

THE INVISIBLE WOMAN: AVAILABILITY AND CULPABILITY IN REPRODUCTIVE HEALTH JURISPRUDENCE

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ABSTRACT

Women's health is widely assumed to be a central consideration in reproductive rights cases. I examine court decisions relating to contraception, abortion and childbirth and demonstrate that while this assumption has historical validity, consideration of women's reproductive health as a protectable interest is declining in reproductive health cases. This is being accomplished in significant part through application of one or both of two recurring devices.

First, judges regularly -- and often inaccurately -- cite the theoretical availability of alternative reproductive health services as proof that women's health won't suffer even if a law curtailing reproductive rights is upheld. I label this the "availability tool." Second, when alternatives are not available, decisions blame women for the lack of availability. I call this the "culpability tool." Application of the availability and culpability tools in reproductive health cases regularly results in a truncated analysis of how laws impact women's reproductive health.

I show that while the availability and culpability tools can be applied in a manner that appropriately considers women's health interests, in practice, the tools are often used incorrectly, and thus may contribute to the undervaluing of women's health in reproductive health jurisprudence.

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INTRODUCTION

“In health there is freedom. Health is the first of all liberties.”

–Henri Frederic Amiel¹

If health is the first of all liberties then, for women, reproductive health is liberty’s foundation.² The ability to control one’s reproductive capacity is a health issue. Medical and surgical technologies that prevent or terminate pregnancy pose risks to women’s health,³ as does pregnancy itself.⁴ But women’s health is not just a medical issue: increasingly it is political, with both proponents and opponents of reproductive rights accusing the other of using health to further a political agenda.⁵

¹ HENRI FREDERIC AMIEL, *AMIEL’S JOURNAL: THE JOURNAL INTIME OF HENRI FRÉDÉRIC AMIEL* 104 (Mrs. Humphry Ward, trans., London, MacMillan 1889).

² See Ruth Bader Ginsburg, *Some Thoughts on Autonomy in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 383 (1985) (arguing that a woman’s ability to control her reproductive capacity is equivalent to her ability to take autonomous charge of her life).

³ See Food and Drug Administration, *Birth Control Guide*, available at <http://www.fda.gov/Fdac/features/1997/babytabl.html> [listing the contraceptive technologies and the corresponding risks, including the following: oral, vaginal and patch hormonal contraceptives (dizziness, nausea, changes in menstruation, mood, and weight, cardiovascular disease, including high blood pressure, blood clots, heart attacks and strokes); intrauterine devices (pelvic inflammatory disease, infertility and perforation of the uterus); and diaphragm, cervical cap or sponge with spermicide (allergic reaction, urinary tract infections and toxic shock syndrome)].

⁴ One in 4,800 women dies from pregnancy or childbirth-related causes in the United States every year, ranking it 47th in the world in maternal mortality. See Women Deliver, *Maternal Mortality Scorecard* (2007) available at [http://www.womendeliver.org/fact/MM_Country_Rankings_factsheet_\(A4\).pdf](http://www.womendeliver.org/fact/MM_Country_Rankings_factsheet_(A4).pdf) (citing the maternal mortality rates of most countries, including Ireland, which had the lowest mortality rate: 1 in 47,600). This number does not include all maternal deaths: pregnancy-related deaths occurring more than 42 days after the end of the pregnancy or death not specified as pregnancy-related on a death certificate are excluded. Arialdi M. Minino et al., *Deaths: Final Data for 2004*, NATIONAL VITAL STATISTICS REPORTS, vol. 55, no. 19, at 12 (Aug. 21, 2007), available at http://www.cdc.gov/nchs/data/nvsr/nvsr55/nvsr55_19.pdf.

⁵ One recent example of the “women’s health” debate occurred during the final 2008 presidential debate, when Sen. John McCain used his fingers to put “air quotes” around the word “health,” suggesting that health is used disingenuously by pro-abortion rights advocates to argue for fewer abortion restrictions. See, e.g., Jason Linkins, *McCain Mockingly Suggests that Concerns for a Woman’s Health are Extreme*, HUFFINGTON POST (Oct. 15, 2008), http://www.huffingtonpost.com/2008/10/15/mccain-mockingly-suggests_n_135072.html (saying Sen. McCain suggested support for woman’s health considerations represented an “extreme” pro-abortion position).

The rights to use contraception or obtain an abortion are well-established in constitutional jurisprudence, but the extent to which the Constitution protects a more general right to health, or the right to make autonomous medical decisions, is murky at best.⁶ Historically, health has been an interest weighed in reproductive rights jurisprudence, albeit inconsistently, but even that inconsistent presence is diminishing.⁷ The central issue in reproductive rights cases is no longer whether women's health is threatened, but where health ranks vis-à-vis competing interests, such as religious freedom, physicians' right to practice as they deem fit and, most controversially, the rights, if any, of a fetus. As women's health competes with other interests of potentially constitutional dimension, it triggers an ideologically loaded confrontation of interests that judges, understandably, may want to avoid. And avoid it they can.

An analysis of major reproductive rights decisions involving contraception, abortion or childbirth reveals that judges can -- and do -- avoid or abbreviate consideration of women's health issues by looking to the reproductive health care marketplace for available alternatives to the threatened reproductive health service.⁸ If such alternatives are available, judges cite them as guarantors of women's continuing ability to access the service needed and, correspondingly, as vindicators of women's reproductive health. I call this the "availability tool." The problem with the availability tool is this: when applied incorrectly, it focuses the analysis on the *ends* desired -- e.g. can women still terminate a pregnancy -- and neglects the importance of the *means* -- e.g. is the remaining abortion method as safe as the one banned.

⁶ See generally B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277 (2007) (suggesting that the degree of legal protection afforded to autonomous medical decisions depends upon the context in which the issue arises).

⁷ Health is considered as a factor in contraception, abortion and childbirth-related cases. See *infra* Parts II-III (discussing the treatment of health in various reproductive health cases).

⁸ Compare Alex M. Azar II, Deputy Sec. of Health and Hum. Servs., *The Importance of Competition in Health Care* (May 3, 2006), available at <http://www.hhs.gov/deputysecretary/depsecspeeches/060503.html> (suggesting that health care is a commodity that obeys economic laws) with Gina Kolata, *As Abortion Rate Decreases, Clinics Compete for Patients*, N.Y. TIMES, Dec. 30, 2000, at A1 (citing sociologist Carole Joffe as questioning whether abortion is truly part of the health care industry or part of a social movement). This paper is not an attempt to explain the outcome of every reproductive health case but identifies two related techniques used in significant reproductive health decisions involving different reproductive health controversies (preventing pregnancy, terminating pregnancy and obtaining obstetrical services).

Hypothetically, the availability tool can be used to protect women's health -- in fact there are cases where courts do just that -- but most often, the availability tool, as applied, is an analytical shortcut that shortchanges women. For example, if a law banning diaphragms was passed, a judge *incorrectly* applying the availability tool might uphold that law, citing women's ability to access alternative birth control methods such as the birth control pill or intrauterine devices as evidence that a diaphragm ban wouldn't impact women's health. However, a correct application of the availability tool would lead to the diaphragm ban's demise, as the judge would not stop at a mere citation of available alternatives: the judge would see that no true replacement for the diaphragm is available. Hormonal contraceptives such as the birth control pill may be contraindicated for women with certain cardiovascular risks, and the intrauterine device may be inappropriate for women who may want to become pregnant in the future. Theoretically, the diaphragm is a safer method for both populations of women. Therefore, there is no available, true substitute for diaphragms.

As the hypothetical diaphragm ban shows, proper use of the availability tool requires two steps: identifying available, potential replacements for the product or service in question and then analyzing whether those alternatives are true substitutes in that they have the same or better health risk profiles. In other words, judges should determine whether the availability of alternatives identified is an adequate substitute *given all health considerations*. Case law shows that the availability tool is often used incorrectly: judges complete step one of the tool but neglect step two, thus failing to complete the analysis.⁹ This is not to say that women's health is not mentioned in these cases -- it often is. Judges merely point to the general presence of alternatives in lieu of performing a nuanced analysis of the impact a legal restriction may have on women's health generally or on a particular woman.¹⁰

When the availability tool is used, the availability invoked may appear in one or more of several forms. It may take the form of citation of statistics on the use of a specific product or service and identification of potential substitutes.¹¹ A judge may make comparisons between different types of services or even comparisons between providers.¹² Regardless of

⁹ See generally *infra* Part II (discussing availability of multiple providers and availability of multiple procedures).

¹⁰ See *id.*

¹¹ See *id.*

¹² See *id.*

the type of availability discussed, availability of alternatives serves as a surrogate for an analysis of whether the law at issue would impact women's health.¹³

When available alternatives are not present, judges may suggest that women themselves are culpable for a perceived failure to access reproductive health services at a time when options were available. I call this the culpability tool. By using the culpability tool, judges can imply that the woman at issue let her options die out, leaving her (and the judge) in a predicament where alternatives are not present and cannot be relied upon as the protector of the woman's health.¹⁴ In these cases, which include abortion decisions and forced-cesarean section rulings, the weight of the woman's health interest -- even when discussed -- is diminished because she is seen to have voluntarily waived options previously available to her.¹⁵

Hypothetically, the culpability tool could function to protect women's health if the woman was truly making a medically unsound decision -- for example, if a pregnant woman and her fetus faced certain death during a vaginal delivery, but the woman insisted on a vaginal delivery in spite of her physician's insistence otherwise. In that case, the application of the culpability tool would protect the pregnant woman from herself as it would find her culpable for trying to get a service doctors were unwilling to provide, impose blame on her for making a decision leading to her demise and, thus, undercut any health interests she may claim. (But, in this unlikely scenario, the woman would arguably still have a strong autonomy interest with which a court would have to wrestle.)

