Eighth Circuit upheld an admitting-privileges requirement, even after *Whole Woman's Health* suggested all such requirements would be unconstitutional, by relying on geographical differences between Arkansas and Texas.¹⁴⁹ As another example, in a case challenging restrictions on the provision of medication abortion, advocates note that more than half of all women in Maine, which is the most rural state in the United States, live in counties without surgical abortion providers; advocates suggest that this fact might weigh against the constitutionality of restrictions that would pass muster in another state.¹⁵⁰ Thus, the place- and context-sensitive attention to

146. Jonathan M. Bearak, Kristen Lagasse Burke & Rachel K. Jones, *Disparities and Change over Time in Distance Women Would Need to Travel to Have an Abortion in the USA: A Spatial Analysis*, 2 LANCET PUB. HEALTH e493, e495, e499 (2017). Although almost all of the states in which travel distances increased also adopted abortion restrictions and suffered declines in the number of clinics, *id.* at e499, the study did not examine causal factors; it therefore does not confirm that restrictive abortion laws cause such access issues, *id.*

147. This systematic reinforcement of existing inequality is reminiscent of the Supreme Court's approach to Medicaid coverage for abortion, which it held not to be constitutionally required. *Maher v. Roe*, 432 U.S. 464, 469–80 (1977). Against indigent women's arguments that, by paying for childbirth but not abortion, the government was coercing their reproductive choices, the Court responded:

The State may have made childbirth a more attractive alternative, thereby influencing the woman's decision, but it has imposed no restriction on access to abortions that was not already there. The indigency that may make it difficult—and in some cases, perhaps, impossible—for some women to have abortions is neither created nor in any way affected by the [state] regulation.

Id. at 474.

148. See Greenhouse & Siegel, *supra* note 105, at 161 (“In identifying the burdens imposed by the Texas law, the Court describes how enforcing the law would transform women's experience of abortion, and treats these changes in the conditions of access as constitutionally cognizable harms to women.”); Mary Ziegler, *Rethinking an Undue Burden: Whole Woman's Health's New Approach to Fundamental Rights*, 85 TENN. L. REV. 461, 491 (2018) (“*Whole Woman's Health* announces a test centered much more on the facts of how a law affects the exercise of a right in the real world.”); see also Lisa R. Pruitt, *Toward a Feminist Theory of the Rural*, 2007 UTAH L. REV. 421, 458 (“Abortion is perhaps the only legal context in which the particular realities of rural women have been an explicit focus—if only barely and briefly—in making law.”).

149. *Planned Parenthood of Ark. & E. Okla. v. Jegley*, 864 F.3d 953, 958–60 (8th Cir. 2017).

150. See Complaint ¶¶ 111–13, *Jenkins v. Almy*, No. 2:17-cv-00366-NT (D. Me. Sept. 20, 2017) (citing U.S. CENSUS BUREAU, U.S. DEPT' OF COMMERCE, MAINE: 2010 POPULATION AND HOUSING UNIT COUNTS (2010), <https://www2.census.gov/library/publications/cen2010/cph-2-21.pdf> [<https://perma.cc/MBL9-SB32>]; Press Release, U.S. Census Bureau, Growth in Urban Population Outpaces Rest of

the realities of abortion access suggested by *Whole Woman's Health* could help ensure that the abortion right is meaningfully available, rather than just an abstraction. But at the same time, it ensures significant geographic variation—a patchwork—in both the real scope of the constitutional right to privacy and in how Supreme Court doctrine is understood and applied.

Though a product of the state's power to regulate medicine, facility regulation has ironically both resulted from and reinforced the legal and cultural isolation of abortion from health care in general, further aggravating the burdens on abortion access. For example, the differential legal treatment of abortion facilities and providers arguably reinforces the stigma faced by those providers, which in turn makes it easier to regulate abortion in ways that do not affect other, similarly situated medical services and reduces the likelihood that a political coalition of physicians and health care professionals would rally behind abortion providers when they are so targeted.¹⁵¹ By continuing to ensure that abortion services are primarily provided in specialized clinics outside of mainstream medical spaces, states have made abortion clinics and abortion doctors easier targets of harassment and violence by anti-abortion activists.¹⁵² This targeting creates an additional barrier and burden, on top of the problem of travel distance, for people seeking access to abortion services.

At the same time, legal regulation of abortion-providing facilities entrenches their legal designation as medical or even “surgical” spaces, to the exclusion of other sites where abortions may take place. Facility regulations channel the performance of surgical abortions and even medication abortions into abortion clinics, even though the latter, at least, can be safely performed in other settings such as the home.¹⁵³ Certainly, there is no need for medication abortions to be performed in ambulatory *surgical* centers. In fact, most so-called surgical first-trimester abortions are arguably not even surgical procedures because they do not

Nation, Census Bureau Reports (Mar. 26, 2012), http://www.census.gov/newsroom/releases/archives/2010_census/cb12-50.html [<https://perma.cc/US4R-MCQL>].

151. Perhaps this differential form of regulation has also contributed to the unique and somewhat sui generis constitutional jurisprudence surrounding abortion, with its unique doctrinal tests and terminology. See, e.g., *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 857 (1992) (plurality opinion) (describing *Roe* as sui generis in the context of a discussion of substantive due process doctrine); B. Jessie Hill, *The First Amendment and the Politics of Reproductive Health Care*, 50 WASH. U. J.L. & POL'Y 103, 103–04 (2016) (noting that “reproductive health is doctrinally, and often even physically or geographically, isolated from health care more generally”).

152. See generally DAVID S. COHEN & KRISTEN CONNOR, *LIVING IN THE CROSSHAIRS: THE UNTOLD STORIES OF ANTI-ABORTION TERRORISM* 6–7 (2015) (discussing “targeted harassment” of abortion providers, and noting that harassment of clinic workers is an inexpensive and efficient way for anti-abortion activists to increase the costs of providing abortion services).

153. See Mifeprex REMS Study Grp., *Sixteen Years of Overregulation: Time to Unburden Mifeprex*, 376 NEW ENG. J. MED. 790, 792 (2017); Yael Swica, Erica Chong, Tamer Middleton, Linda Prine, Marji Gold, Courtney A. Schreiber & Beverly Winikoff, *Acceptability of Home Use of Mifepristone for Medical Abortion*, 88 CONTRACEPTION 122, 125 (2013). Professor Yvonne Lindgren argues that prohibiting medication abortion in the home violates the right to privacy. Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy, and At-Home Reproductive Care*, 32 CONST. COMM. 341 (2017).

require cutting the skin and do not involve a sterile opening.¹⁵⁴ Indeed, the border between what is health care and what is something else—self-care, perhaps—is not at all an obvious or natural one. Long before abortion became heavily regulated and medicalized, it was something women did on their own with limited or no medical intervention.¹⁵⁵ One movement currently seeks to rediscover and vindicate the pre-*Roe*, pre-modern right of women to manage their own pregnancy terminations without fear of state criminal intervention.¹⁵⁶ Yet, the designation of abortion clinics as surgical spaces both minimizes access and increases state control over the procedure by entrenching its designation as a surgical procedure subject to the state’s police power to regulate the practice of medicine.

The profound but underappreciated way in which facility regulation shapes the abortion landscape reflects a deeper causal relationship between spatial regulation and moral regulation by the state. As the geographer Margo Huxley has explained, the governmental production and regulation of physical spaces performs numerous functions; such regulation not only controls or confines conduct but also produces a particular “social and moral order.”¹⁵⁷ Spatial regulation to promote the interests of health and safety, in particular, is often tied to notions of “moral and spiritual health” as well: consider the longstanding association of “slums” with both unhealthy conditions and amorality.¹⁵⁸ “If these diseased areas and their inhabitants can be cured and improved,” the logic goes, “the body of the city, the social body, and the proper relations between its parts and processes, will be restored to normal, healthy equilibrium.”¹⁵⁹

A similar logic seems to have driven the shift to widespread facility regulation with respect to abortion: legislatures seized on the horrendous conditions at the clinics operated by one criminal and deeply unscrupulous abortion provider,

154. See, e.g., *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2316 (2016) (“[A]bortions typically involve either the administration of medicines or procedures performed through the natural opening of the birth canal, which is itself not sterile.”). In fact, some courts have begun using the term “procedural abortion” rather than “surgical abortion,” so as to emphasize that no actual surgery is involved. See, e.g., *Adams & Boyle, P.C. v. Slatery*, 956 F.3d 913, 917 (6th Cir. 2020); *In re Abbott*, 954 F.3d 772, 781 n.15 (5th Cir. 2020).

155. For a fascinating history, see Monica E. Eppinger, *The Health Exception*, 17 *Geo. J. Gender & L.* 665, 683–87 (2016).

156. See FARAH DIAZ-TELLO, MELISSA MIKESSELL & JILL E. ADAMS, SIA LEGAL TEAM, *ROE’S UNFINISHED PROMISE: DECRIMINALIZING ABORTION ONCE AND FOR ALL* (2017), https://docs.wixstatic.com/ugd/aa251a_66c348049b5c4871a5c867d09cf9a994.pdf [<https://perma.cc/S5H4-MSNR>]. Similarly, researchers have begun to study delivery of other forms of health care outside of traditional health care settings, such as by training barbers to check blood pressure and make referrals or even provide prescription medications—both to increase access and to capitalize on the pre-existing relationship of trust—to great positive effect. See Aaron E. Carroll, *What Barbershops Can Teach About Delivering Health Care*, *N.Y. TIMES* (May 21, 2018), <https://www.nytimes.com/2018/05/21/upshot/what-barbershops-can-teach-about-delivering-health-care.html>.

157. Margo Huxley, *Geographies of Governmentality*, in *SPACE, KNOWLEDGE AND POWER: FOUCAULT AND GEOGRAPHY* 185, 190–91, 194, 196 (Jeremy W. Crampton & Stuart Elden eds., 2007). Huxley’s work explicitly draws upon and applies that of French historian and philosopher Michel Foucault. *Id.* at 190–91.

158. *Id.* at 196–97.

159. *Id.* at 197.

Kermit Gosnell, as a reason for regulating abortion-providing facilities.¹⁶⁰ There is thus a “causal logic” that endows spatial regulation with a moral valence. The moral goal is not to make abortion safer—a goal that the Supreme Court has demonstrated to be pretextual—but rather to advance the social and moral aim of eliminating the practice of abortion within the state.¹⁶¹ Yet spatial facility regulations effectively conceal the moral agenda behind the legislation by providing a health and safety rationale for it. In similar fashion, the physical isolation of abortion clinics has caused, or aggravated, the legal and social isolation of abortion from health care more generally.

Finally, and perhaps most importantly, facility regulations conceal the role of the state in burdening abortion rights. There seems to be a causal relationship between the existence of onerous facility regulations and reduced abortion access, but the line of causality is not always obvious.¹⁶² Instead, a number of factors play undetermined roles in aggravating the vulnerability of clinics to closure in the face of such regulations.¹⁶³ The reluctance of third-party hospitals to grant clinics the arrangements that they require to operate appears to be a factor external to state regulation, but it is a reality that legislators exploit as part of an intentional strategy to reduce abortion access. The legal rule, which does not appear to be aimed at advancing moral goals (such as reducing abortions), relies upon social realities on the ground to achieve precisely those goals. Those realities include the concentration of hospitals in urban areas; the refusal of most hospitals to perform abortions, due in part to legal rules or industry norms preventing insurance coverage for the procedure in most circumstances; the widespread religious affiliation of hospitals;¹⁶⁴ and the isolation of freestanding abortion providers from other health care providers.

Courts do not take these realities into account when analyzing the constitutionality of facility regulations, however. Instead, they are seen as neutral, pre-existing states of affairs unrelated to the legislation itself. For example, in one case, the Sixth Circuit acknowledged the extensive difficulties that one Ohio clinic experienced in attempting to obtain a legally required transfer agreement with a local hospital.¹⁶⁵ One hospital simply declined to enter into such an agreement,

160. See *Whole Woman’s Health v. Hellerstedt*, 136 S. Ct. 2292, 2343–44 (2016) (Alito, J., dissenting) (noting that Texas’s facility regulation “was one of many enacted by States in the wake of the Kermit Gosnell scandal”); *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 923–24 (7th Cir. 2015) (Manion, J., dissenting) (describing Gosnell’s “shop of horrors” as the impetus for Wisconsin’s admitting privileges requirement).

161. See *supra* text accompanying notes 39–44.

162. See *supra* note 146.

163. See generally Michelle L. McGowan, Alison H. Norris & Danielle Bessett, *Care Churn—Why Keeping Clinic Doors Open Isn’t Enough to Ensure Access to Abortion*, 383 NEW ENG. J. MED. 508 (2020) (discussing several state restrictions that resulted in abortion clinic closures).

164. A recent study determined that, in 2018, Catholic hospitals had a median market share of 18.5% in U.S. counties. Coleman Drake, Marian Jarlenski, Yuehan Zhang & Daniel Polsky, *Market Share of US Catholic Hospitals and Associated Geographic Network Access to Reproductive Health Services*, 3 JAMA NETWORK OPEN 1, 7 (2020), https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2759762?utm_campaign=articlePDF&utm_medium=articlePDFlink&utm_source=articlePDF&utm_content=jamanetworkopen.2019.20053 [https://perma.cc/LP3Y-V84T].

165. *Women’s Med. Prof’l Corp. v. Baird*, 438 F.3d 595, 599–601 (6th Cir. 2006).

and the other rescinded an agreement after objections from a member of the hospital's board who opposed abortion.¹⁶⁶ Yet the court held that the facility regulation was a “facially neutral” regulation and had no invalid purpose; these facts did not ultimately play a role in the court's analysis, which focused solely on the distance women would have to travel to obtain an abortion if the clinic were to shut down.¹⁶⁷

Some courts and scholars have begun to recognize, however, that the geographical disparities that result from facility regulation are a direct result of state policies. In *Whole Woman's Health*, the Court recognized for the first time the disproportionate impact of facility regulations on poor and rural women and used this fact as a reason in support of its decision.¹⁶⁸ Similarly, scholars have described how physical location—one's neighborhood or zip code—functions as a powerful predictor of life expectancy and determinant of health.¹⁶⁹ Sociologist Carolette Norwood has explicitly connected this reality to the history of segregation and official discrimination, which now manifest as “structural violence”—violence in the form of severe inequality in access to goods and services arising from underlying social and political arrangements that disadvantage poorer citizens—and “spatial violence”—violence that is concentrated in a particular geographical space.¹⁷⁰ Facility regulations thus follow the pattern—that is demonstrated in Part IV as well—of seemingly neutral laws exploiting existing conditions to magnify inequality and advance the state's hidden moral agenda.

IV. SPATIAL REGULATION OF PREGNANT BODIES

Though less obvious in their relationship to borders, space, and geography than laws regulating abortion facilities and affecting state and national borders, another category of abortion restrictions may also be a form of spatial regulation. In this category are laws that map and regulate the internal geography of women's bodies.¹⁷¹ These include abortion method bans, which include laws that regulate the procedure sometimes referred to as “partial-birth abortion,” as well as forced ultrasound requirements, which require doctors to show women an ultrasound image of the fetus and sometimes to provide a narrative explanation of it. As Section IV.A explains, these laws turn women's anatomy into a kind of

166. *Id.* at 599 & n.3.

167. *Id.* at 605–07. The Sixth Circuit did not indicate how far was too far for patients to travel, but it held that forcing some second-trimester patients to travel from the Dayton area to Cleveland—a distance of more than 200 miles each way—did not constitute an undue burden. *See id.* at 605–06.

168. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2302 (2016).

169. *See, e.g.*, Garth Graham, MaryLynn Ostrowski & Alyse Sabina, *Defeating the ZIP Code Health Paradigm: Data, Technology, and Collaboration Are Key*, HEALTH AFF. BLOG (Aug. 6, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20150806.049730/full>; *Mapping Life Expectancy*, VA. COMMONWEALTH UNIV. CTR. ON SOC'Y & HEALTH (Sept. 26, 2016), <https://societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html> [<https://perma.cc/8MXE-LYJM>].

170. Carolette R. Norwood, *Mapping the Intersections of Violence on Black Women's Sexual Health Within the Jim Crow Geographies of Cincinnati Neighborhoods*, 39 FRONTIERS 97, 97–98 (2018).

171. Mae Kuykendall has also recognized both abortion method bans and ultrasound mandates as regulations of “places” within a woman's body. *See Kuykendall, supra* note 3, at 789.

geographical terrain, leading to effects similar to those resulting from other forms of spatial regulation. The effects they produce are similar to “mapping” of women’s internal anatomy, in that they depict a physical space, including chosen, highlighted features, and they create a graphic representation of something that cannot be easily perceived with the naked eye.¹⁷²

Both types of laws became popular around the same time as the uptick in TRAP laws and were likely motivated by many of the same factors, such as a desire by abortion opponents to mobilize *Casey*’s doctrinal ambiguities in their favor and to demonstrate that abortion opponents were not anti-woman.¹⁷³ As Section IV.B further elaborates, abortion method bans and mandatory ultrasound laws function in similar fashion to other spatial regulations by manipulating borders—in this case the borders of the woman’s body. Such laws exploit the notion of abortion as a medical procedure, drawing on the objective and respected rhetoric of science to support abortion restrictions, thus reinforcing women’s inequality—if not erasing the woman’s very existence—while concealing the state’s role in this act.¹⁷⁴

A. LAWS MAPPING WOMEN’S BODIES

I have written elsewhere about the way in which the Supreme Court’s rhetoric in *Gonzales v. Carhart*,¹⁷⁵ the 2007 “partial-birth” abortion case, rhetorically maps the terrain of women’s reproductive anatomy.¹⁷⁶ The essence of this argument is that legislatures have used spatial and geographic techniques to control women’s bodies in ways that are similar to their use of spatial regulation or manipulation of state and local borders. These techniques are employed in relation to both abortion method bans and ultrasound laws.

1. Abortion Method Bans

Throughout the 1990s and 2000s, state legislatures passed laws banning an abortion method that they referred to as “partial-birth abortion.”¹⁷⁷ This legislation was followed, in 2003, by federal legislation aimed at essentially the same procedure.¹⁷⁸ Two different Supreme Court cases resulted from this legislative activity: *Stenberg v. Carhart* in 2000, which struck down a Nebraska ban, and

172. Professor Anita Bernstein presents a related perspective on abortion restrictions as invading a woman’s property and “intimate environment.” Cf. ANITA BERNSTEIN, *THE COMMON LAW INSIDE THE FEMALE BODY* 143, 151 (2019).

173. See Ziegler, *supra* note 2, at 457–58; Ziegler, *supra* note 84, at 97–98. Thanks to Mary Ziegler for pointing out this connection.

174. See Ziegler, *supra* note 84, at 97.

175. 550 U.S. 124 (2007).

176. See Hill, *supra* note 3.

177. See *Stenberg v. Carhart*, 530 U.S. 914, 995 (2000) (Thomas, J., dissenting) (noting that, as of 2000, twenty-eight states had banned the method known as “partial birth abortion”). The term *partial-birth abortion* is a political term, not a medically accurate one. It is, however, the popular terminology and the language used by the legislation banning the abortion method at issue. See Hill, *supra* note 3, at 651 & n.12; see also Siegel, *supra* note 84, at 1707 (clarifying that there is no textbook reference to any operation or medical condition known as “partial birth”).

178. Partial-Birth Abortion Ban Act of 2003, 18 U.S.C. § 1531 (2018).

Gonzales v. Carhart in 2007, which upheld the federal ban.¹⁷⁹ Thus, after *Gonzales*, federal law bans this particular procedure, as do some state laws that mirror the federal law.¹⁸⁰

In the course of describing the proscribed “partial-birth” abortion procedure, both the legislation and case law conduct a narrative mapping of the female body that replicates the sort of border manipulation that takes place in more obviously geographical forms of regulation. In particular, the Supreme Court engaged—in both cases—in a minute, graphic description of the abortion procedure known as intact dilation and evacuation in ways that construct the woman’s body as a geographical space that not only permits but also requires regulation and renders the borders of her body profoundly manipulable.¹⁸¹

One form of border manipulation results from the Court’s graphic descriptions of the procedure that takes place inside the woman’s body. Here, for example, is one (edited but still lengthy) description of the banned abortion procedure by the *Gonzales* Court:

In [the banned procedure, also known as intact D&E], the doctor extracts the fetus in a way conducive to pulling out its entire body, instead of ripping it apart. . . . Rotating the fetus as it is being pulled decreases the odds of dismemberment. A doctor also “may use forceps to grasp a fetal part, pull it down, and re-grasp the fetus at a higher level—sometimes using both his hand and a forceps—to exert traction to retrieve the fetus intact until the head is lodged in the [cervix].”

. . . In the usual intact D & E the fetus’ head lodges in the cervix, and dilation is insufficient to allow it to pass. . . .

At this point, the right-handed surgeon slides the fingers of the left [hand] along the back of the fetus and ‘hooks’ the shoulders of the fetus with the index and ring fingers (palm down).

While maintaining this tension, lifting the cervix and applying traction to the shoulders with the fingers of the left hand, the surgeon takes a pair of blunt curved Metzenbaum scissors in the right hand. He carefully advances the tip, curved down, along the spine and under his middle finger until he feels it contact the base of the skull under the tip of his middle finger.

179. *Gonzales*, 550 U.S. at 133; *Stenberg*, 530 U.S. at 922.

180. See, e.g., ARK. CODE ANN. § 20-16-1202 to -03 (West 2020); MICH. COMP. LAWS ANN. § 750.90h (West 2020); N.H. REV. STAT. ANN. § 329:33 to :34 (2020). See generally *Bans on Specific Abortion Methods Used After the First Trimester*, *supra* note 120 (showing how many states have banned partial-birth abortions). A more recent spate of state laws goes further and bans the most common second-trimester abortion procedure, known as dilation and evacuation or D&E. See *supra* notes 120–23 and accompanying text. Both *Stenberg* and *Gonzales* implied that such a ban would be unconstitutional—and indeed, the *Gonzales* Court upheld the ban on partial-birth abortion partly because of the availability of D&E as an alternative procedure. *Gonzales*, 550 U.S. at 147, 164; *Stenberg*, 530 U.S. at 938. As of this writing, no case involving a ban on ordinary D&E abortion has been decided by the Supreme Court.

181. See Hill, *supra* note 3, at 656–69.

[T]he surgeon then forces the scissors into the base of the skull or into the foramen magnum. Having safely entered the skull, he spreads the scissors to enlarge the opening.

The surgeon removes the scissors and introduces a suction catheter into this hole and evacuates the skull contents. With the catheter still in place, he applies traction to the fetus, removing it completely from the patient.¹⁸²

This step-by-step detailing of this surgical procedure that occurs *inside* the woman's body rhetorically erases the borders of her body. The woman herself does not appear at all in this description. It is as if her body is without borders; the most intimate parts of her interior anatomy are narratively placed on display as if they were in public view.¹⁸³ The procedure involves "dilation of *the cervix*," just as the fetal head becomes lodged in "*the cervix*."¹⁸⁴ The fetus "pass[es] through" parts of the woman's anatomy and "is removed."¹⁸⁵ It is as though the Court is describing an act of violence that a doctor is committing against a fetus on open terrain, punctuated by "anatomical *landmarks*" that invoke the law's application.¹⁸⁶

This depiction provides a justification for intrusive regulation because it makes the abortion procedure resemble a criminal act perpetrated by the doctor upon the fetus, rather than a surgical procedure by a doctor on the patient.¹⁸⁷ "The female body is," simply, "a geographic space in which the drama plays out between the fetus and the doctor."¹⁸⁸ Indeed, the fetus is arguably the only entity in this conflict that has a recognizable body with clearly demarcated borders.¹⁸⁹

To the extent that the woman appears at all, she is present only as a victim, entirely lacking in agency.¹⁹⁰ The woman's primary appearance in *Gonzales* is as

182. *Gonzales*, 550 U.S. at 137–38 (second, third, and fourth alterations in original) (citations omitted).