Labor can also provide an example of an incorrect -- and commonly employed -- application of the culpability tool. A judge, asked by a physician to order a laboring woman to have a cesarean section when she refuses to willingly consent, may cite the woman's alleged failure to find an obstetrician willing to support her preferred delivery method as evidence that she is making a bad decision, thus making the lack of available delivery

¹³ It is assumed, for the purpose of this examination, that the use of the availability tool is neutral; it signifies a judge's desire to take the path of least resistance, not use as a means to an end. However, it is possible that the availability tool is not always used in a neutral fashion. *See infra* Part IVB and accompanying text (discussing the biased rhetoric in some abortion cases).

¹⁴ *See infra* Part III and accompanying text (discussing how courts use women's choice not to terminate a pregnancy as the basis for accepting state regulation of the pregnancy post-viability).

¹⁵ *See id.*

options her fault.¹⁶ This use of the culpability tool fails to consider the risks to the woman's health that a cesarean section poses (regardless of any culpability on her part) and also fails to examine whether the pregnant woman's inability to locate a provider was truly because her request was medically unsound or was innocent, stemming from issues such as limited availability of obstetrical care.

In the contraception, abortion and childbirth cases below, the development of the availability and culpability tools is described, analyzed and critiqued. Through this analysis, we will see that although the tools have the ability to vindicate women's health, most often their use results in the underestimation of women's health interests relative to competing interests, resulting in a demonstrable risk to women.¹⁷ Thus, these tools -- as typically applied -- contribute to the doctrinal shift away from the significance of women's health in reproductive rights decisions.

Part I of this paper provides an overview of the significant role reproductive rights have played in women's push for autonomy and equity. It highlights the fact that, historically, the regulation of reproductive health products and services placed significant weight on protecting women's reproductive health.

Part IIA argues that *Planned Parenthood v. Casey* created a jurisprudential environment in which the availability and culpability tools could thrive, thus contributing to the declining visibility of women's health in case law. Next, it explains how the availability tool functions in case law, showing that how the tool is applied impacts whether women's health is adequately valued. Part IIB focuses on cases in which provider availability is threatened and Part IIC examines cases in which procedure availability is threatened.

¹⁶ See *infra* Part III (discussing the culpability tool).

¹⁷ The number of reproductive rights cases is vast. For the purposes of this paper, significant post-*Casey* precedent from three types of reproductive rights cases were examined. These cases represent three phases in many women's reproductive lives: pregnancy prevention (cases involving contraception and pharmacist refusal to dispense it), pregnancy termination (cases involving abortion) and childbirth (cases involving court-ordered cesarean sections). This paper does not make empirical claims about the frequency with which the availability and culpability tools are used, but rather demonstrates that they are used in many of the most significant recent reproductive rights decisions and that they contribute to a doctrinal shift away from the significance of health in reproductive rights cases, therefore the tools necessitate scrutiny.

Part III describes the culpability tool and its search for women's role in the narrowing of their reproductive health care options. It demonstrates through case law that the culpability tool functions in a way that may unfairly assign blame to women, truncate women's health analyses and ultimately lead courts to undervalue women's health interests relative to competing interests.

Part IV discusses whether there is legitimate, ongoing use for the availability and culpability tools. From a normative perspective, Part IVA finds that the availability tool can be used in ways that adequately value women's health, but that the requisites for proper application are onerous and often not followed by courts. Part IVB questions the utility of the culpability tool and argues that in the few, hypothetical scenarios where the culpability tool adequately values women's health, significant autonomy interests arise, thus negating any analytical value the culpability tool may provide.

I. THE SIGNIFICANCE OF WOMEN'S REPRODUCTIVE HEALTH

Women's ability to safely control their reproductive capacity has been central to women's struggle for autonomy and self-determination from the beginning of the women's rights movement.¹⁸ In 1914, women's health pioneer Margaret Sanger declared that the "first step towards getting life, liberty or the pursuit of happiness for any woman is her decision whether or not she will become a mother."¹⁹ Then and now, birth control was seen as necessary for women to be able to fully participate in society.²⁰ And when a woman experienced an unplanned pregnancy, access to safe abortion was imperative.²¹

The ability to control reproduction is meaningless, however, if that control cannot be exercised safely. Early abortion law, for example,

¹⁸ See ALEXANDER SANGER, *BEYOND CHOICE: REPRODUCTIVE FREEDOM IN THE 21ST CENTURY* 71 (Public Affairs 2004); Joan Williams, *Gender Wars: Selfless Women in the Republic of Choice*, 66 N.Y.U. L. REV. 1559, 1573-74 (1991) (noting that, in the 1800s, abortion was legal, and providers advertised their services without fear).

¹⁹ See SANGER, *supra* note 18, at 33.

²⁰ See generally Judith G. Waxman, *Privacy and Reproductive Rights: Where We've Been and Where We're Going*, 68 MONT. L. REV. 299 (2007) (discussing the history of women's attempts to control their fertility from ancient Greece to present).

²¹ See SANGER, *supra* note 18, at 19-47 (tracing reproductive rights debates prior to the 18th century through today).

recognized this fact, emphasizing women's health and giving it substantial weight in judicial decisions.²² In the early- to mid-1900s, illegally performed abortions took the lives of thousands of women per year in the United States.²³ Many abortion regulations centered on concerns over the health of the pregnant woman, as sepsis was a life-threatening potential complication of abortion at that time.²⁴ The same reasoning dominated many of the early state abortion cases.²⁵

As women's ability to regulate their reproductive lives grew (both legally and illegally), so too did the recognition that women's reproductive health was central to women's ability to function as autonomous individuals.²⁶ Women became increasingly aware that reproductive autonomy

crucially affects women's health and sexual freedom, their ability to enter and end relationships, their education and job training, their ability to provide for their families and their ability to negotiate work-family conflicts in institutions organized on the basis of traditional sex-role assumptions that this society no longer believes fair to enforce, yet is unwilling institutionally to redress.²⁷

²² See *id.*

²³ See Melanie M. Lee, *Defining the Agenda: A New Struggle for African-American Women in the Fight for Reproductive Self-Determination*, 6 WASH. & LEE RACE & ETHNIC ANC. L.J. 87, 90 (2000) (asserting that the 20th century birth control movement started in response to the criminalization of birth control and abortion).

²⁴ See *Roe v. Wade*, 410 U.S. 113, 148-49 (1973) (describing the threats abortion posed to women's health prior to the advent of antibiotics). Additionally, there was an organized, financially motivated movement by the medical establishment to curtail competition for their services by restricting the practice of abortion to physicians only. See SANGER, *supra* note 18, at 25 (discussing the risk of abortion before the advent of antibiotics).

²⁵ See *Roe*, 410 U.S. at 151-52 ("The few state courts called upon to interpret their laws in the late 19th and early 20th centuries did focus on the State's interest in protecting the woman's health, rather than in preserving the embryo and fetus.").

²⁶ See Rebecca J. Cook, *Human Rights and Reproductive Self-Determination*, 44 AM. U. L. REV. 975, 1001-02 (1995) (defining reproductive health as "the ability to reproduce, to regulate their fertility and to practice and enjoy sexual relationships. It further implies that reproduction is carried to a successful outcome through infant and child survival, growth, and healthy development. It finally implies that women can go safely through pregnancy and childbirth, that fertility regulation can be achieved without health hazards and that people are safe in having sex.").

²⁷ See Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 819 (2007) (arguing

The legal recognition of the rights to access contraception and abortion fundamentally changed women's role in society, enabling women to improve their status in both the private and public sphere by allowing them to plan childbearing and thus enter the paid labor force.²⁸ Now, 98 percent of women use contraception at some point in their lives, making it one of the most widely used forms of health care.²⁹

After the law recognized the right to access birth control, legal support for abortion rights followed. *Roe* established the right to have an abortion and, in doing so, cited the significance of women's health literally dozens of times in the decision, emphasizing the health risks posed by abortion and pregnancy itself.³⁰ Now, approximately one-third of all women have an abortion at some point in their lives.³¹ Since *Roe*, the Supreme Court has resisted the prodding by some to overturn its declaration that

that control over reproduction is necessary for women's dignity and to repudiate the assumption that women's primary function is to care for others); *see also* Naomi Cahn and Anne T. Goldstein, *The Legacy of Roe: The Constitution, Reproductive Rights and Feminism*, 6 U. PENN. J. CONST. L. 695, 699 (2004) ("Indeed, the right to an abortion and the availability of contraceptives have been linked in the United States to women's increased ability to make career and marriage choices and to improve their status in the household. The right to an abortion and to use contraception have been identified with two different phenomena: first, and most obviously they impact fertility because they allow women to have fewer children in a generally reliable manner; second, they have a bargaining effect, allowing women more autonomy within marriage so they can invest in their careers.").