183. Indeed, the word *woman* appears only five times in the entire majority opinion, whereas the words *fetal* and *fetus* occur forty-one times and *doctor* thirty-one times. Hill, *supra* note 3, at 660 (citing *Gonzales*, 550 U.S. at 134–40).

184. *Gonzales*, 550 U.S. at 137–39 (emphasis added).

185. *Id.* at 139–40.

186. Hill, *supra* note 3, at 666–67 (emphasis added) (quoting *Gonzales*, 550 U.S. at 148–56).

187. As I argue elsewhere:

The Court's language . . . renders completely public even those body parts one might think of as profoundly private. . . . [T]he law, not the woman herself, controls . . . the divide between what is inside and outside the body, between what is private and what is publicly exposed. If the Court constructs her vagina as somehow "outside the body," and if her cervix and uterus become, generically, "the cervix" and "the uterus," then they cannot belong to her in the sense that our private bodies belong to us.

Id. at 668–69 (footnote omitted).

188. *Id.* at 661.

189. Note, for example, that the *fetus's* body is delineated in extensive detail. The Court speaks of the fetus's "entire body," "fetal part[s]," the fetal "head," "back of the fetus," "shoulders of the fetus," "spine," "skull," and "foramen magnum." *Gonzales*, 550 U.S. at 137–38. Thus, the Court acknowledges numerous borders of the fetus's body during the process, reinforcing its corporeality and integrity while undermining the woman's.

190. In the federal partial-birth abortion ban, as in virtually all modern abortion restrictions, the woman is exempted from prosecution—as if she has no agency and hence can bear no criminal responsibility. *See* 18 U.S.C. § 1531(e) (2018).

an unknowing victim, suffering regret for an act that she did not intend to commit. For example, Justice Kennedy's majority opinion declared it

self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event, what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.¹⁹¹

The woman's verbal absence from the scene of the crime, so to speak, represents an absence of agency, which nonetheless does not prevent her from regretting what she "allowed" to be done to her. Indeed, the possibility of regret, along with the purportedly deceptive or coerced nature of the abortion act, ironically grounds the restriction on the abortion procedure in protecting women's autonomy.¹⁹² Yet, the abortion method ban upheld in *Gonzales* is entirely unlike the informed consent provisions approved by the *Casey* Court, which were "calculated to inform the woman's free choice, not hinder it."¹⁹³

But rather than simply disappearing, the woman is *made to* disappear through the total occupation of her body by a law that manages and controls it at an almost microscopic level. One might even think metaphorically here of the use of the term "disappear" as a transitive verb, as when agents of totalitarian governments seize individual citizens and make them disappear from society.¹⁹⁴ Both the statutory language of the ban and the Court's opinion in *Gonzales* redraw the female anatomy. Perhaps most strikingly, both the statute and the majority opinion describe the banned procedure as one in which a portion of the fetus is "outside the body" of "the mother."¹⁹⁵ Apparently, the reason for this turn of phrase is that the prohibited abortion procedure involves passage of the fetus beyond the woman's cervix.¹⁹⁶ Yet, the cervix is not, in fact, the external border of the woman's body.¹⁹⁷ Nonetheless, the Court and the legislature assume the authority to redraw

191. *Gonzales*, 550 U.S. at 159–60. Note, again, that the fetus has a human body, but the woman does not.

192. Professor Jeannie Suk argues that "[t]he harm envisioned in *Carhart* had the structure of trauma: an event whose meaning is not fully realized at the time of its occurrence, followed by a period of delay, latency, or ignorance, and then later symptoms that trace to the now-realized meaning of the earlier event." Jeannie Suk, *The Trajectory of Trauma: Bodies and Minds of Abortion Discourse*, 110 COLUM. L. REV. 1193, 1236 (2010). She explains that regret becomes trauma as it is "[r]efracted through the prism of coercion and non-consent," thus justifying restrictions on women's autonomy in the name of protecting their autonomy. *Id.* at 1251.

193. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (plurality opinion).

194. Thanks to Marc Spindelman for pointing this out.

195. 18 U.S.C. § 1531(b); *Gonzales*, 550 U.S. at 160.

196. *Gonzales*, 550 U.S. at 138 (explaining that, during the banned procedure, "the fetus' head lodges in the cervix, and dilation is insufficient to allow it to pass" until the physician performs another procedure that ultimately allows intact removal).

197. As I have pointed out elsewhere:

Though the Court seems strangely loath to acknowledge it, there is, technically, something between the woman's cervix and the outside world—namely, her vagina. And indeed, the Court's opinion in *Stenberg*, like the statute at issue in that case, had described the fetus not

these boundaries at will. And this disappearance of the woman, like politically motivated disappearances, entails an erasure of the woman's citizenship and liberty, as her very interior anatomy becomes state-occupied and -controlled territory.

The insistence that the abortion procedure occurs “outside the body” of the woman in turn justifies its regulation. Suggesting that the fetus is killed outside the woman's body makes the procedure more akin to infanticide than to abortion. It also justifies the Court's and the legislature's insistently calling the pregnant woman a “mother”—as if she has already given birth.¹⁹⁸ This rhetoric rationalizes intrusive regulation by turning the private surgical abortion procedure into a public, criminal act.

2. Ultrasound Laws

Mandatory ultrasound laws, like abortion method bans, have also been popular in state legislatures since the 1990s.¹⁹⁹ Obstetric ultrasound is an imaging technique that uses sound waves to create a real time, moving, visual image of the fetus inside the uterus.²⁰⁰ Like the Supreme Court's narrative description of the “partial-birth” abortion procedure in *Gonzales*,²⁰¹ laws requiring ultrasound imagery of the fetus to be displayed prior to an abortion create a map of a space within the woman's body, making external and visible that which is internal and private. And like the Court's narrative in *Gonzales*, the laws similarly turn the woman herself into a passive background or geographic space rather than a fully human agent.

Mandatory ultrasound laws take various, more or less coercive, forms. Some states require abortion providers to perform an ultrasound before an abortion—which has become a common medical practice in any case—and a majority of those states also require the provider to offer the woman an opportunity to view the ultrasound image.²⁰² A handful of states go further and require that the provider offer a narrative description of the visual image, which includes pointing out the fetus's or embryo's location, making sure the fetal heartbeat is audible, and noting the presence of limbs and organs.²⁰³ As Carol Sanger has observed,

as being outside the *body* but rather as being delivered “into the vagina” prior to fetal demise.

Hill, *supra* note 3, at 664–65 (citing *Stenberg v. Carhart*, 530 U.S. 914, 938–40 (2000)).

198. *Id.* at 663–64. To be fair, the Court refers to the pregnant person as a “mother” in other cases as well, including in *Roe* itself. *Roe v. Wade*, 410 U.S. 113, 150, 159–60 (1973).

199. *Requirements for Ultrasound*, GUTTMACHER INST., <https://www.guttmacher.org/state-policy/explore/requirements-ultrasound> [<https://perma.cc/A7WC-AFC5>] (last updated Feb. 1, 2021).

200. F. GARY CUNNINGHAM, KENNETH J. LEVENO, STEVEN L. BLOOM, JODI S. DASHE, BARBARA L. HOFFMAN, BRIAN M. CASEY & CATHERINE Y. SPONG, *WILLIAMS OBSTETRICS* 182 (25th ed. 2018) (“The real-time image on the ultrasound screen is produced by sound waves that are reflected back from fluid and tissue interfaces of the fetus, amniotic fluid, and placenta.”).

201. See *supra* text accompanying notes 182–86.

202. See *Requirements for Ultrasound*, *supra* note 199; see also CAROL SANGER, *ABOUT ABORTION: TERMINATING PREGNANCY IN TWENTY-FIRST CENTURY AMERICA* 120 (2017) (“To be sure, many doctors now administer ultrasound routinely before an abortion even without legal dictate.”).

203. For example, Kentucky's mandatory ultrasound law requires performance of an ultrasound before an abortion, as well as “a simultaneous explanation of what the ultrasound is depicting, which

such laws not only require women, for no medical reason, to view a particular image that they may or may not wish to see, but they also require women “to offer up the content of their bodies in the form of an image for inspection before the law permits them to end a pregnancy.”²⁰⁴ In other words, these laws not only coerce viewing and listening to a state-mandated “message,” but they also “coerce[] production” of the message itself by the woman.²⁰⁵ And the message that is coerced is a “map” of the woman’s uterus, often with key landmarks demarcated; the main difference between a territorial map and an ultrasound being that the ultrasound map magnifies the object it represents, rather than shrinking it to a visually useful scale.²⁰⁶ Thus, although justified as measures designed to ensure informed consent, in both their compelled-production aspect and their detailed narrative and visual mapping of the woman’s own body, mandatory ultrasound laws diverge from more straightforward informed consent requirements focusing on the risks and benefits of the procedure.

Like the Supreme Court’s narrative descriptions of the partial-birth abortion procedure, mandatory ultrasound laws marginalize the woman herself. As Rosalind Pollack Petchesky has written, fetal imagery by its nature “represent[s] the fetus as primary and autonomous, the woman as absent or peripheral.”²⁰⁷ The fetus’s body, in all its detail, is the focus of mandatory ultrasound laws; the woman is the mere physical backdrop for the image she is forced to view. The woman “now becomes the ‘maternal environment,’ the ‘site’ of the fetus, a passive spectator in her own pregnancy.”²⁰⁸ This passivity is further enforced by mandatory ultrasound laws that deprive the patient of the option to decline the imaging and may even, for all intents and purposes, force her to participate in an objectifying ritual—one that turns both the fetus and the woman’s anatomy into objects that she must visually contemplate as if they are separate from herself.²⁰⁹

shall include the presence and location of the unborn child within the uterus and the number of unborn children depicted,” display of the image so that the woman can see it, and auscultation of “the fetal heartbeat of the unborn child so that the pregnant woman may hear the heartbeat if the heartbeat is audible.” KY. REV. STAT. ANN. § 311.727 (West 2020). If she so chooses, the patient may avert her eyes or request that the heartbeat volume be turned off. *Id.* § 311.727(3); *see also, e.g.*, TEX. HEALTH & SAFETY CODE ANN. § 171.012(a)(4) (West 2019) (requiring abortion providers to perform an ultrasound (“sonogram”) and give, “in a manner understandable to a layperson, a verbal explanation of the results of the sonogram images, including a medical description of the dimensions of the embryo or fetus, the presence of cardiac activity, and the presence of external members and internal organs”).

204. SANGER, *supra* note 202, at 111. Proponents of such laws argue that there is a medical purpose for them because they ensure fully informed consent to the abortion procedure. *Id.* at 110.

205. *Id.* at 111.

206. *See, e.g., id.* at 121–22.

207. Rosalind Pollack Petchesky, *Fetal Images: The Power of Visual Culture in the Politics of Reproduction*, 13 FEMINIST STUD. 263, 268 (1987).

208. *Id.* at 277 (citing Ruth Hubbard, *Personal Courage Is Not Enough: Some Hazards of Childbearing in the 1980s*, in TEST-TUBE WOMEN: WHAT FUTURE FOR MOTHERHOOD? 331, 350 (Rita Arditti, Renate Duelli Klein & Shelley Minden eds., 1984)); *see* BARBARA KATZ ROTHMAN, *THE TENTATIVE PREGNANCY: PRENATAL DIAGNOSIS AND THE FUTURE OF MOTHERHOOD* 113–15 (1986).