²⁸ *See* Martha J. Bailey, *More Power to the Pill: The Impact of Contraceptive Freedom on Women's Life Cycle Labor Supply*, 121 Q. J. ECON. 289, 289-320 (2006) (concluding through empirical analysis of employment data that contraceptive availability catapulted women into the workplace); JUDITH F. DAAR, REPRODUCTIVE TECHNOLOGIES AND THE LAW 104-17 (LexisNexis 2006) (discussing the impact of *Griswold v. Connecticut*, 381 U.S. 385 (1965), legalizing contraception for individuals, and *Eisenstadt v. Baird*, 405 U.S. 438 (1972), legalizing contraceptives for married couples). *But see generally* GARY S. BECKER, A TREATISE ON THE FAMILY (Harvard University Press 1981) (asserting that birth control was merely part of the reason why fertility rates declined in the United States and that other, non-specified demands contributed to the reduction).

²⁹ *See* National Abortion Rights Action League, *Birth Control*, http://nara.org/issues/birth_control (last visited Feb. 9, 2009).

³⁰ *See* *Roe v. Wade*, 410 U.S. 113, 153 (1973) (saying, regarding pregnancy, "Specific and direct harm medically diagnosable even in early pregnancy may be involved. Maternity, or additional offspring, may force upon the woman a distressful life and future. Psychological harm may be imminent.").

³¹ *See* Guttmacher Institute, *In Brief: Facts on Induced Abortion in the United States* (July 2008), available at http://www.guttmacher.org/pubs/fb_induced_abortion.html (explaining that 50 percent of women having abortions are younger than 25 and 60 percent of all abortions are sought by woman who have one or more children).

women have a right to choose an abortion, acknowledging in *Casey* that “the ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.”³² But *Casey*’s impact, as we will see, has been far from uniformly positive.

Whether there exists a *general* constitutional right to make autonomous health decisions -- reproductive or otherwise -- is an issue that remains unsettled by the Supreme Court and is beyond the scope of this paper.³³ For the purposes of the availability and culpability tools, the resolution of this question is arguably unnecessary: as cases show, these tools can be used when analyzing health as a separate, constitutional interest, when conducting an “undue burden” analysis that conflates the issues of health and access or even when health must be weighed against other interests.

Despite the significant protections afforded by reproductive rights jurisprudence and advances in reproductive health technology, the health care system still fails to meet the reproductive health needs of all women, especially women who are poor.³⁴ Pregnant women in the United States still face significant maternal morbidity and mortality.³⁵ Contraceptives, when accessible, still pose significant health risks³⁶ and development of new

³² See *Planned Parenthood v. Casey*, 505 U.S. 833, 856 (1992); see also, BOSTON WOMEN’S HEALTH COLLECTIVE, *OUR BODIES OURSELVES: A NEW EDITION FOR A NEW ERA* 322 (Touchstone 2005) (saying that “Birth Control is fundamental to our ability to have autonomy in our lives” and noting that advances in women’s reproductive health historically have been followed by a conservative backlash).

³³ See generally Hill, *supra* note 6 (arguing that a general right to make autonomous medical decisions is found in Supreme Court jurisprudence).

³⁴ See generally Pamela D. Bridgewater, *Reconstructing Rationality: Towards a Critical Economic Theory of Reproduction*, 56 EMORY L.J. 1215 (2007) (theorizing whether a regulated market for health services might improve women’s lives); OUR BODIES OURSELVES, *supra* note 32 (providing an exhaustive overview of the U.S. health care system and how women are disproportionately impacted by its shortcomings).

³⁵ See DAAR, *supra* note 28, at 993-94 (discussing maternal mortality worldwide).

³⁶ See David Voreacos and Patricia Hurtado, *J&J Pays \$1.25 Million to Settle Suit Over Death of 14-Year-Old*, BLOOMBERG.COM (Oct. 24, 2008), <http://www.bloomberg.com/apps/news?pid=newsarchive&sid=aTTqmPEzxr9U> (discussing suits by 2,400 users claiming they developed blood clots in their legs or lungs after using the contraceptive patch); KATHERINE BARTLETT & DEBORAH RHODE, *GENDER & THE LAW: THEORY, DOCTRINE, COMMENTARY* 855-56 (Aspen 2006) (discussing the history of tort litigation surrounding the risks of various birth control technologies, emphasizing problems with Dalkon Shield intrauterine devices); OUR BODIES OURSELVES, *supra* note 32, at 326-80 (arguing that birth control is often approved by the Food and Drug Administration

contraception is slow.³⁷ Continued efforts by some groups to limit the availability of abortion threaten women's ability to plan childbearing and thus impacts women's ability to, among many opportunities, participate in the paid labor force.³⁸ Inadequate access to reproductive health services continues to result in tangible loss of liberty for women, whose inability to control their reproductive capacity prevents them from participating fully in the labor market -- a loss to society as a whole.³⁹ It is in this context that courts must decide whether contraception, abortion and childbirth-related regulations pose a risk to women's health and, additionally, what that risk might mean to women's autonomy and bodily integrity.

Women's bodies "are at once and the same time sources of oppression and among women's primary arenas of empowerment."⁴⁰ It is difficult to decouple women's health from the polarizing moral and political controversies surrounding their potential reproductive role – controversies that any person, judge or not, may understandably want to avoid. As the cases below will demonstrate, the availability and culpability tools, when used, can help a judge avoid those controversies and attendant discussions of women's health. What must then be determined is whether such avoidance results in the undervaluing of women's health.

before its long-term health effects are understood and detailing the health risks of every major contraceptive technology).

³⁷ See Dawn MacKeen, *Brave New World?*, SALON (Aug. 11, 1999), <http://dir.salon.com/health/feature/1999/08/11/contraceptives/index.html> (quoting one contraception researcher as saying that the U.S. is in the "backwaters" of contraception development).

³⁸ See Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 360-61 (1992) (discussing a poll of Louisiana state officials showing that 79 percent opposed abortion when the rationale for the decision was concern over the effect of childbirth on a woman's career).

³⁹ See *Planned Parenthood v. Casey*, 505 U.S. 833, 852 (1992) ("That is because the liberty of the woman is at stake in a sense unique to the human condition and so unique to the law. The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society."); see also Cook, *supra* note 26, at 984 (noting that, although women enjoy greater sex equity at present, their participation in society outside the home continues to be balanced against their reproductive capacity and reproductive role as mother).

⁴⁰ See LIBBY S. ADLER ET AL., *MARY JOE FRUG'S WOMEN AND THE LAW* 55-56 (4th ed. 2008).

II. AVAILABILITY

Availability is cited in myriad reproductive rights cases, in varying manners and to varying degrees.⁴¹ For example, in pharmacist refusal controversies, in which pharmacists refuse to fill contraception prescriptions for religious reasons, the large number of competing providers may be cited to show that the refusal of any one provider to dispense birth control will not impact women's health.⁴² But a large number of competing providers or procedures is not required to use the availability tool: in areas of limited availability, such as abortion, reliance on the availability tool is still readily identifiable.⁴³ In each area of reproductive health jurisprudence, the manner in which the availability tool is employed may differ, but the result is typically the same: the discussion of women's health is truncated, based on an unstated assumption that the availability of women's health services will protect women from any significant adverse impact from the controversy in question.⁴⁴ Although they do exist, cases in which the availability tool appropriately values women's health and rejects laws that negatively impact it are few and far between.

Part II describes the origins of the availability tool and how its application is impacting reproductive health jurisprudence. Section A discusses *Planned Parenthood v. Casey*⁴⁵ and how both its rhetoric and its adoption of the "undue burden" standard invited increased reliance on the presence of availability in reproductive rights analysis.⁴⁶ Sections B and C analyze judicial use of the availability tool -- specifically, how judges use reference to theoretically available alternative providers and procedures as a reassurance that women's health will not be adversely impacted by legal restrictions on reproductive rights. Part II concludes by uniting all

⁴¹ The factors that impact abortion availability, for example, are not well understood. See, e.g., Deborah Haas-Wilson & Kristen Lindberg, *Regulation and the Optimal Size and Type of Abortion Provider*, 31 APP. ECON. 409, 415 (1999) (stating that little empirical analysis has been done on what factors influence the availability of abortion providers).

⁴² See *infra* Part IIB and accompanying text.

⁴³ See *id.*

⁴⁴ For an example showing how availability may not protect women's health, see Jennifer 8. Lee & Cara Buckley, *For Privacy's Sake, Taking Risks to End Pregnancy*, N.Y. TIMES, JAN. 5, 2009, at A15 (discussing the fact that although legal abortion is available, many women in particular communities resort to illegal techniques for terminating pregnancies because of lack of money to pay for legal termination, problems with clinic protestors and other social reasons).

⁴⁵ 505 U.S. 833 (1992).

⁴⁶ See *infra* Part IIA and accompanying text.

availability tactics to discuss their collective import in reproductive rights jurisprudence.

A. Availability Facilitated: Planned Parenthood v. Casey

Casey's impact on reproductive rights jurisprudence is irrefutable.⁴⁷ While deciding the fate of a panoply of abortion restrictions,⁴⁸ *Casey* simultaneously affirmed *Roe v. Wade*'s protection of a woman's right to have an abortion, rejected *Roe*'s trimester framework for judging the constitutionality of abortion restrictions⁴⁹ and adopted a new "undue burden" standard for adjudicating reproductive rights disputes – quite a feat of jurisprudential gymnastics.⁵⁰ *Casey*'s impact reverberates today: among other consequences, by explicitly linking women's reproductive health to the economy and introducing the "undue burden" standard, *Casey* empowered judicial use of the availability and culpability tools in reproductive rights jurisprudence.

At issue in *Casey* was the constitutionality of numerous Pennsylvania state restrictions on abortion, including "informed consent,"⁵¹ "spousal notification"⁵² and "parental consent"⁵³ regulations, a mandatory waiting period prior to receiving abortion services⁵⁴ and strict regulation of

⁴⁷ For a thorough discussion of the impact of *Casey* on subsequent reproductive rights cases, see generally, Linda J. Wharton et al., *Preserving the Core of Roe: Reflections on Planned Parenthood v. Casey*, 18 YALE J. L. & FEM. 317 (2006) (arguing that *Casey* has the ability to meaningfully protect reproductive rights if applied correctly by courts).

⁴⁸ See *Casey*, 505 U.S. at 844 (describing the provisions of the Pennsylvania Abortion Control Act).

⁴⁹ See *id.* at 872-73 (describing the trimester framework as "rigid" and "unnecessary" to protect both the woman's interest in having an abortion and the state's interests).

⁵⁰ See *id.* at 874 ("Only where state regulation imposes an undue burden on a woman's ability to make this decision does the power of the State reach into the heart of the liberty protected by the Due Process clause.").

⁵¹ See *id.* at 881-83 (explaining that "informed consent" requires that a woman be provided with state-authored materials on the health risks of abortion and birth, the probable gestational age of the fetus and various information on adoption, child support and public support services for pregnant women and holding that the law was a constitutionally permissible expression of the state's preference against abortion).

⁵² See *id.* at 887-98 (finding that the spousal notification requirement posed a substantial obstacle for women facing domestic violence, thus holding that it violated the undue burden test).

⁵³ See *id.* at 899-900 (upholding the parental consent requirement and noting that such requirements had been upheld in several prior U.S. Supreme Court cases).

⁵⁴ See *id.* at 886 (describing the 24-hour "waiting period" as potentially increasing women's exposure to anti-abortion protester harassment and being particularly burdensome

facilities where abortions were provided.⁵⁵ More significantly, *Casey* presented the Court with the opportunity to overturn *Roe*.⁵⁶

In 1973, *Roe* upheld a woman's constitutional right to have an abortion and outlined the trimester framework for judging whether an abortion regulation was constitutional.⁵⁷ In the first trimester of a woman's pregnancy, the decision whether to terminate a pregnancy was controlled by the pregnant woman; during the second trimester, the state could regulate abortion solely for the purpose of protecting maternal health; and post-viability, abortion could be outlawed as long as there was an exception for the life or health of the pregnant woman.⁵⁸ *Roe* centered on the premise that the health of the pregnant woman was of paramount concern, whether the risks at issue related to the abortion or to health concerns stemming from the pregnancy itself.⁵⁹

Although *Casey* preserved *Roe*'s primary holding protecting a woman's constitutional right to have an abortion,⁶⁰ it adopted a standard that permitted more state regulation of abortion: the "undue burden" standard, which simply asks whether a regulation has "the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion."⁶¹ The *Casey* Court upheld all of the regulations at issue in the

for women who live in rural areas and poor women, but finding that these burdens were not substantial).

⁵⁵ *See id.* at 900 (upholding various recordkeeping and reporting requirements, but finding those related to spousal notice unconstitutional for the reasons set forth in *Casey*'s spousal notification analysis).

⁵⁶ The court's reconsideration of *Roe v. Wade* begins with the oft-quoted passage: "Liberty finds no refuge in a jurisprudence of doubt. Yet 19 years after our holding that the Constitution protects a woman's right to terminate her pregnancy ... that definition of liberty is still questioned." *Casey*, 505 U.S. at 844. For a history of abortion jurisprudence leading up to *Roe* and the current state of the law, see Caitlin E. Borgmann, *Winter Count: Taking Stock of Abortion Rights After Casey and Carhart*, 31 *FORDHAM URB. L. J.* 675 (2004) (describing the impact of President George H.W. Bush's Supreme Court appointments on abortion jurisprudence).

⁵⁷ *Roe*, 410 U.S. at 113 (establishing the framework by which state regulation of abortion was judged until the *Casey* decision).

⁵⁸ *See id.*

⁵⁹ *See id.*; see also CELESTE MICHELLE CONDIT, *DECODING ABORTION RHETORIC: COMMUNICATING SOCIAL CHANGE* 99-100 (University of Ill. Press 1990) (quoting Sara Weddington as asserting that pregnancy "is one of the most determinative events of [a woman's] life" disrupting her body, education, employment and family).

⁶⁰ *See Casey*, 505 U.S. at 845-46 (reaffirming *Roe*'s central holding protecting access to abortion).

⁶¹ *See id.* at 872-73 (describing the trimester framework as "rigid" and "unnecessary" to protect both the woman's interest in having an abortion and the state's interests).

case save for the spousal notification requirement (and its related recordkeeping requirements).⁶²

Casey facilitates use of the availability tool in two ways. First, it links access to abortion with women's ability to participate in the public sphere of the nation, thus solidifying the link between women's health, reproductive rights and the economy. Second, *Casey* conflates what were once two separate analyses -- access to services and women's health -- and in doing so, allows health concerns to be mitigated by the continued availability of alternative reproductive health services. Thus, *Casey* enables the use of the availability tool and, consequently, the decreased visibility of women's health in reproductive rights jurisprudence.

First, *Casey* directly ties the availability of specific reproductive health services to women's ability to fully participate in society. *Casey* says:

[F]or two decades of economic and social developments, people have organized intimate relationships and made choices that define their view of themselves and their places in society in reliance on the *availability* of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.⁶³

This link is significant, as it signals to future courts that availability (and, arguably, the availability of multiple providers or services) is important in any reproductive rights analysis insofar as availability may protect women's health and autonomy.

Second, in lieu of *Roe*'s separate analyses of burdens on access and burdens on health, *Casey* treats these two issues singularly and equivalently, allowing availability to assuage health concerns. The "undue burden" standard collapsed *Roe*'s trimester framework, weakened the standard of analysis and arguably subsumed the separate health analysis formerly

⁶² *See id.* at 901 (holding that the spousal notification provision and reporting provision constituted "undue burdens").

⁶³ *See id.* at 856 (emphasis added).

demanded by *Roe*.⁶⁴ Under “undue burden,” the total burden on women is simply judged to be substantial or not.⁶⁵ Arguably, burdens on women’s health are acceptable up until the point that they substantially burden women’s ability to access abortion.⁶⁶ Although when read generously, *Casey* may be understood to require a health exception in limited circumstances,⁶⁷ whether *Casey* mandated such exceptions is unclear.⁶⁸ Recent decisions suggest that, if the burden on a woman’s health does not rise to the level of being “undue,” a health exception may not be necessary.⁶⁹

The “undue burden” standard presents the perfect backdrop for use of the availability tool: health issues are considered side-by-side with issues of abortion access, so health concerns can be assuaged by the presence of competition, ensuring that no health burden rises to the level of being “substantial” or “undue.”⁷⁰ As will be seen in the cases discussed, if judges use the availability tool, the continued existence of the reproductive health provider or service at issue (or a suitable substitute) can be used to undercut an argument that an abortion regulation burdens women’s health -- or, on rare occasions, to prove that the lack of protective competition compels a law’s downfall.⁷¹

⁶⁴ See Gillian E. Metzger, *Unburdening the Undue Burden Standard: Orienting Casey in Constitutional Jurisprudence*, 94 COLUM. U. L. REV. 2025, 2033 (1994) (noting that what constitutes an “undue burden” is inherently subjective as the determination rests on the threshold set by a particular court for what is “undue”).

⁶⁵ See *id.* (noting the fact that the “undue burden” standard doesn’t weigh countervailing interests supports the argument that it is something less than intermediate scrutiny, which does require such weighing).

⁶⁶ See Borgmann, *supra* note 56, at 682-85 (noting that *Casey* suggests that only those restrictions that are functionally equivalent to an outright ban on abortion will be held to be “substantial obstacles”).

⁶⁷ See *Casey*, 505 U.S. at 879 (these exceptions are commonly called the “health exception” and the “life exception”).

⁶⁸ See Borgmann, *supra* note 56, at 699-700 (suggesting that *Casey* “subsumed” the medical exception within the “undue burden” test, rather than requiring two separate analyses). *Stenberg* suggested that separate analysis were required in some cases. *Id.* at 706. However, as we will see in later cases, courts continue to conflate the health and “undue burden” analysis and do so with the aid of the availability tool. See *infra* Parts IIB-C and accompanying text.

⁶⁹ See *id.*

⁷⁰ See SANGER, *supra* note 18, at 55 (asserting that Justice O’Connor’s opinion in *Casey* removed abortion from the medical realm and shifted the focus of abortion jurisprudence to a “quasi-feminist” vision of autonomy, which allowed for greater political influence over women’s childbearing decisions).

⁷¹ See generally *infra* Parts IIB-C and accompanying text.

Casey's impact is not limited to cases in which the "undue burden" standard applies. Its juxtaposition of health and availability provided a roadmap for the use of the availability tool in non-abortion cases as well. In cases demanding the weighing of women's health interests against competing interests, courts use the perceived availability of reproductive health services to recast women's health as an a non-constitutional "convenience" interest, a tactic analogous to the sublimation of women's health in *Casey*'s undue burden analysis.

To understand how the availability tool functions in reproductive rights cases, one must examine individual cases. Reference to availability appears in numerous forms. Case law demonstrates that the presence of competing reproductive health *providers* and *procedures* are cited as counteracting the potential risks restrictive laws or regulations pose to women's health.