209. *See* *Stuart v. Camnitz*, 774 F.3d 238, 253 (4th Cir. 2014) (observing that, to avoid the display and recitation required by North Carolina’s mandatory ultrasound law, a woman “must endure the

Thus, as in *Gonzales*, the woman is transformed into a passive geographical space on which the real action—fetal activity—occurs.²¹⁰

Similarly, the ultrasound requirement involves erasing the boundaries of the woman's body. "Obstetrical technologies of visualization . . . disrupt the very definition, as traditionally understood, of 'inside' and 'outside' a woman's body, of pregnancy as an 'interior' experience."²¹¹ The image of the fetus displayed on a screen, outside the context of the woman's body, is meant to suggest it is *already* a (living, separate) baby, much as the language of *Gonzales* and the Federal Partial-Birth Abortion Ban Act imply that the birth has already occurred and the woman is already a mother.²¹² Moreover, although ultrasound may be performed externally (abdominally) or internally (vaginally), some state ultrasound mandates essentially compel a vaginal probe—requiring the doctor, by law, to breach the borders of the woman's body.²¹³

Finally, mandatory ultrasound laws, too, seem to call forth further regulation of women's bodies. Carol Sanger has emphasized that, although abortion is legal throughout the United States, the shaming and physical intrusion inherent in the process "underscore[] for women that what they are about to do is wrong."²¹⁴ In creating a suggestion of fetal personhood, like the Court's language in *Gonzales*, the laws imply that what is about to occur is not an abortion but a murder.²¹⁵ Moreover, mandatory ultrasound bears a relationship to other forms of excessive, intrusive monitoring—including sovereign states' monitoring and control of their own borders.²¹⁶ Ultrasound creates a "panoptics of the womb"—a space of

embarrassing spectacle of averting her eyes and covering her ears while her physician—a person to whom she should be encouraged to listen—recites information to her").

210. Popular culture and language are full of geographic metaphors for women's bodies. For example, male semen is sometimes referred to as his "seed," which makes the woman's body into fertile ground where the seed is expected to grow. One might also think of baseball metaphors for heterosexual intimacy—which necessarily consider such intimacy from the male perspective and cast the woman in the role of the passive field. See generally *Baseball Metaphors for Sex*, WIKIPEDIA, https://en.wikipedia.org/wiki/Baseball_metaphors_for_sex [<https://perma.cc/7XM8-XJL7>] (last visited Mar. 2, 2021). Thanks to Mae Kuykendall for this connection.

211. Petchesky, *supra* note 207, at 272.

212. SANGER, *supra* note 202, at 119; see *supra* text accompanying notes 195–98.

213. See SANGER, *supra* note 202, at 125–26; cf. BERNSTEIN, *supra* note 172, at 179–80 (describing mandatory vaginal ultrasound as a forced "intrusion that violates possessory rights and interests" of the woman to her own body).

214. SANGER, *supra* note 202, at 126.

215. See, e.g., Jessica Knouse, *Mandatory Ultrasounds and the Precession of Simulacra*, 54 SAN DIEGO L. REV. 117, 119–20 (2017) (arguing that ultrasound mandates "render fetuses 'children' and pregnant women their 'mothers'" and "privilege the imagined 'personhood' of the fetus over the pregnant woman's reality").

216. Or in Mae Kuykendall's words, such laws "expand the place within the body subject to regulation—sonograms and monitoring—and reduce the space available to female embodiment for receipt of services." Kuykendall, *supra* note 3, at 793. Of course, the ultrasound is a brief and limited encounter, so it may not in itself be seen as a particularly excessive form of monitoring. It is, however, just one part of the larger picture of intensive surveillance that women undergo during pregnancy—surveillance that is more pronounced for poor women and women of color. See, e.g., Khiara M. Bridges, *Poor Women and the Protective State*, 63 HASTINGS L.J. 1619, 1623 (2012).

continual monitoring in the name of surveillance and regulation.²¹⁷ Such a space of continual monitoring enables constant regulation without active enforcement; it is a metaphor for the mechanism of the modern state, in which governmental power, particularly over individuals' bodies, is always felt, even if not itself visibly present.²¹⁸

B. IMPLICATIONS OF LAWS MAPPING WOMEN'S BODIES

Though they appear, at first blush, to be quite different from TRAP laws and other geographic restrictions, both mandatory ultrasound laws and bans on intact D&E function in much the same way as those other spatial regulations. They use the manipulation of boundaries as a form of control, inscribing or re-inscribing women's inequality while concealing the mechanism by which they do so. They rely on the apparent naturalness of particular boundaries—here, bodily ones—to advance a political agenda while assuming a posture of objectivity. And they use physical boundaries to define personhood, just as other spatial regulations use geographical boundaries to define and delimit citizenship.

Both kinds of laws rely upon seemingly objective perspectives: medical discourse in the case of *Gonzales* and medical imaging technology in the case of the ultrasound.²¹⁹ Yet the apparent objectivity in each case underlies a moral agenda of stigmatizing and restricting access to abortion, in part by constructing the fetus as a person and the abortion as a murder.²²⁰

In the case of *Gonzales*, the clinical description of the “partial-birth” procedure constructs the fetal demise as occurring partly “outside the body” of the woman—but does so only by manipulating the very border of that body.²²¹ As in other spatial regulation contexts, the placement of borders, as well as their function and permeability, matters far less than the ability to manipulate them. The “line demarcating activity that can be criminalized from that which cannot . . . [is] not drawn at viability, as it always has been since *Roe v. Wade*, but rather at a place inside the woman's body.”²²² Yet, the Court's description of the female anatomy is, if not entirely inaccurate, at least open to question.²²³ It is precisely this ability

217. Petchesky, *supra* note 207, at 277 (emphasis omitted). The term “panoptics” is derived from Michel Foucault's concept of the panopticon, a prison design invented by Jeremy Bentham, in which it is possible to observe each prisoner at all times without the prisoner knowing whether she is being watched. MICHEL FOUCAULT, DISCIPLINE & PUNISH: THE BIRTH OF THE PRISON 200–03 (Alan Sheridan trans., Vintage Books 2d ed. 1995) (1977).

218. *Cf.* Petchesky, *supra* note 207, at 269 (“Historically, photographic imagery has served . . . the uses of scientific rationality—as in medical diagnostics and record keeping—and the tools of bureaucratic rationality—in the political record keeping and police surveillance of the state.”).

219. Petchesky points to “the visual apparatus's claim to be ‘an unreasoning machine’ that produces ‘an unerring record,’” noting that “the French word for ‘lens’ is *l'objectif*.” *Id.*

220. *Cf.* *Stenberg v. Carhart*, 530 U.S. 914, 951–52 (2000) (Ginsburg, J., dissenting) (“[T]he [partial-birth abortion] law prohibits the procedure because the state legislators seek to chip away at the private choice shielded by *Roe v. Wade* . . .”).

221. *Gonzales v. Carhart*, 550 U.S. 124, 147–48 (2007).

222. Hill, *supra* note 3, at 667 (citation omitted).

223. *See supra* note 197 and accompanying text.

to draw and redraw borders at will and to infuse them with significance or insignificance that is the mark of sovereignty and social control.

Indeed, one author, writing about the viability line in 1985, went so far as to erase the woman entirely, stating that “there is no reason from the point of view of physiology why fetal humans should be viewed as different from born humans,” and that “nothing physiologically important happens at the exact instant of birth except that the fetus is exposed to the cold air of the world.”²²⁴ Note the medically impersonal, objective-sounding language: “[F]rom the point of view of physiology.” Of course, the context demonstrates that the author is referring to fetal rather than maternal physiology—but this is precisely the point. The woman and her experience of pregnancy and birth are so completely absent from the discussion that the irony of these words appears not to register with their author.

Similarly, the mapping of the fetal anatomy required by some ultrasound laws occurs through the use of a technology that makes the fetus appear autonomous and separate from the pregnant woman and essentially effaces the borders of her own body.²²⁵ The artificiality of this impression often goes unnoticed, however; one court, for example, insisted “[t]hat these medically accurate depictions are inherently truthful and non-misleading.”²²⁶ Women’s internal geography, like the geography of state borders and freestanding abortion clinics, is taken for granted, while still subject to manipulation and interpretation.

The hand of the state is ever present but invisible in the drawing of this internal geography. Though driven by legislative mandate, the intrusive ultrasound examination may be carried out by any medical professional or ultrasound technician.²²⁷ “Any individual, taken almost at random, can operate the machine.”²²⁸ Thus, it may seem as though the woman’s disappearance from the scene, or her presentation as being already a mother, results purely from the impersonal technology of the ultrasound machine or the equally impersonal medical language borrowed by the Court.²²⁹ Yet while the woman is subjected to such impersonal treatment, the fetus is foregrounded and described in a way that gives it bodily

224. John M. Goldenring, *The Brain-Life Theory: Towards a Consistent Biological Definition of Humanness*, 11 J. MED. ETHICS 198, 199, 201 (1985). Goldenring advocates for brain life, which he asserts begins at approximately eight weeks *in utero*, as the point at which an embryo becomes a human being. *Id.* at 199.

225. See *supra* text accompanying notes 207–13.

226. *Tex. Med. Providers Performing Abortion Servs. v. Lakey*, 667 F.3d 570, 577 (5th Cir. 2012); see also *EMW Women’s Surgical Ctr., P.S.C. v. Beshear*, 920 F.3d 421, 429 (6th Cir. 2019) (“[N]o one argues that the heartbeat, sonogram, or its description is false or misleading. We have previously held that similar information conveys objective medical facts.”).

227. See SANGER, *supra* note 202, at 113 (“[A]s the use of ultrasound became more commonplace, the methods of obtaining measurements, such as the relation of cranium size to age, became standardized. This meant that doctors themselves no longer needed to conduct the scans; trained sonographers could do the job.”).

228. FOUCAULT, *supra* note 217, at 202 (referring to the machinery of modern state power as represented by the panopticon).

229. Dissenting in *Gonzales v. Carhart*, Justice Ginsburg observed that the majority effaces women’s agency by assuming that an abortion method ban—rather than a robust informed consent requirement—

substance and integrity. Thus, however impersonal they may appear, the adoption of these tools and their mobilization in the abortion context result from conscious decisions by state actors to require narrated ultrasounds or to single out particular, minutely described abortion procedures for criminalization.

Such laws also put into question the relevance of viability as a boundary line in constitutional doctrine, perhaps displacing it in favor of the cervix as the legally relevant border. This act of border displacement is echoed in the anti-abortion literature, which argues that viability—designated by the Supreme Court as the point before which the state cannot impose an undue burden on abortion access²³⁰—is an arbitrary line and should be replaced by another. For example, David Forte has argued that viability is arbitrary and should be replaced with fetal cardiac activity as the point at which “life” begins.²³¹ His argument supports the adoption of so-called heartbeat bans, which criminalize abortion beginning around six weeks of pregnancy, when fetal cardiac activity can first be detected. Others have pointed to the supposed ability of the fetus to feel pain at twenty weeks gestation as support for pre-viability abortion bans.²³² The irony is that this incessant search for a new and more definitive border or marker, with its constant appeals to purported objective medical facts, results only in a proliferation of potential borders, highlighting their arbitrariness.

Of course, it is not the existence of the borders themselves that is problematic. Nor is the arbitrariness of a border necessarily problematic. The law functions through the drawing of lines and designating points at which conduct crosses over from legal to illegal, constantly producing what could be considered arbitrary borders. Rather, the problem lies in the failure to recognize that such borders represent moral and political judgments, rather than objective medical or technical judgments.²³³ In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court reaffirmed the viability line as the relevant one for determining when the state’s interest in the fetus could outweigh the woman’s decision-making autonomy. Asserting that “[l]iberty must not be extinguished for want of a line that is clear,” the plurality opinion drew the line at viability not only because of its workability but also because it was the most morally justifiable demarcation point.²³⁴ Any attempt to replace the line drawn by the Court, then,

was the only way to protect women from a lack of information about the nature of the procedure. 550 U.S. 124, 184 (2007) (Ginsburg, J., dissenting).

230. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 878 (1992) (plurality opinion).

231. David F. Forte, *Life, Heartbeat, Birth: A Medical Basis for Reform*, 74 OHIO ST. L.J. 121, 140 (2013) (“There is a better marker. . . . That marker is the point at which the onset of cardiac activity in the fetus occurs. We are speaking of heartbeat.”).

232. See John A. Robertson, *Abortion and Technology: Sonograms, Fetal Pain, Viability, and Early Prenatal Diagnosis*, 14 U. PA. J. CONST. L. 327, 365 (2011).