B. The Availability of Alternative Providers

When a law impacts the number of reproductive health service providers, the availability tool can be used to determine whether that law burdens women's health. For example, in a hypothetical case where the judge is analyzing "law B" that bans midwives from performing abortions, a judge perfunctorily applying the availability tool might cite the continuing availability of competing *providers*, such as physicians, to show that "law B's" ban on midwife providers won't have a deleterious impact on women's health. Or, the judge might take the analysis further, saying that such a ban would harm certain women, namely rural women served primarily by midwives. The extent to which alternative providers are available and can be relied on to protect women's health is a central issue in the contraception and abortion-related cases applying the availability tool. These cases show that accurate identification of available alternative providers determines whether the availability tool functions to undercut women's health or to protect it.

1. Contraception

Generally speaking, contraception is a reproductive health product that enjoys robust availability both in terms of providers willing to dispense

it and the range of available contraceptive products.⁷² The proliferation of contraceptive products likely reflects widespread support for this particular reproductive health technology.⁷³ Support for contraceptive access is not universal, however. This is particularly the case when it comes to Plan B, a post-intercourse contraceptive taken either when pre-intercourse contraception is not used or when it fails.⁷⁴

By one account, Plan B is responsible for almost half of the decline in the number of abortions between 1994 and 2000.⁷⁵

According to the U.S. Food and Drug Administration, Plan B “works like other birth control pills:” it can stop ovulation; prevent fertilization; or prevent a fertilized egg from implanting in the uterine wall, but Plan B will not terminate an already established pregnancy.⁷⁶ Given that

⁷² The U.S. hormonal contraceptives market, including oral contraceptives and hormonal IUDs, is valued at \$2.5 billion annually. See Aude Lagorce, *Schering AG Storms Birth Control Market*, FORBES.COM (July 11, 2003) (discussing the various corporate players in the birth control market), http://www.forbes.com/2003/07/11/cx_ad_0710shr.html. U.S. condom sales are expected to top \$444 million annually by 2010. See Calie LaFevre, *Spray-On Condoms: Still a Hard Sell*, TIME (Aug. 13, 2008), available at <http://www.time.com/time/business/article/0,8599,1832445,00.html>.

⁷³ See Harris Interactive, *Large Majorities Support More Access to Birth Control Information, and Agree that it is a Good Way to Prevent Abortions*, (June 22, 2006), <http://www.harrisinteractive.com/NEWS/allnewsbydate.asp?NewsID=1064> (finding 73 percent of poll respondents think contraception access should not be limited by a person’s ability to pay for it, and 89 percent think more information on contraception should be available to adults).

⁷⁴ See *id.* (finding that only 58 percent of respondents think Plan B should be “widely available,” but also finding that 62 percent think pharmacists should not be allowed to refuse to dispense it). For general information on Plan B, see *What is plan B?*, <http://www.go2planB.com> (describing how the drug works). Contraceptive-related controversies have not been confined to only to Plan B, however. Traditional oral contraceptives have also been the product of pharmacist refusal. See CRISTINA PAGE, *HOW THE PRO-CHOICE MOVEMENT SAVED AMERICA: FREEDOM, POLITICS AND THE WAR ON SEX 1-2* (Basic Books 2006) (retelling the stories of several women who were refused Plan B or oral contraceptives at pharmacies across the country).

⁷⁵ See Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000-2001*, 34 PERS. ON SEXUAL & REPRO. HEALTH 226 (2002) available at <http://www.guttmacher.org/pubs/journals/3429402.html> (discussing the decline between 1992 and 2000).

⁷⁶ See Food & Drug Administration, *FDA’s Decisions Regarding Plan B: Questions and Answers*, <http://www.fda.gov/CDER/DRUG/infopage/planB/planBQandA.htm> (last visited Feb. 9, 2009).

Plan B functions by interrupting a biological sequence of events, it is crucial to Plan B's efficacy that it be taken as soon as possible after intercourse.⁷⁷

The fact that Plan B is taken after intercourse leads some pharmacists to believe that it functions as an abortifacient, rather than a contraceptive: for this reason, some pharmacists refuse to fill prescriptions for Plan B, saying that it violates their religious beliefs.⁷⁸ Many women, on the other hand, claim that such refusal jeopardizes their ability to use the drug in a timely manner, thus diminishing their chance to prevent an unplanned pregnancy.⁷⁹ "Pharmacist refusal" has sparked heated reactions on both sides, prompting several states to enact legislation to address the issue, some states protecting pharmacists' right to refuse and others limiting it.⁸⁰ Most case law surrounding pharmacist refusal focuses on the interplay between the state's interests (or the pharmacy employer's) in balancing religious freedom and the health needs of customers and the religious practice rights of the pharmacist. Despite the fact that pharmacist refusal has the potential to impact women's health, pharmacist refusal cases typically focus on the religious rights of the pharmacist.⁸¹

⁷⁷ See PAGE, *supra* note 74, at 99-100 (noting that the chance of pregnancy if taken within 24 hours of intercourse is 0.4 percent. The likelihood increases to 2.7 percent if taken between 24 and 72 hours.).

⁷⁸ One group of pharmacists who oppose abortion and describe Plan B as an abortifacient is Pharmacists for Life International. See generally Pharmacists for Life International, <http://www.pfli.org/main.php?pfli=planbfaq> (outlining various policy positions and examples of pro-life pharmacist actions) (last visited Feb. 9, 2009); see also Rob Stein, *New Rule Protects Health Care Workers' Right of Conscience*, WASH. POST, Dec. 19, 2008, at A10 (asserting that religious-based refusal to provide various health care services is on the increase); Rob Stein, *'Pro-Life' Drugstores Market Beliefs*, WASH. POST, June 16, 2008, at A1 (discussing the opening of pro-life drug stores, which do not stock contraceptives).

⁷⁹ For more information, see National Women's Law Center, *The Pharmacy Refusal Project*, <http://www.nwlc.org/details.cfm?id=2185§ion=health> (detailing the pharmacist refusal issue and providing instructions to women who have been refused).

⁸⁰ See *id.* (describing the varying pharmacist refusal laws by state) (last visited Feb. 9, 2009).

⁸¹ Typically, cases surrounding pharmacist refusal focus on the religious freedom rights of the refusing pharmacists rather than on the health interests of the women refused. See generally *Menges v. Blagojevich*, 451 F. Supp. 2d 992 (C.D. Ill. 2006) (examining whether an Illinois law regulating pharmacist refusal violated pharmacists' rights by forcing them to dispense Plan B. In fact, refusal was permitted when another pharmacist was available to fill the prescription). However, women's health is dealt with specifically in some administrative matters before state pharmacy boards. See generally *In the Matter of Disciplinary Proceedings Against Neil T. Noesen*, No. LS0310091PHM (Wisconsin Pharmacy Examining Board Feb. 2005) available at <http://www.naralwi.org/assets/files/noesendecision&finalorder.pdf> (recommending discipline of a pharmacist who refused to fill or to transfer oral contraceptives, and noting

The significance of access to Plan B to women's health was squarely before a court, however, in one recent case. *Storemans Inc. v. Selecky* was brought by pharmacists seeking the right to refuse to fill contraception in contravention of a Washington state law restricting pharmacist refusal.⁸² A group of woman intervened, placing women's health squarely before the court and setting up a potential legal confrontation between women's health interests and the religious freedom of pharmacists. But this confrontation never materialized: ultimately, the availability tool -- specifically, reference to competing providers -- was used at both the trial and appellate levels, resulting in a truncated (and arguably eliminated) analysis of how women's health is impacted by pharmacist refusal.⁸³

Although the state of Washington sought to restrict pharmacist refusal in the interest of "promoting [women's] health by ensuring access to Plan B,"⁸⁴ the *Storemans* courts used the availability tool to successfully recast this health interest as an interest in "convenience" -- saying the women's interest "had more to do with convenience and heartfelt feelings than with actual access to certain medications."⁸⁵ This recasting was

"Women still die during childbirth. Every pregnancy has the potential for morbidity or mortality."). It is worth noting that Noesen refused to transfer contraceptive prescriptions to competing pharmacies, rendering the availability of alternative providers meaningless to the women Noesen served. *See id.* at 19. Geographically specific information on the efficacy of available alternatives as a protector of women's health, in combination with state codes of conduct prohibiting pharmacist actions that constitute a danger to a patient's health, may make state pharmacy boards more effective at protecting women's health than federal courts.

⁸² 526 F.3d 406 (9th Cir. 2008) (refusing to stay a district court injunction halting enforcement of regulations making it unlawful for a pharmacy to permit pharmacists to refuse to fill a prescription on moral or religious grounds).

⁸³ Five women intervened: one woman faced a hostile pharmacist at a pharmacy that did not carry Plan B, was generally referred to another store, but given no directions to it and had to cut a trip short to return home to a known pharmacy; one woman was refused by a pharmacist, but another pharmacist at the same pharmacy provided the Plan B; one woman used Plan B twice -- once after a sexual assault -- and both times got it from Planned Parenthood because she had heard stories of refusals elsewhere; one woman did not use Plan B, but found two out of five local pharmacies unwilling to provide it; and one woman participated in the suit because she agreed with its goals. *See Storemans v. Selecky*, 524 F. Supp. 2d at 1254-55 (describing the standing of each woman); *see also Storemans*, 526 F.3d at 409 (discussing the "most serious" intervenor cases as those in which there was a pharmacist refusal, but noting that both women were able to get Plan B ultimately).

⁸⁴ *See Storemans*, 524 F. Supp. 2d at 1263 (asserting a secondary interest as "preventing sex discrimination").

⁸⁵ *See id.* To the contrary, the appellate dissent sets up a direct confrontation between women's health and the religious interests of pharmacists who don't want to dispense contraceptives, specifically characterizing the potential delay in receiving Plan B as a

accomplished via use of the availability tool. By emphasizing what it saw as the availability of numerous Plan B providers for both the individual intervening women and for all women, the court negated any health concerns posed by the intervening women, who had previously been refused Plan B.

On an individual level, according to the courts, the intervening women failed to demonstrate a health burden because those women who attempted to get the drug successfully accessed pharmacists willing to dispense Plan B.⁸⁶ Presumably, the women neither became pregnant because of the delay in receiving contraception nor did they suffer other health effects. Therefore, via the availability tool, each court implied that these individual women's health was not implicated in the present controversy and the presence of multiple providers would protect them from a health issue in the future.⁸⁷ Thus, the availability tool effectively negated any health concerns the court may have addressed.

The availability tool was also used in *Storemans* to negate potential women's health issues on a broader, more systemic level. Both the trial and appellate court used statistics on pharmacy availability ostensibly to demonstrate that no woman in the state of Washington faced a health risk from pharmacist refusal: the sheer number of pharmacies that stocked Plan B prevented the health risks from pharmacist refusal from coming to fruition.⁸⁸ According to the court, a survey showed that out of 121

health risk: "unwanted pregnancies and all that accompanies it." *Storemans*, 526 F.3d at 410-17 (Tashima, J., dissenting in part) (focusing not on the ultimate ability of the individual women to successfully get Plan B, but instead on the delay and concomitant health risks that each woman faced).

⁸⁶ "There is no evidence that any woman who sought Plan B was unable to obtain it." *Storemans*, 526 F.3d at 409. The district court noted that, at trial, it wanted the parties to address whether there were patients who "failed to access Plan B" due to the conduct of pharmacists who refused to dispense for moral or religious reasons. *Storemans*, 524 F. Supp. 2d at 1260-67.

⁸⁷ Neither court considered that the ability to access Plan B in the past does not guarantee the ability to access in the future, nor does a harm-free delay in getting Plan B in the past guarantee harm-free delay in the future. For a further discussion of the potential errors in use of the availability tool in *Storemans*, see *infra* Part IV and accompanying text.

⁸⁸ *Storemans*, 524 F. Supp. 2d at 1260 ("[A]s to Plan B, there has been no evidence presented to the Court that access is a problem. It is available at all but a few licensed pharmacies in Washington state and can be accessed through physicians' offices, certain government health centers, hospital emergency rooms, Planned Parenthood and the internet."). Interestingly, although the court cites the internet as one source for Plan B, the Food and Drug Administration warns against purchasing such drugs from the internet. See FDA News, *FDA Finds Consumers Continue to Buy Potentially Risky Drugs Over the Internet*,

pharmacies, 93 typically stocked emergency contraceptives while 28 did not.⁸⁹ These statistics were cited to support the notion that the presence of pharmacies that stocked Plan B and the absence of any evidence that women failed to get Plan B proved that there was no women's health issue. Citing the presence of competing pharmacies directly replaced any direct discussion of how pharmacist refusal to dispense Plan B impacts women's health.

According to *Storemans*, women's health was not in question: the women's stake, according to the district court, was simply that they "understandably may not want to drive farther than the closest pharmacy" to get Plan B.⁹⁰ During this recasting of women's health as a "convenience" interest, the court neglected any meaningful analysis of whether the delay inherent in being refused medication and having to locate another, willing provider increased women's chance of pregnancy.⁹¹ By casting women's interest as "convenience" instead of health, the court not only failed to conduct a proper health analysis, it effectively made the weighing of women's interests against the compelling religious interest of pharmacists a superfluous exercise.⁹² It also placed women in a classic double bind: in order to have a cause of action, they must have "failed" to access Plan B, but given that access is a matter of "convenience," certainly if they had failed to access Plan B, they would have been culpable for their own failure to find a provider.⁹³

Perhaps more significant than its individual outcome, *Storemans* presents significant concerns over the courts' use of the availability tool and specifically, whether the tool really demonstrated that available alternative Plan B providers truly protected women's health. In *Storemans*, the statistics cited were admittedly incomplete and simply indicated which

<http://www.fda.gov/bbs/topics/NEWS/2007/NEW01663.html> (last visited Feb. 9, 2009).

⁸⁹ Of the pharmacies that did not stock Plan B, eighteen cited low demand, three relied on an "easy alternative source," and two cited religious or personal reasons. *Storemans*, 524 F. Supp. 2d at 1260; 526 F.3d at 408-09.

⁹⁰ See *Storemans*, 524 F. Supp. 2d at 1263.

⁹¹ Compare *Storemans*, 526 F.3d at 406 (citing with approval the district court discussion of Plan B's "72-hour window of effectiveness" but failing to analyze the drug's declining efficacy after 24 hours) *with id.* at 416-17 (Tashima, J., dissenting) (describing the potential for unwanted pregnancies due to Plan B delay).

⁹² See *id.*

⁹³ See *Storemans*, 524 F. Supp. 2d at 1266-67 (asking parties to provide information on "patients who have failed" to get Plan B, thus implying culpability on the women's part); MARTHA CHAMALLES, INTRODUCTION TO FEMINIST LEGAL THEORY 8-10 (Aspen 2d 2003) (discussing the importance of identifying double binds in which women have no good options in feminist theory inquiries); see also *infra* Part III (discussing the culpability tool).

pharmacies *stocked* Plan B, not whether individual pharmacists at those pharmacies were willing to *dispense* it. This is a crucial distinction: one of the plaintiff pharmacists, for example, was fired for refusing to dispense Plan B at a pharmacy because he was the sole pharmacist and the pharmacy could not afford to hire a second to work as a back-up.⁹⁴ This fact scenario shows that although a pharmacy stocks Plan B it may not necessarily have a pharmacist willing to dispense it. Therefore, although the availability tool was used, the availability cited -- pharmacies stocking Plan B -- did not show that women's health in the State of Washington was protected.⁹⁵

2. Abortion

The availability tool and, more specifically, reference to multiple providers is not unique to pharmacist refusal: the tool is also used in abortion cases where provider availability is threatened. In these cases, the availability of alternative providers is cited to signal that a regulation is not an undue burden on a woman's ability to access abortion services, and, by implication, is not a burden on women's health.⁹⁶

The availability tool is not used in all abortion-related cases: the tool is not apparent in controversies over conditions on accessing the right to have an abortion (*e.g.* waiting periods or parental notification requirements). However, when a law threatens to decrease the number of providers, the availability tool is evident.⁹⁷ In these cases, the exit of a

⁹⁴ See *Storemans*, 524 F. Supp. 2d at 1253-54 (noting that the pharmacy could not afford to hire a second pharmacist who wouldn't refuse to work with the plaintiff, thereby implying that the refusing pharmacist had been working -- and presumably refusing to provide Plan B -- by himself at this pharmacy).

⁹⁵ See *infra* Part IV (discussing the various concerns raised by the availability tool).

⁹⁶ In 2005, 87 percent of U.S. counties did not have an abortion provider. See Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSP. ON SEXUAL & REPRO. HEALTH 6 (2008). Sixty-nine percent of counties in metropolitan areas lack providers, and this number is increasing. See *id.* at 14. The number of providers for later gestation abortion appears to be declining. See *id.* One group of economists has argued that the presence of competing abortion providers allows women to "shop among providers for a price and quality combination that meets their preferences." Bonnie J. Kay et al., *An Economic Interpretation of the Distribution and Organization of Abortion Services*, 18 INQUIRY 322, 324 (1981).

⁹⁷ See, *e.g.*, *Women's Medical Professional Corp. v. Baird*, 438 F.3d 595, 604-05 (6th Cir. 2006) (holding that an abortion facility's likely closure due to an inability to fulfill a requirement that abortion facilities have a transfer agreement with a local hospital did not constitute an undue burden because women could travel to other abortion providers in the region); *Greenville Women's Health Clinic v. Bryant*, 222 F.3d 157, 170 (4th Cir. 2000)

provider from the market is, according to abortion rights advocates, an undue burden on women, who would have to travel greater distances to obtain abortion services and overcome the resulting increased costs, delay and attendant health risks.⁹⁸ Courts have held, however, that such travel is not an undue burden on women, and that the existence of multiple abortion providers protects women's right to access abortion.⁹⁹ Access to competing providers impliedly guarantees not only the right to have an abortion but women's health itself.

The significance of the availability tool in abortion provider cases is apparent, for example, in *Greenville Women's Clinic v. Bryant*, where both the district and appellate courts grappled with whether the presence of multiple providers impacted the constitutionality of abortion restrictions and came to decidedly different results.¹⁰⁰ The regulations at issue in *Greenville Women's Clinic* were extensive, mandating detailed recordkeeping by abortion providers, regulating facility construction and imposing onerous building requirements.¹⁰¹ Implementing these types of regulations costs abortion providers money, which in turn can lead to increased costs (and concomitant delay while raising the funds) for patients and, as was the case

(holding that administrative regulations that may force one abortion provider to close would not pose an undue burden because women could travel seventy miles to an alternative provider). *But see* *Mazurek v. Armstrong*, 520 U.S. 968, 974 (1997) (explaining in dicta that, even after upholding an abortion-related regulation, women would not be "required to travel to a different facility than was previously available" and therefore implying that a regulation forcing travel may constitute a burden of some unspecified degree).