233. Cf. Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 275 (1992) (explaining, in the abortion context, how “medical analysis displaces social analysis of the exercise of state power entailed in restricting women’s access to abortion”).

234. *Casey*, 505 U.S. at 869–70 (plurality opinion).

must also be morally justified, and this moral task cannot be circumvented by simply pointing to purportedly objective scientific markers.

V. RECONSIDERING THE CONSTITUTIONAL LANDSCAPE

Several common themes emerge from examining the various forms of spatial regulation of abortion. As discussed in Section V.A, these shared features of spatial regulations help to explain the particular attractiveness of this mode of legislation, particularly for lawmakers who seek to restrict access without making this purpose apparent. Section V.A summarizes those features, drawing connections among the three types of spatial restrictions—facility regulations, border management, and mapping of women’s bodies. Section V.B then considers the constitutional implications of understanding spatial abortion restrictions in this way. In particular, Section V.B argues that a new understanding of spatial regulation may ground a new approach to three different aspects of constitutional law: (1) the right to travel, (2) the private nondelegation doctrine, and (3) the viability line in abortion doctrine.

A. WHY SPATIAL REGULATION?

Because of certain features inherent in this type of law, spatial regulation of abortion is particularly appealing when the goal is to restrict abortion access. The effects of spatial regulation often arise from existing social and economic arrangements, such that the role of the state in bringing about those effects appears to be attenuated, if present at all. At the same time, the manipulation of borders and boundaries is submerged under an appearance of inevitability. Spatial regulation, which relies upon and invokes the state’s police power to protect the health and safety of citizens, often appears uncontroversial and apolitical. For example, spatial regulations may simply designate certain places as *types* of places, in which certain activity is or is not permitted to occur, with legal consequences that flow from those designations. The drawing of lines and labeling of places appears to be technical or administrative, but significant political consequences flow from it—including, often, the exacerbation of preexisting inequalities. Although this exacerbation may not always be an explicit goal of spatial regulation, the former is at a minimum a known and expected outcome of the latter, albeit one that by and large escapes constitutional scrutiny.

When a state passes legislation that makes it nearly an “abortion-free zone” or limits access to out-of-state abortion, or even when the U.S. government forces young asylum seekers to choose between forgoing an abortion and leaving the United States, the government may appear to be exercising exactly the kind of “border control” that sovereigns are expected and entitled to exercise. Yet it is acting not only upon the borders themselves but also upon individuals; it is designating those individuals as either fully entitled to the benefits and protections of the Constitution, or entitled to something less.²³⁵ It is also stigmatizing both

235. See NICHOLAS K. BLOMLEY, *LAW, SPACE, AND THE GEOGRAPHIES OF POWER* 54 (1994) (“Legal categories are used to construct and differentiate material spaces which, in turn, acquire a legal potency that has a direct bearing on those using and traversing such spaces.”).

abortion and the people who seek it by designating them as outsiders with respect to the political community.²³⁶

This sort of sovereign line drawing also occurs with respect to the physical places where abortions take place. If any place where abortions are regularly performed is designated an “ambulatory surgical facility,” it is required to conform to licensing and other requirements, which often depend on a relationship with a local hospital.²³⁷ As explained above, this sort of differential spatial regulation of abortion clinics has arguably led to the increased isolation of abortion from health care and of abortion providers from “mainstream” health care providers.²³⁸ It further disempowers abortion providers and patients by making the availability of abortion services dependent on private actors, such as hospitals, that operate outside the field of abortion provision and may themselves be influenced by the abortion stigma that this form of spatial regulation creates.

Finally, the state both draws and manipulates boundaries within pregnant bodies by means of mandatory ultrasound laws and partial-birth abortion laws. Particular legal consequences flow from the location of the fetus during an abortion procedure and from the features of the visual and auditory map of the fetus during an ultrasound.²³⁹ Moral consequences also flow from the state’s mapping and line drawing because the woman symbolically appears to be separate from her fetus; she narratively becomes a mother rather than a pregnant woman, and her abortion is analogized to murder.

In each case, spatial regulation operates in two key ways. First, spatial regulation both relies upon and conceals the reality that borders are profoundly manipulable. Legal categories—such as “ambulatory surgical center”—may appear neutral and technical, but they are politically determined and often have significant consequences that are far from unavoidable. As Richard Ford has argued, the very “practice of organizing activities as first and foremost occurring in a place defined by its borders is a habit, not a necessity.”²⁴⁰ Nonetheless, courts often treat such realities as

236. See Zick, *Constitutional Displacement*, *supra* note 4, at 537 (“[R]esort to spatiality or territory often produces more than mere regulation of populations and behaviors. Displacement sometimes has a *communicative function*; it may brand those who are displaced.”).

237. See *supra* Section III.A; see also, e.g., OHIO REV. CODE ANN. § 3702.30(A)(1)(a) (West 2020); *Founder’s Women’s Health Ctr. v. Ohio State Dep’t of Health*, No. 01AP–872, 2002 WL 1933886, at *14 (Ohio Ct. App. Aug. 15, 2002) (holding that abortion clinics are “ambulatory surgical facilities” under state law and therefore subject to particular licensing requirements).

238. See *supra* Section III.B.

239. Specifically, if the fetal heartbeat is detectable during the ultrasound, the abortion may be prohibited under so-called “heartbeat” abortion bans. All of these bans have been held unenforceable as of this writing. See *Jackson Women’s Health Org. v. Dobbs*, 951 F.3d 246, 248 (5th Cir. 2020) (per curiam) (holding Mississippi’s “heartbeat” abortion ban unconstitutional); *MKB Mgmt. Corp. v. Stenehjem*, 795 F.3d 768, 772–73 (8th Cir. 2015) (holding North Dakota’s “heartbeat” abortion ban unconstitutional); *Preterm-Cleveland v. Yost*, 394 F. Supp. 3d 796, 804 (S.D. Ohio 2019) (holding Ohio’s “heartbeat” abortion ban unconstitutional); *Planned Parenthood of the Heartland, Inc. v. Reynolds*, No. EQCE 83074, 2019 WL 312072, at *4 (Iowa Dist. Ct. Jan. 22, 2019) (holding Iowa’s “heartbeat” abortion ban unconstitutional).

240. Richard Thompson Ford, *Law and Borders*, 64 ALA. L. REV. 123, 128 (2012). Ford has produced an extensive literature on the relationship between law and geography, with a particular

—in the words of one court—“not a factor of state law.”²⁴¹ It is precisely the ability to impose and enforce legal categories while minimizing the appearance of state action that makes spatial regulation so attractive for lawmakers wishing to avoid constitutional challenge. “[C]reating a border is not an act of recognizing a difference but one of making a distinction”; yet, at the same time, “[b]orders do their work by making the distinctions seem natural and inevitable.”²⁴²

Second, spatial regulation reinscribes underlying inequalities, while appearing to act neutrally and without reference to categories of race, sex, or poverty.²⁴³ Likewise, the geography of a given state may seem natural and inevitable; but laws such as admitting-privileges requirements that encourage the concentration of abortion availability in large cities also have predictable and usually intended consequences for abortion access, particularly for poor and rural women.²⁴⁴ Indeed, nearly all abortion restrictions disproportionately impact poor women and women of color, who are more likely to seek abortions in the first place.²⁴⁵ Although this might not be the explicit intention of lawmakers, it is a known consequence.²⁴⁶ In many cases, reducing abortion access by imposing restrictions on already vulnerable individuals may be the simplest tool at hand.²⁴⁷ And because the law’s unequal effects are not its explicit purpose, it evades constitutional scrutiny that might otherwise arise under the Equal Protection Clause of the Fourteenth Amendment²⁴⁸ or the “purpose” prong of the undue burden analysis.²⁴⁹

emphasis on the ways in which law’s mobilization of boundaries and space creates and aggravates racial inequalities. *See, e.g.*, Ford, *supra* note 20.

241. *Utah Women’s Clinic, Inc. v. Leavitt*, 844 F. Supp. 1482, 1491 n.11 (D. Utah 1994).

242. Ford, *supra* note 240, at 139.

243. *See* BLOMLEY, *supra* note 235, at 190–91 (“The construction of racism and sexism through the division and encoding of urban space . . . can easily be obscured: spatial boundaries and differences can easily appear as natural or simply accidental.”).

244. *See supra* Section II.B.

245. *See* Susan A. Cohen, *Abortion and Women of Color: The Bigger Picture*, 11 GUTTMACHER POL’Y REV. 2, 2–3 (2008), <https://www.guttmacher.org/gpr/2008/08/abortion-and-women-color-bigger-picture> [<https://perma.cc/T4CR-BDRU>] (observing that Black and Hispanic women have disproportionately high abortion rates and that most abortions in the United States are among women of color); Sabrina Tavernise, *Why Women Getting Abortions Now Are More Likely to Be Poor*, N.Y. TIMES (July 9, 2019), <https://www.nytimes.com/2019/07/09/us/abortion-access-inequality.html> (“Half of all women who got an abortion in 2014 lived in poverty, double the share from 1994.”).

246. *See, e.g.*, Jeremy Waldron, *Homelessness and the Issue of Freedom*, 39 UCLA L. REV. 295, 315–18 (1991) (analyzing the impact of spatial regulation on homeless individuals, distinguishing between harm that is *intended* by lawmakers and harm for which lawmakers should be *blamed*).

247. During the 1977 congressional debate over the Hyde Amendment, Representative Henry Hyde stated, “I certainly would like to prevent, if I could legally, anybody having an abortion, a rich woman, a middle-class woman, or a poor woman. Unfortunately, the only vehicle available is the . . . Medicaid bill.” Magda Schaler-Haynes, Arina Chesnokova, Cynthia Cox, Marla Feinstein, Amanda Sussex & Julia Harris, *Abortion Coverage and Health Reform: Restrictions and Options for Exchange-Based Insurance Markets*, 15 U. PA. J.L. & SOC. CHANGE 323, 337 n.108 (2012) (alteration in original).

248. *See* *Washington v. Davis*, 426 U.S. 229, 239 (1976) (holding that a law does not violate the Equal Protection Clause solely because it has a disparate racial impact; the law must also have a discriminatory purpose).

249. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (plurality opinion) (“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

B. CONSTITUTIONAL CONTEXTS

Do the insights presented in this Article about the nature and functioning of spatial abortion regulation lead to any new constitutional implications? Some possibilities present themselves. First, some scholars have already considered the constitutional right to travel in relation to territorial restrictions. Below, I summarize and expand on that line of argument. Second, a careful analysis of spatial regulation has yielded the insight that state action is pervasively present yet often invisible. Recognizing this fact might lead to a broader understanding of state action than the case law has adopted to date. In particular, this broader understanding of state action could affect the treatment of nondelegation claims in the abortion context. Third, a close examination of spatial discourse in mandatory ultrasound and procedure-ban cases produces the insight that it is moral and political judgments, rather than scientific ones, that lead to the construction of particular ideas about abortion and motherhood. As discussed below, this insight should lead courts to reject the notion that particular scientific advances have changed our understanding of abortion in ways that are legally relevant.

The discussion that follows here is not intended to present an exhaustive analysis of each of these potential constitutional claims. In fact, each potential claim could likely generate a complete scholarly article of its own. Rather, this Section is intended primarily to serve as an overview of how a proper understanding of spatial regulation might affect constitutional law. It may serve as a potential research agenda on spatial regulation in the abortion context and as a series of suggestions for new arguments that could be mobilized in both the courts and the political arena to challenge abortion restrictions in the future, including a possible future in which *Roe v. Wade* has been overturned or radically limited. As such, these arguments fill a critical gap in the literature and discourse on abortion rights.

1. The Right (Not) to Travel and States' Duties to Afford Access

As an increasing number of states are left with only one abortion clinic, and other states continue to adopt increasingly onerous abortion restrictions, the underlying principles of the 1938 case *Missouri ex rel. Gaines v. Canada*²⁵⁰ have become more pertinent. *Gaines*, which dealt with racial segregation, stands for the propositions that federalism does not necessarily entail a patchwork in which individual access to basic constitutional rights differs widely depending on one's state of residence, and that states may not delegate their responsibility for protecting citizens' freedom to other sovereign states.²⁵¹ The case involved a challenge to Missouri's policy of denying Black students admission to its state-sponsored law school, the University of Missouri, but paying for them to attend an

fetus.”). See generally Note, *After Ayotte: The Need to Defend Abortion Rights with Renewed “Purpose,”* 119 HARV. L. REV. 2552, 2565–73 (2006) (arguing for renewed focus on the “purpose” prong of *Casey*'s undue-burden test).

250. 305 U.S. 337 (1938).

251. *Id.* at 350.

out-of-state school that would accept them.²⁵² Noting that “the obligation of the State to give the protection of equal laws can be performed only where its laws operate, that is, within its own jurisdiction” and “[t]hat obligation is imposed by the Constitution upon the States severally as governmental entities,—each responsible for its own laws establishing the rights and duties of persons within its borders,” the Court held the Missouri policy to be an unconstitutional violation of the Equal Protection Clause.²⁵³ Indeed, the Court implied that this holding derived not only from the Fourteenth Amendment but also from federalism itself:

It is an obligation the burden of which cannot be cast by one State upon another, and no State can be excused from performance by what another State may do or fail to do. That separate responsibility of each State within its own sphere is of the essence of statehood maintained under our dual system.²⁵⁴

This language, translated to the abortion context, suggests that states may have an obligation to avoid an undue burden on abortion rights by affording at least some minimal access to abortion within their borders; they cannot foist that responsibility onto neighboring states.²⁵⁵ The understanding of federalism derived from *Gaines* and its application in the abortion context may connect, moreover, with case law and scholarship pertaining to the constitutional right to travel under Article IV, Section 2 of the Constitution and under the Fourteenth Amendment.

The possibility of a future in which *Roe v. Wade* has been overruled has already generated scholarly literature considering the possibility that some states may choose not only to ban abortion within the state but also to prohibit their residents from traveling to other states where abortion is legal in order to access abortion.²⁵⁶ Seth Kreimer has argued that such an extraterritorial abortion ban would violate several constitutional provisions, including the right to travel protected by Article IV, Section 2 of the Constitution.²⁵⁷ Kreimer opines that this right, which includes the right to enter and leave any state of the union and to be treated on equal terms with each state’s citizens while there, would be inhibited by a law that threatens criminal penalties for women who travel out of the state to access

252. *Id.* at 342–43.

253. *Id.* at 350.

254. *Id.*

255. See *supra* text accompanying notes 66–67.

256. See sources cited *supra* note 3. Indeed, with the passing of Justice Ruth Bader Ginsburg and her replacement with Justice Amy Coney Barrett, the future of *Roe v. Wade* looks even more precarious as of the time of this writing. Barrett, who now forms part of a 6–3 conservative majority on the Supreme Court, has expressed opposition to abortion in the past. See, e.g., Adam Liptak, *Barrett’s Record: A Conservative Who Would Push the Supreme Court to the Right*, N.Y. TIMES (Oct. 12, 2020), <https://www.nytimes.com/2020/10/12/us/politics/barretts-record-a-conservative-who-would-push-the-supreme-court-to-the-right.html>.

257. U.S. CONST. art. IV, § 2, cl. 1 (“The Citizens of each State shall be entitled to all Privileges and Immunities of Citizens in the several States.”); Kreimer, *The Law of Choice*, *supra* note 3, at 509–11.

abortion services.²⁵⁸ Other commentators have been more skeptical, noting that courts, including the Supreme Court, have upheld laws restricting travel by a state's adult citizens with the purpose of evading state law.²⁵⁹ This relatively open constitutional question could turn on how courts might resolve what Richard Fallon has called "the competing claims of state and national citizenship": courts in a post-*Roe* world would be forced to decide whether a state's interest in protecting fetuses outweighs the woman's physical liberty, including the right to travel among the states and to enjoy the privileges and immunities of those states.²⁶⁰ On one hand, this balancing test may weigh in favor of the woman who seeks to travel, given the significant degree of moral disagreement about this issue; the possibility of travel to another state could be seen as a kind of accommodation to women who disagree with an anti-abortion state's moral judgment.²⁶¹ Yet, one might ask, if a state has a constitutionally sufficient interest in enforcing its fetal protection laws on its own citizens within its own borders, why should it not have an interest in enforcing its laws when its citizens go to other states?²⁶²

Ultimately, the answer to this question may depend in part on whether the Privileges and Immunities Clause of Article IV, Section 2 is best understood as a grant of individual rights to U.S. citizens or as a federalism constraint on states that is meant to protect goodwill and unity among them by prohibiting legislation that advances economic protectionism or otherwise discriminates against out-of-staters. If it is only the latter, then perhaps Article IV protects only against actions *by destination states* that prevent citizens of other states from availing themselves of the benefits of the destination state.²⁶³ If it is the former—as Part I argues, a protection of liberty itself in its most fundamental form—then the Privileges and Immunities Clause would appear to limit the extraterritorial reach of abortion prohibitions because individual citizens of a restrictive state would nonetheless

258. Kreimer, *The Law of Choice*, *supra* note 3, at 510–11 (first citing *Paul v. Virginia*, 75 U.S. 168, 180 (1868); then citing *State v. Cutshall*, 15 S.E. 261, 264 (N.C. 1892); and finally citing *City of Detroit v. Osborne*, 135 U.S. 492, 498 (1890)); *see also Saenz v. Roe*, 526 U.S. 489, 500 (1999) (explaining that the right to travel under Article IV protects "the right to be treated as a welcome visitor rather than an unfriendly alien when temporarily present in" another state). It is possible that criminalizing such travel would also violate the component of the right to travel that includes "the right of a citizen of one State to enter and to leave another State." *Saenz*, 526 U.S. at 500. This right is not specifically identified in the Constitution but has been considered either a fundamental component of U.S. federalism, *see id.* at 501, or an aspect of the liberty protected by the Due Process Clause of the Fourteenth Amendment, *see Jones v. Helms*, 452 U.S. 412, 418–19 (1981).

259. *See, e.g., Appleton*, *supra* note 3, at 675–76; Fallon, Jr., *supra* note 3, at 638–39.

260. Fallon, Jr., *supra* note 3, at 639–40.

261. *See Cohen*, *supra* note 3, at 1369–71; G Pennings, *Reproductive Tourism as Moral Pluralism in Motion*, 28 J. MED. ETHICS 337, 340 (2002).

262. Glenn Cohen makes this argument in the context of international travel, where its logic is perhaps even more compellingly supportive of extraterritorial application. *See Cohen*, *supra* note 3, at 1370–71. Moreover, he notes that accommodation would benefit only individuals with the means to travel and that his approach "instead keys enforcement to where the harm is done." *Id.* at 1371.

263. *See Doe v. Bolton*, 410 U.S. 179, 200 (1973) (holding that the Privileges and Immunities Clause protects persons who enter a state seeking medical services available in that state).

possess an entitlement by virtue of Article IV to travel to other states to enjoy the benefits of the laws of those states, and that entitlement could not be infringed by their home states.²⁶⁴

This right-to-travel framework may provide a powerful doctrinal and political argument in a possible future world without *Roe*. If *Roe* is overturned, states may seek to criminalize traveling to another state to access abortion services, and advocates may be able to use Article IV to strike down such criminal laws. It appears to have limited applicability in the current context, however. Other than in the case of minors, states have not attempted to apply their restrictions extraterritorially and, in fact, have instead seemingly encouraged women to travel out of state to access abortion.²⁶⁵

By contrast, one possibility for combatting abortion restrictions that result in a lack of access, or severely reduced access, to abortion in a particular state might derive from a right *not* to travel.²⁶⁶ This right not to travel is the flip side of the right to travel—just as the First Amendment right to speak includes a right not to speak.²⁶⁷ A right not to travel would mean that women have a right to access constitutionally protected health care services within their own states and cannot be required to become “reproductive refugees” to retain control over their reproductive decisionmaking.

Such a principle may be identified in those cases in which courts have relied on *Gaines* to strike down laws that would close the last abortion clinic in a given state. In *JWHO*, for example, the Fifth Circuit held that the availability of abortion services in neighboring states did not absolve Mississippi of its responsibility to avoid imposing an undue burden on abortion access within the state.²⁶⁸ As the Seventh Circuit explained in a similar case:

[The idea that] the harm to a constitutional right [can be] measured by the extent to which it can be exercised in another jurisdiction . . . [is] a profoundly mistaken assumption. In the First Amendment context, the Supreme Court long ago made it clear that one is not to have the exercise of his liberty of expression in appropriate places abridged on the plea that it may be exercised in some other place. . . . It’s hard to imagine anyone suggesting that Chicago may prohibit the exercise of a free-speech or religious-liberty right within its

264. Of course, an additional constraint on the right-to-travel argument is that the Privileges and Immunities Clause protects only citizens of the United States. Thus, noncitizens, already uniquely burdened by abortion restrictions in some parts of the country, could not avail themselves of the arguments described here.

265. See *supra* note 66 and accompanying text.

266. A theoretical right not to travel (albeit not in the U.S. constitutional context) has been suggested by Nicholas Blomley. See BLOMLEY, *supra* note 235, at 210.

267. See U.S. CONST. amend. I (“Congress shall make no law . . . abridging the freedom of speech”); *Wooley v. Maynard*, 430 U.S. 705, 714 (1977) (“[T]he right of freedom of thought protected by the First Amendment against state action includes both the right to speak freely and the right to refrain from speaking at all.”).

268. *Jackson Women’s Health Org. v. Currier*, 760 F.3d 448, 457 (5th Cir. 2014).

borders on the ground that those rights may be freely enjoyed in the suburbs.²⁶⁹

In that case, the Seventh Circuit relied in part on its prior decision in *Ezell v. City of Chicago*, in which it struck down a Chicago law that effectively banned handguns within city limits by requiring handgun owners to have at least one hour of training at a firing range and then prohibiting firing ranges within the city limits.²⁷⁰ In *Ezell*, the court rejected the idea that the plaintiffs did not suffer any harm because they could travel outside the jurisdiction to exercise their Second Amendment rights.²⁷¹ It also noted the irony that “the City considers live firing-range training so critical to responsible firearm ownership that it mandates this training as a condition of lawful firearm possession,” while at the same time prohibiting such ranges.²⁷² Similarly, in the abortion context, states consider written transfer agreements and admitting privileges vital to safe abortion practice, while at the same time creating various obstacles to obtaining them.²⁷³

Abortion restrictions that effectively “force[] [women] to leave the state to exercise their constitutional right”—whether because they close all abortion clinics in the state or, for example, make the procedure unavailable after a particular stage of pregnancy—could be considered unconstitutional under this logic.²⁷⁴ The rationales of *Gaines* and *Ezell* thus provide a tool for challenging laws that hollow out the right to access abortion such that a state is left without a single abortion provider. Citizens have a right not to be forced to travel to another state to exercise their federally guaranteed constitutional rights; *Gaines* thus presents a sort of mirror image of the right to travel—a right *not* to be forced to travel in order to access basic rights. Indeed, as Jeremy Waldron has explained in the context of considering states’ obligations to refrain from legislation that limits homeless persons’ access to public spaces: “Everything that is done has to be done somewhere. No one is free to perform an action unless there is somewhere he is free to perform it.”²⁷⁵ Making and enforcing rules that result in the unavailability

269. *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908, 918–19 (7th Cir. 2015) (second, third, and fourth alterations in original) (quotation marks and citations omitted) (quoting *Ezell v. City of Chicago*, 651 F.3d 684, 697 (7th Cir. 2011)).

270. *Id.*; *Ezell*, 651 F.3d at 691, 711.

271. *Ezell*, 651 F.3d at 697.

272. *Id.* at 704–05.

273. *See, e.g.*, OHIO REV. CODE ANN. § 3727.60(B)(1) (LexisNexis 2020) (forbidding public hospitals from entering written transfer agreements with abortion clinics).