⁹⁸ For an excellent example of these arguments and how they were received by one court, see *Greenville Women's Clinic v. Bryant*, 66 F. Supp. 2d 691 (D.S.C. 1999) (holding that increased cost, delay or distance to an abortion provider each constitute an "undue burden"), *rev'd* 222 F.3d 157 (4th Cir. 2000).

⁹⁹ See *Women's Medical Professional Corp.*, 438 F.3d at 604-05 (citing the Fourth and Eighth Circuits for the proposition that increased travel is not an "undue burden" but acknowledging Supreme Court dicta that could be read to suggest otherwise).

¹⁰⁰ See 222 F.3d 157 (4th Cir. 2000) (restricting the applicability of the regulations to facilities where five or more first trimester abortions were performed per month).

¹⁰¹ See *id.* at 160-62 (describing a 10-part regulatory scheme). These regulations are typically described as TRAP laws, or targeted regulations of abortion providers, by abortion rights organizations. See Center for Reproductive Rights, *Targeted Regulation of Abortion Providers (TRAP): Avoiding the TRAP*, http://www.reproductiverights.org/pub_fac_trap.html (detailing TRAP regulations state-by-state).

in *Greenville Women's Clinic*, can even cause providers to close their doors.¹⁰²

Although the district and appellate courts came to opposite decisions on whether regulations posed an undue burden for women, both used the availability tool to arrive at their result. In an unusual application of the availability tool, the district court marshaled a perceived lack of competing abortion providers in a specific geographic area to demonstrate that access was inadequate to protect women's health.¹⁰³ The appellate court's view of availability was quite different: it cited what it saw as the presence of competing providers as proof that the law would not impact women's health.¹⁰⁴

The district court opinion makes women's health the central issue throughout the analysis, including in its evocation of availability.¹⁰⁵ Although the availability tool was used, the court quickly established that if the law was allowed to stand, thus forcing a provider out of business, there were insufficient available alternative providers in certain areas of the state, thus jeopardizing women's health.¹⁰⁶

The *Greenville Women's Center* district court opinion starts from the *Roe*-like premise that the regulations at issue must protect maternal health in order to be legitimate, and then it quickly concludes that, far from protecting maternal health, the regulations may harm women.¹⁰⁷ The district court then proceeds to compare the health risks of abortion and the health risks of pregnancy, noting that early abortion has a mortality rate 25 times

¹⁰² See *Greenville Women's Clinic*, 222 F.3d at 162 (describing the impact on abortion cost to be between \$23 and \$368 per procedure, depending on the impacted clinic and whether the clinic decided to remain open).

¹⁰³ See *Greenville Women's Clinic*, 66 F. Supp. 2d at 720 (saying that regulators failed to assess whether the increased cost of abortion would have an adverse impact on the availability of abortion services in the state).

¹⁰⁴ See *Greenville Women's Clinic*, 222 F.3d at 170 (noting that competition protected women typically served by the clinic to be closed and that evidence was not presented to support the notion that increased cost alone would be unduly burdensome).

¹⁰⁵ See *id.* (noting that, in addition to potentially decreasing abortion access, the regulation may increase the risk of health complications for women).

¹⁰⁶ See *Greenville Women's Clinic*, 66 F. Supp. 2d at 735 (noting the foreseeable closure of an abortion clinic and finding that increasing the distance a woman has to travel to obtain an abortion constitutes an undue burden).

¹⁰⁷ See *id.* at 725-31 (citing *Casey's* requirement that regulations of abortion from the outset of pregnancy should be to protect the health of the woman and calling the regulations "at best medically unnecessary and at worst contrary to accepted medical practice.").

lower than carrying a pregnancy to term.¹⁰⁸ The discussion of the relative risks of abortion and pregnancy is significant because it frames the opinion as one that concerns women's health, not only the right to access abortion services. The decision then outlines the increased costs the regulations would force physicians to impose, which ranged from approximately \$22 to \$370 per procedure.¹⁰⁹ This cost increase provides the basis for the court's flipped use of the availability tool to show that there was insufficient available alternative providers to protect women's health if the law in question was permitted to stand.

Delay in accessing abortion is a health risk, and regulations that increase cost or drive providers out of business cause delay.¹¹⁰ This, according to the district court, is why the regulations at issue constituted an undue burden for South Carolina women seeking an abortion.¹¹¹ Specifically, the court said that regulations would likely force one provider out of business, and the available alternative of asking women to travel more than 70 miles to another provider was insufficient either to protect their right to access abortion services or to protect their health.¹¹² In other words, the presence of distant providers did not constitute adequate availability of alternatives: although distant providers were able to provide substitute services, their distance posed other health risks, thus preventing them from being characterized as substitute providers for the provider facing closure.

¹⁰⁸ *See id.* at 705 (citing a total complication rate of 1 in 100; serious complications as 1 in 2,000; and mortality as 1 in 100,000 for suction curettage abortion).

¹⁰⁹ *See id.* at 717 (describing the cost increases in dollar amount ranges by facility, with the highest increase being so extreme that the provider anticipated it would force closure of the facility).

¹¹⁰ *See id.* at 720 (“This increase in the cost of abortion services will delay a significant number of women from obtaining the procedure and, in some cases, result in their inability to obtain the procedure. As pregnancy advances, the medical risks associated with abortion increase, and a full term pregnancy and childbirth is much more risky to the physical health of a woman than a first trimester abortion.”).

¹¹¹ *See id.* (explaining that “by imposing additional costs and impediments to women seeking abortions, the regulation may have the unintended effect of increasing the risk of adverse health conditions”).

¹¹² *See id.* at 735 (noting that the decreased availability of abortion services due to the closure of one provider would constitute a substantial burden to women, and asking women to travel to obtain an abortion would, at best, result in an unacceptable delay); *see also* Kay et al., *supra* note 96, at 324 (noting abortion services are unevenly distributed and that the vast majority of all unmet abortion needs are concentrated in rural areas).

To the appellate court, however, the increased procedure costs were “speculative” and “modest.”¹¹³ There was no discussion of the impact that increased costs and potential delays would have on accessing abortion services or, ultimately, on women’s health. In the eyes of the appellate court, the increased costs were questionable and, even if assumed, there were available alternative providers: “Moreover, even for women in Beaufort, no evidence suggests that they could not go to the clinic in Charleston, some 70 miles away.”¹¹⁴ The presence of what the appellate court evidently saw as alternative providers filled the gap that hypothetically would be created by the loss of providers due to increased, regulatory-imposed costs.¹¹⁵ Therefore, according to the appellate court, the regulations did not constitute an undue burden on women seeking an abortion nor did they threaten women’s health.

Greenville Women’s Center is a significant case when examining the availability tool because (1) it demonstrates the reliance on the availability tool by two courts who came to entirely different results regarding the constitutionality of abortion restrictions and, in doing so, (2) it confirms the significance of judicial characterization of available alternatives. First, unlike autonomy-based arguments, which are only effective for abortion rights advocates, or fetal life arguments, which are only useful to abortion rights opponents, *Greenville Women’s Center* shows that the availability tool is hypothetically useful to both sides in reproductive health cases. The availability tool draws on the perceived neutrality of the health care system (and the providers and procedures part of it) and unexpectedly crosses abortion’s moral and political divides to be used by both pro- and anti-

¹¹³ See 222 F.3d at 160. From the outset of the opinion, the pertinent issues were framed much differently by the appellate court, which did not emphasize women’s health, but instead the impact the regulations would have on women’s “desire to obtain an abortion.” *Id.* at 162.

¹¹⁴ See *id.* at 165. The court repeated this statement, at no time addressing the health issues of delay raised by the district court. *Id.* at 170 (saying that while the regulations may make securing an abortion “more difficult” they did not constitute an undue burden emphasizing the impact on a woman’s decision making regarding having an abortion and not discussing women’s health.) The dissent has quite a different view on whether an abortion provider seventy miles away constitutes adequate availability to protect women’s right to access or abortion services or their health. *Id.* at 202 (characterizing the majority’s treatment of rural women as “with caval.”). See also Kay et al., *supra* note 96, at 330 (noting that travel distance is negatively correlated with the use of abortion services).

¹¹⁵ We will see later, in the context of vaginal births after prior cesarean sections, that other courts may cite the unavailability of a service – specifically providers willing to supervise vaginal births after cesarean sections -- or “VBACs” -- as evidence that there is no provider for a reproductive health service because the service is unsafe. See *infra* Part III (discussing court ordered cesarean sections).

abortion rights advocates. Second, as did *Storemans*, *Greenville Women's Center* demonstrates that how a court defines “available alternative” may prove outcome-determinative when the availability tool is used. Specifically, in *Greenville Women's Center*, each decision was driven by whether the court saw a provider located more than 70 miles away as “available” competition that could substitute for providers impacted by the regulations, thus preventing the regulations from unduly impacting women's health.

Provider-based applications of the availability tool are not the only use of the availability tool. In recent years, cases involving the proposed abolishment of particular reproductive health *procedures* have risen in jurisprudential profile. Specifically, debate over so-called “partial-birth” abortion has been omnipresent in reproductive rights jurisprudence.¹¹⁶ In these cases, the availability of multiple providers is of no consequence, as it is a single procedure that is at issue. The availability tool, however, is still used. As is discussed below, the availability tool's focus merely shifts to the presence of multiple procedures to resolve any potential impacts on women's health.