274. *Jackson Women’s Health Org. v. Currier*, 760 F.3d 448, 456 (5th Cir. 2014) (citing *Jane L. v. Bangerter*, 102 F.3d 1112, 1114 (10th Cir. 1996) (striking down a law significantly restricting abortions after twenty weeks gestation)). The current wave of laws banning abortions by the common method known as D&E similarly threatens to make abortion unavailable after about fourteen to seventeen weeks of pregnancy. *See, e.g.*, *Hopkins v. Jegley*, 267 F. Supp. 3d 1024, 1069 (E.D. Ark. 2017) (noting that women “would immediately lose the right to obtain a pre-viability abortion anywhere in the State of Arkansas after 14.0 weeks LMP if the D & E Mandate were allowed to take effect”), *modified*, No. 4:17-CV-00404-KGB, 2017 WL 6946638 (E.D. Ark. Aug. 2, 2017), *vacated*, 968 F.3d 912 (8th Cir. 2020).

275. Waldron, *supra* note 246, at 296.

of places where an action may legally be performed restricts that activity just as surely as a direct ban might.²⁷⁶

One might argue that *Gaines* should have limited relevance in the abortion context, however, because a state's duty to provide equal protection of the laws—that is, to provide a benefit such as public education on equal terms to all citizens, *if* it provides that benefit at all—is conceptually quite different from a state's responsibility under the Due Process Clause not to interfere with abortion access, which is provided by private entities. Indeed, this was the counterargument raised by the dissent in *JWHO*, which declined even to find state action behind hospitals' refusal to grant legally required admitting privileges to abortion clinics in the state.²⁷⁷ The dissenting judge in that case noted that in the *Gaines* context, unlike the abortion context, the state was providing a service, and that unlike the Equal Protection Clause, the substantive due process guarantee “does not require a state to *take* any action but rather to *refrain* from taking unconstitutional actions.”²⁷⁸ The dissent thus suggests that applying *Gaines* in the substantive due process context wrongly imposes a positive obligation on states to provide a service rather than a negative obligation to avoid interfering with women's access to abortion.²⁷⁹

Yet, some right of access is already implied by existing abortion jurisprudence. *Whole Woman's Health*, after all, held that a law was unconstitutional because it would shut down too many abortion clinics, creating a substantial obstacle to abortion access in the state.²⁸⁰ In addition, the above discussion of spatial regulation demonstrates that what appears to be a neutral restriction on abortion access often has differential effects on poor women, rural women, and women of color. Moreover, courts and scholars—including, most prominently, the plurality opinion in *Casey*—have also come to recognize that the right to abortion *is* a form of equality right, one necessary to women's economic and social equality.²⁸¹ Though abortion restrictions are not generally found to be in direct conflict with the Equal Protection Clause, this insight demonstrates the fundamental connection between equality concerns and substantive due process principles.

Still, there must be meaningful limits to this principle. Otherwise, it suggests that states must always provide whatever individuals need in order to exercise their rights. If there is no clinic or gun manufacturer in a given state for reasons

276. *See id.* at 304–06.

277. *Jackson Women's Health Org.*, 760 F.3d at 461 (Garza, J., dissenting) (“Regardless of the propriety or the legality of the hospitals' actions, what matters for this substantive due process analysis is that *JWHO* has not shown that the Clinic's closure would result directly from [the statute], as opposed to the independent decisions of local hospitals—non-state actors.”).

278. *Id.* at 463.

279. For a discussion of the distinction between positive and negative rights, and the often (if somewhat incorrect) understanding that the U.S. Constitution confers only the former, see, for example, Cynthia Soohoo & Jordan Goldberg, *The Full Realization of Our Rights: The Right to Health in State Constitutions*, 60 CASE W. RES. L. REV. 997, 1003–12 (2010).

280. *Whole Woman's Health v. Hellerstedt*, 136 S. Ct. 2292, 2299 (2016).

281. *See Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992) (plurality opinion); Appleton, *supra* note 3, at 660–62.

that have nothing to do with the laws of the state, is the state required to build one? Does the right not to travel to access abortion services imply that each state must adopt the regulations of the most liberal state in the Union? Further specification of this claim would be necessary. It seems, however, that the notion of a right not to travel, combined with the equality-inspired doctrinal tradition of *Gaines*, might provide a basis for arguing that states have an obligation to ensure at least a minimum level of abortion access as an incident of citizenship. Such a minimal level of access could ensure not only reproductive liberty but also equality for those marginalized groups who currently suffer disproportionately from a lack of access to reproductive health care, such as poor people and people of color.

2. Private Nondelegation Claims

In the abortion context, plaintiffs have sometimes raised a species of “private nondelegation” claim to challenge spatial regulations. Such claims have a long pedigree, but the doctrinal line has recently begun to falter. For over a century, courts have accepted the notion that the government cannot, consistent with the Due Process Clause, grant standardless discretion to private entities to enforce certain kinds of legal rules in ways that infringe others’ constitutional rights. However, this rule has remained underdeveloped, and in the abortion regulation context, it seems to be losing force.²⁸² As the above discussion indicates, however, this doctrine captures an important but often unrecognized problem with many spatial abortion regulations: in relying on neutral-seeming rules that delegate authority to private parties, they conceal the role of the state in exploiting preexisting hostility to abortion and other features of the geographical context to intentionally reduce abortion access. As such, a revitalized private nondelegation doctrine could be used to challenge spatial abortion restrictions that might otherwise survive judicial review. The need for such an alternate path is particularly pressing in light of the uncertainty over the status of the *Whole Woman’s Health* balancing test after *June Medical Services L. L. C. v. Russo*.²⁸³

In the 1912 case *Eubank v. City of Richmond*,²⁸⁴ the Supreme Court held unconstitutional a city ordinance that allowed two-thirds of property owners on a street to dictate a particular setback for future buildings.²⁸⁵ This decision directly affected the plaintiff, who had purchased land and had begun planning a home that would not conform to the setback.²⁸⁶ Although the lower courts had upheld the law, the Supreme Court found it to be an unconstitutional use of the state’s police power, emphasizing that the law allowed “[o]ne set of owners [to] determine not only the extent of use but [also] the kind of use which another set of

282. As explained below, *infra* text accompanying notes 299–303, advocates have sometimes raised nondelegation claims in challenges to spatial abortion restrictions, but those claims have rarely carried the day.

283. See *supra* notes 108–14 and accompanying text.

284. 226 U.S. 137 (1912).

285. *Id.* at 141, 144.

286. *Id.* at 142.

owners may make of their property.”²⁸⁷ In particular, the Court was concerned that the law imposed no standard on those private parties’ use of their power, allowing them to act capriciously, out of self-interest, or simply out of their own arbitrary sense of taste.²⁸⁸ Indeed, the Court noted, if an individual owned enough property, that single person could dictate the rights of a number of property owners.²⁸⁹

The Supreme Court subsequently relied upon *Eubank* in another case from the same era—*Washington ex rel. Seattle Title Trust Co. v. Roberge*.²⁹⁰ There, the Court found a similar law—allowing certain kinds of buildings to be constructed only with the consent of nearby property owners—to be unconstitutional.²⁹¹ Noting that the neighbors’ authority was “uncontrolled by any standard or rule prescribed by legislative action,” with no possibility of review, the Court again expressed concern that the private property owners were “free to withhold consent for selfish reasons or arbitrarily.”²⁹² Thus, the Court held that the law was an “unconstitutional delegation of power” that violated the Fourteenth Amendment.²⁹³

Both cases arose during an era in which courts engaged in close scrutiny of states’ use of their police power, freely striking down laws that did not advance health, safety, or morals. Moreover, these cases preceded the modern era of equal protection and substantive due process jurisprudence.²⁹⁴ Nonetheless, they embody principles that retain vitality today. As noted below, courts continued to reject standardless delegation of governmental authority to private parties well into the twentieth century.²⁹⁵

This principle has sometimes been used to strike down abortion regulations that require clinics to seek the permission of a private third party to operate, such as by requiring admitting privileges or hospital transfer agreements. In a case decided shortly after *Roe v. Wade*, for example, a federal district court in North Carolina held that a law requiring abortion clinics to have either a transfer agreement or hospital admitting privileges for its physicians violated due process.²⁹⁶ Noting that the law imposed no standards for the grant or denial of agreements or

287. *Id.* at 143.

288. *Id.* at 143–44; see also *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936) (striking down a delegation of legislative power to a private group).

289. *Eubank*, 226 U.S. at 144.

290. 278 U.S. 116 (1928).

291. *Id.* at 122–23.

292. *Id.* at 122.

293. *Id.* at 122–23.

294. See generally HOWARD GILLMAN, *THE CONSTITUTION BESIEGED: THE RISE AND DEMISE OF LOCHNER ERA POLICE POWERS JURISPRUDENCE* 12, 14 (1993) (noting that judges in the *Lochner* Era sought to distinguish between valid and invalid exercises of police powers).

295. Cf. *Bell v. Wolfish*, 441 U.S. 520, 584 n.15 (1979) (Stevens, J., dissenting)) (first citing *Rinaldi v. Yeager*, 384 U.S. 305 (1966)); and then citing *Ill. Elections Bd. v. Socialist Workers Party*, 440 U.S. 173 (1979)) (noting that arbitrary government actions are inherently unconstitutional by lacking a rational basis).

296. *Hallmark Clinic v. N.C. Dep’t of Human Res.*, 380 F. Supp. 1153, 1158 (E.D.N.C. 1974).

privileges by hospitals and no opportunity for judicial or administrative review, the court analogized to cases in the First Amendment context striking down licensing schemes that grant standardless discretion to state officials.²⁹⁷ The state cannot grant hospitals the arbitrary power to veto the performance of abortions for any reason or no reason at all, it explained: “The state cannot grant hospitals power it does not have itself.”²⁹⁸

But more recent case law is mixed. Some courts have struck down spatial abortion restrictions on this basis. In *Planned Parenthood of Wisconsin, Inc. v. Van Hollen*, for example, the district court struck down Wisconsin’s admitting privileges law on precisely this basis.²⁹⁹ The Eighth Circuit rejected a similar challenge to an admitting privileges requirement—but one that was imposed directly on physicians who perform abortions rather than on clinics—by asserting that the law “involve[d] state regulation of the qualifications of persons who perform abortions rather than standards for licensure of abortion clinics.”³⁰⁰ More commonly, though, both courts and parties have shown discomfort with such claims, either cursorily rejecting them or simply avoiding them. For example, the Seventh Circuit simply glossed over the nondelegation argument in affirming the *Van Hollen* decision on other grounds.³⁰¹ In other recent cases, courts have declined to reach such claims,³⁰² or plaintiffs have declined to press them.³⁰³

Private nondelegation doctrine is particularly well suited to application in the context of spatial regulations for several reasons. First, private nondelegation doctrine has primarily been applied in the zoning and licensing contexts—contexts which are subject to spatial regulation—because they implicate property rights, which cannot be infringed without due process of law.³⁰⁴ More

297. *Id.*

298. *Id.* at 1158–59; see also *Birth Control Ctrs., Inc. v. Reizen*, 508 F. Supp. 1366, 1374 (E.D. Mich. 1981) (striking down a written transfer agreement requirement as “violat[ing] due process concepts because they delegate a licensing function to private entities without standards to guide their discretion”).

299. 94 F. Supp. 3d 949, 997 (W.D. Wis.), *aff’d sub nom.* *Planned Parenthood of Wis., Inc. v. Schimel*, 806 F.3d 908 (7th Cir. 2015).

300. *Women’s Health Ctr. of W. Cty., Inc. v. Webster*, 871 F.2d 1377, 1382 (8th Cir. 1989); see also *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 748 F.3d 583, 600 (5th Cir. 2014) (rejecting a nondelegation claim on the same grounds as *Webster*); *Greenville Women’s Clinic v. Comm’r, S.C. Dep’t of Health & Envtl. Control*, 317 F.3d 357, 362–63 (4th Cir. 2002) (rejecting a nondelegation challenge because the likelihood of hospitals exercising an arbitrary veto was remote).

301. See *Schimel*, 806 F.3d at 922.

302. See, e.g., *EMW Women’s Surgical Ctr., P.S.C. v. Glisson*, No. 3:17-CV-00189-GNS, 2018 WL 6444391, at *28 n.29 (W.D. Ky. Sept. 28, 2018) (declining to reach nondelegation claim), *rev’d in part, vacated in part sub nom.* *EMW Women’s Surgical Ctr., P.S.C. v. Friedlander*, 978 F.3d 418 (6th Cir. 2020).

303. *Jackson Women’s Health Org. v. Carrier*, 940 F. Supp. 2d 416, 420 n.2 (S.D. Miss. 2013) (“[W]hile [the clinic] may have a valid due-process claim, it expressly reserved the claim in its Reply, which may indicate that it is somehow infirm. The Court will stop here, but to avoid piece-meal adjudication, the Court advises Plaintiffs to assert their arguments if they deem them worthy.”), *aff’d as modified*, 760 F.3d 448 (5th Cir. 2014).

304. See, e.g., *Spinelli v. City of New York*, 579 F.3d 160, 169 (2d Cir. 2009) (“[O]nce the government has granted a business license to an individual, the government cannot ‘depriv[e] [the individual of] such an interest . . . without [due process].’” (second, third, and fourth alterations in original) (quoting *Arnett v. Kennedy*, 416 U.S. 134, 167 (1974) (Powell, J., concurring in part)));

importantly, when they operate to shut down abortion clinics, delegations to private actors rely on several factors unique to spatial regulation in the abortion context. For example, admitting privileges and written transfer agreement laws may specify a particular maximum distance that the hospital can be from the clinic. Inevitably, such distance specifications limit the universe of institutions from which clinics may seek assistance to stay in business, thus increasing their vulnerability to closure at the whim of powerful actors within those institutions. More fundamentally, such spatial requirements also rely upon the geographical isolation of clinics, including the fact that abortions are mostly performed outside the hospital setting—a fact attributable to the precise hostility to abortion on the part of hospitals and hospital-based physicians that makes it so hard for clinics to meet these requirements.³⁰⁵

The private nondelegation doctrine, properly understood, represents a potentially powerful tool for challenging spatial abortion regulations. The idea that the government may not act arbitrarily, either on its own or by delegating arbitrary and standardless authority to private parties, has survived the vicissitudes of constitutional doctrine for more than a century. It can be identified in cases such as *Larkin v. Grendel's Den, Inc.*, in which the Supreme Court struck down a statute allowing churches to veto the issuance of liquor licenses to nearby businesses,³⁰⁶ and *Palmore v. Sidoti*, in which the Court held that presumed private racial biases could not be allowed to dictate official decisionmaking with respect to child custody.³⁰⁷ Although *Grendel's Den* and *Palmore* were not decided on due process grounds, they demonstrate that the principle forbidding delegation of an arbitrary veto over a third party's liberty has been incorporated into numerous doctrinal spaces. Thus, the private nondelegation doctrine, if it can be made conceptually robust and coherent, could become a powerful tool for challenging spatial abortion regulations.

Moreover, the case law demonstrates the relationship between the due process concern at the heart of the private nondelegation doctrine and equality concerns. Both the early cases, such as *Roberge*, and more modern cases, such as *Hallmark*

Women's Med. Prof'l Corp. v. Baird, 438 F.3d 595, 611 (6th Cir. 2006) (“[D]ue process protects an interest in the continued operation of an existing business.”).

305. See GINSBURG, *supra* note 132, at 55 & n.21 (explaining that hospitals' refusal to perform abortions after *Roe* was largely attributable to “the convictions of individual medical personnel or . . . the fears of hospital officials and governing bodies that too high an abortion rate would give their institution the reputation of being an ‘abortion mill’” (citing Nathanson & Becker, *supra* note 139)); Ziegler, *supra* note 2, at 442 (noting that the anti-abortion strategy behind TRAP laws relied on “the burden created by a law result[ing] not from the statute itself but rather from economic and political circumstances over which the government had no control”).

306. 459 U.S. 116, 127 (1982) (striking down the law on Establishment Clause grounds, and finding that it “substitute[d] the unilateral and absolute power of a church for the reasoned decisionmaking of a public legislative body acting on evidence and guided by standards”). In fact, the district court in *Grendel's Den* struck down the law on the ground that it was an unconstitutional delegation to a private party in violation of the Due Process Clause, not the Establishment Clause. *Grendel's Den, Inc. v. Goodwin*, 495 F. Supp. 761, 766 (D. Mass. 1980), *rev'd*, 662 F.2d 88 (1st Cir. 1981), *aff'd on reh'g en banc*, 662 F.2d 102 (1st Cir. 1981), *aff'd sub nom. Larkin v. Grendel's Den, Inc.*, 459 U.S. 116.

307. 466 U.S. 429, 433 (1984).

Clinic, cite to *Yick Wo v. Hopkins* as authority for the notion that the right to do business cannot be delegated to private or public individuals' arbitrary whim.³⁰⁸ *Yick Wo*, of course, was a case involving an ordinance forbidding laundries to operate in wood-frame buildings, unless the board of supervisors consented to it.³⁰⁹ The petitioner alleged that the prohibition was enforced only against businesspeople of Chinese descent.³¹⁰ Though the Supreme Court did not focus on the racial discrimination committed by city officials, it did find that the ordinance conferred "a naked and arbitrary power to give or withhold consent, not only as to places, but as to persons," and therefore violated the petitioner's Fourteenth Amendment rights.³¹¹ In fact, while citing both the Due Process and Equal Protection Clauses, the Court made explicit the connection between standardless discretion and discrimination, noting that the ability to make arbitrary decisions allowed officials to discriminate against Chinese business owners, treating otherwise similarly situated businesses differently.³¹² This connection between arbitrariness and discrimination is evident in *Palmore* as well.³¹³

This private nondelegation principle may also raise some new concerns, such as whether it has coherent limits that can be consistently applied by courts. To some extent, the case law itself identifies such limits. Generally, courts have found that a nondelegation challenge will fail if the private delegation is subject to judicial or administrative review (in which codified standards may be applied),³¹⁴ or if there is reason to believe that the authority will not be exercised arbitrarily.³¹⁵ Comprehensive development of the private nondelegation doctrine and its application to spatial regulations must therefore await further exposition; the goal of this Section is merely to show that the doctrine may provide a basis for challenge to some regulations that otherwise appear likely to survive under current doctrine, especially given Chief Justice Roberts's articulation of the undue burden standard in *June Medical Services*.³¹⁶

308. See *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153, 1158 (E.D.N.C. 1974) (citing *Yick Wo v. Hopkins*, 118 U.S. 356, 370 (1886)); *Washington ex rel. Seattle Title Tr. Co. v. Roberge*, 278 U.S. 116, 122 (1928) (citing *Yick Wo*, 118 U.S. at 366).

309. *Yick Wo*, 118 U.S. at 357.

310. *Id.* at 359.

311. *Id.* at 366–67.

312. *Id.* at 373–74.

313. See *Palmore v. Sidoti*, 466 U.S. 429, 433 (1984).

314. See, e.g., *Women's Med. Prof'l Corp. v. Baird*, 438 F.3d 595, 610 (6th Cir. 2006) (holding that the state's ability to grant a waiver from the written transfer agreement requirement saved it from invalidation as an impermissible delegation); *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153, 1158 n.8 (E.D.N.C. 1974) ("Because the Department . . . makes no attempt to control the hospital's decision, either by prescribing standards or by offering recourse against an uncooperative hospital, we are not governed by the . . . presumption against arbitrariness . . .").

315. See, e.g., *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 555–56 (9th Cir. 2004) (holding that the delegation scheme did not violate due process because "Arizona law . . . requires hospital procedures to 'comport with due process, i.e., notice and hearing'" (quoting *Holmes v. Hoemako Hosp.*, 573 P.2d 477, 479 (Ariz. 1977))).

316. See *supra* notes 110–12 and accompanying text.

3. Scientific Boundaries

A final insight regarding spatial abortion regulation that might yield some constitutional payoff is the recognition that boundaries—whether geographical or anatomical—are products of legal and moral decisionmaking, not irrefutable facts that must be taken for granted. Borders “are made, not found.”³¹⁷ This insight might evoke skepticism about attempts to draw a different line than viability for when abortion is permissible under the Constitution and about a recent spate of claims that scientific advances have shown definitive support for a different such borderline.

In *Planned Parenthood of Southeastern Pennsylvania v. Casey*, the Supreme Court recognized the inevitable criticism of the viability line as being a moving target, while strongly reaffirming that the core of the privacy right was the woman’s ability to choose abortion before viability.³¹⁸ When faced with arguments urging it to overturn the viability framework, the Court held that there was no line that better balanced the interests of the woman and the state, and no advances in medicine had changed that fact, regardless of when, exactly, viability occurred.³¹⁹ Yet, advocates for restricting abortion rights have argued that the viability line is arbitrary, promoting a different line between legality and illegality for abortion. They have attempted to identify particular “anatomical landmarks” that indicate the point at which an abortion supposedly occurs “outside the body” of the woman.³²⁰ They have also argued that the viability line should be replaced by a different line, such as the presence of fetal cardiac activity, supposedly due to “[r]ecent medical research.”³²¹

However, as discussed above and in *Casey*, these lines are and have always been moral and political ones, rather than scientific or medical ones.³²² The tendency of spatial regulation to mask that reality and to suggest that line drawing is a technical task should not override the logic and reasoning supporting existing legal rules in the abortion context. Though the recognition of this feature does not provide an independent constitutional basis for challenging mandatory ultrasound

317. Ford, *supra* note 240, at 127.

318. 505 U.S. 833, 860–61 (1992) (plurality opinion).

319. *Id.*

320. See *supra* text accompanying note 195; see also *Gonzales v. Carhart*, 550 U.S. 124, 186 (2007) (Ginsburg, J., dissenting) (“Instead of drawing the line at viability, the Court refers to Congress’ purpose to differentiate ‘abortion and infanticide’ based not on whether a fetus can survive outside the womb, but on where a fetus is anatomically located when a particular medical procedure is performed.”).

321. Forte, *supra* note 231. See generally Marc Spindelman, *On the Constitutionality of Ohio’s Proposed “Heartbeat Bill,”* 74 OHIO ST. L.J. 149 (2013) (analyzing the unconstitutionality of Ohio’s “heartbeat bill”).

322. See *supra* notes 233–34 and accompanying text; see also Robertson, *supra* note 232, at 390 (“Legal disputes arising from fetal sonograms, viability, fetal pain, and early prenatal diagnosis are less about the state of the science than they are about the meaning of that science within an existing structure of constitutional doctrine.”); John A. Robertson, *Science Disputes in Abortion Law*, 93 TEX. L. REV. 1849, 1849 (2015) (“Initially, the abortion debate concerned whether fetuses were living human beings. Opponents of abortion appealed to the science of biology, which showed that fetuses are indeed human, living, and individual. However, this biological fact did not mean that they are persons within the protection of the law.”).

laws or abortion procedure bans, it should inform their analysis and may provide a tool for combating them in the political realm.

CONCLUSION

The “spatial turn” in abortion regulation has yielded benefits for those seeking to restrict access to abortion while creating new difficulties for those wishing to challenge abortion restrictions. The goal of this Article is to examine the implications of this consequential shift. In particular, this Article argues that spatial regulation is a particularly appealing option for state actors that wish to appear neutral in their regulations because they tend to exploit existing inequalities to reduce abortion access in a way that conceals the role of the state in doing so. This Article also considers some possible ways in which attending to the dynamics of spatial regulation could affect constitutional analysis in the abortion context. It suggests that a proper understanding of spatial regulation could ground new approaches to the right to travel, to private nondelegation doctrine, and to legislative attempts to displace the significance of the viability line in abortion jurisprudence. As the future of *Roe v. Wade* itself hangs in the balance, the need for new legal and political arguments for protecting reproductive liberty, such as those described here, becomes even more pressing. Spatial regulation is simply too attractive a tool for legislators to resist.