C. The Availability of Alternative Procedures

Judges rely on the presence of available *procedures* when using the availability tool just as they rely on the presence of available *providers*.¹¹⁷ When the availability of a particular reproductive health procedure is threatened, the first step courts take is to determine whether there is an alternative procedure available that would be an adequate substitute for the procedure impacted by the law in question.¹¹⁸ Identifying a true, available alternative procedure, however, requires a second step: courts must examine whether the potential substitute provides not only the same service as the potentially banned procedure, but also has an equivalent (or better) health

¹¹⁶ Compare NARAL Pro Choice America, *Abortion Bans After 12 Weeks*, http://www.prochoiceamerica.org/choice-action-center/in_your_state/who-decides/fast-facts/abortion-bans-after-12-weeks.html (detailing state and federal second trimester abortion bans) with National Right to Life, *Archives on Partial Birth Abortion*, <http://www.nrlc.org/ABORTION/pba/index.html> (containing an exhaustive documentation of the “partial birth” abortion-related controversies this prominent anti-abortion rights group has tackled).

¹¹⁷ See *infra* notes 118-167 and accompanying text (discussing the litigation surrounding “partial-birth” abortion).

¹¹⁸ See *id.*

risk-and-benefit profile. Not all judges take this second step, which often leads to the undervaluing of women's health.

"Partial-birth" abortion bans provide fertile ground for the application of the procedure-based availability tool.¹¹⁹ "Partial-birth" abortion is a descriptor, used by the anti-abortion rights movement, that has been applied to a wide variety of abortion procedures depending upon the particular "partial-birth" abortion ban at issue.¹²⁰ These bans necessarily restrict the type of abortion procedures available to pregnant women and, in so doing, raise questions regarding both access to abortion services and the corollary impact procedure unavailability may have on women's health.

An examination of two Supreme Court cases involving "partial-birth" abortion demonstrates that the use of the availability tool is not outcome determinative -- far from it. In *Stenberg v. Carhart*, a "partial-birth" abortion-related case, the Court applied the availability tool and ultimately found inadequate alternative procedures to justify upholding the ban.¹²¹ In the more recent case, *Gonzalez v. Carhart*, a "partial-birth" abortion ban was upheld on the basis that adequate alternative procedures were available.¹²² The resolution of each case turned on the Court's characterization of whether there was an available alternative to "partial-birth" abortion.

Stenberg was the first Supreme Court case involving a ban on "partial-birth" abortion. *Stenberg* centered on a Nebraska statute

¹¹⁹ Pre-*Casey*, in 1976, the Supreme Court struck down a ban on the saline amniocentesis method of abortion using the availability tool, citing the lack of an alternative procedure. See *Planned Parenthood of Central Missouri v. Danforth*, 428 U.S. 52, 75-79 (1976) (citing the prevalence of the banned technique, health-related limitations on the use of alternatives and the lack of trained providers). Procedure bans are less common than other forms of abortion regulation, perhaps because they invite litigation over their impact. Nonetheless, as the recent flurry of "partial-birth" abortion litigation demonstrates, procedure bans threaten women's health.

¹²⁰ For a detailed examination of the media's conflicts in dealing with the "partial birth" abortion term, see Kenneth L. Woodward, *What's in a Name? The New York Times on "Partial-Birth Abortion,"* 19 NOTRE DAME J.L. ETHICS & PUB. POL'Y 427, 441 (2005) (discussing that "partial birth" abortion is not a medically recognized term for an official procedure, saying "'Partial birth' is a political battle cry, not medical terminology."); Julie Rovner, *"Partial-Birth Abortion: Separating Fact from Spin,"* NPR (Feb. 21, 2006), <http://www.npr.org/templates/story/story.php?storyId=5168163> (explaining the term and confirming that both sides of the abortion debate disagree as to what, exactly, the term describes).

¹²¹ See generally *Stenberg v. Carhart*, 520 U.S. 914, 923-38 (2000).

¹²² See generally *Gonzales v. Carhart*, 127 S. Ct. 1610, 1638 (2007).

criminalizing the act of performing a “partial-birth abortion.”¹²³ Proponents of the ban argued that the statute applied to a particular procedure, dilation and extraction (“D&X”).¹²⁴ D&X was described by ban proponents as a particularly gruesome procedure during which a fetus is partially delivered, its skull collapsed and contents removed.¹²⁵ A Nebraska physician who provides abortion services challenged the vaguely worded ban, arguing that it prohibited not only the less frequently used D&X procedure but also banned dilation and evacuation (“D&E”) the most common abortion procedure, which is typically used in the early stages of pregnancy.¹²⁶ Moreover, whatever the ban covered, it contained no exception for the health of the pregnant woman, an omission that was in direct contravention of *Roe*’s health-related mandates.¹²⁷

Signaling the coming use of the availability tool, *Stenberg* began by describing the procedures available to terminate a pregnancy and outlining the potential risks of each procedure. In doing so, the decision quickly set forth procedures that may serve as alternatives to D&X, both in terms of simple availability and suitability based on each individual procedure’s health risk profile. Approximately 90 percent of all abortions performed in the United States are done during the first trimester, and the predominant technique is vacuum aspiration.¹²⁸ Vacuum aspiration has an extremely low rate of complications; its mortality rate, according to the Court, is five to 10 times lower than carrying a pregnancy to term.¹²⁹ During the second trimester, D&E is used for between 90 and 95 percent of all terminations, but this procedure does carry certain health risks.¹³⁰ D&X is also used

¹²³ See *Stenberg*, 520 U.S. at 920-22 (quoting the Nebraska Partial Birth Abortion statute).

¹²⁴ See *id.* at 922-27 (explaining that D&X procedures are also known by some as intact D&E).

¹²⁵ See *id.* (explaining that the fetus is not disarticulated in a “partial birth” abortion).

¹²⁶ See Center for Reproductive Rights, *Statement of Dr. Leroy Carhart* (Aug. 23, 2001), http://www.reproductiverights.org/pr_01_0823carhartstate.html (describing Dr. Carhart’s reaction to the Supreme Court decision in his favor and the personal ramifications from his involvement in the case).

¹²⁷ See *Stenberg*, 520 U.S. at 937-38 (noting that medical uncertainty as to the procedure’s relative utility shows that risk to women’s health is present, thus requiring a health exception).

¹²⁸ See *id.* at 923 (outlining the various procedures available for terminating pregnancies along with frequency of use and potential health effects).

¹²⁹ See *id.* (discussing the various abortion procedures used at various gestations).

¹³⁰ See *id.* at 923-27 (explaining that organ perforation, damage and infection are potential complications from D&Es, but saying that complication rates for D&E are less than induced labor, another abortion technique).

during the second trimester, but the frequency of use is unknown.¹³¹ The potential benefits of D&X over other procedures were debatable, but, according to many physicians, included lower infection and organ perforation rates for the pregnant woman and additional, particular benefits for women with specific health conditions.¹³²

The application of the availability tool in *Stenberg* (and later in *Gonzales*) hinged on how each Court defined what would constitute an adequate available alternative procedure. *Stenberg* defined this as abortion procedures that are at least as safe as the procedure threatened, D&X.¹³³ If no such procedure was available, a health exception to the “partial-birth” abortion ban was constitutionally mandated.

The tool eventually guided the Court to find that there was no alternative procedure for D&X -- in other words, no other available procedure provided the same service (termination of pregnancy) with the same or less health risk to pregnant women.¹³⁴ The Court reviewed medical evidence and concluded that D&X may pose fewer risks to certain pregnant women desiring to terminate a pregnancy than any alternative procedure.¹³⁵ As no alternate procedure with the same benefits was available, a health exception was required.¹³⁶

¹³¹ See *id.* at 929 (saying that estimates of D&X usage range from 640 to 5,000 procedures per year).

¹³² See *id.* at 927-29 (relating that women with prior uterine scarring or for whom induction of labor may be particularly dangerous benefit from the availability of D&X).

¹³³ See *Stenberg v. Carhart*, 530 U.S. 914, 934-938 (2000) (holding that, if D&X is safer than alternatives, a health exception is mandated).

¹³⁴ See *id.* at 937-38 (citing the significant medical opinion that D&X may have health benefits over other procedures). *But see* *Hope Clinic v. Ryan*, 195 F.3d 857, 873 (7th Cir. 1999) (noting the application of the availability tool by Illinois and Wisconsin to find that D&X was not necessary for the health of women “given the availability of other procedures”).

¹³⁵ See *Stenberg*, 520 U.S. at 935-36 (citing the American College of Obstetricians and Gynecologists statement that D&X may be safer than “available alternatives” for certain women).

¹³⁶ See *id.* at 940 (rejecting a proposed narrowing interpretation of the statute offered by the Nebraska Attorney General because the interpretation ran afoul of the plain language of the statute and was not binding on state courts or local law enforcement officials). If another procedure had the same risk-benefit profile as D&X, the health exception would not have been needed, but as no such alternative procedure was identified, a D&X ban would arguably increase the risk for some women seeking an abortion. See David D. Meyer, *Lochner Redeemed: Family Privacy after Troxel and Carhart*, 48 UCLA L. REV. 1125, 1161-62 (2001) (interpreting the *Carhart* majority opinion as prohibiting any state-imposed increased medical risk to a woman seeking an abortion).

The *Stenberg* health exception analysis is an example of how the availability tool can function in a way that adequately values women's health interests. Inherent in the Court's search for available alternatives to D&X is the assumption that it had some level of medical value, implicitly placing the burden on the government to prove otherwise. The Court undertook a detailed comparison of D&X with available alternative procedures -- a comparison that didn't just focus on women's continued ability to access abortion (which is where many incorrect applications of the availability tool stop) -- but also on their ability to do so as safely as they could have prior to the ban. Moreover, by acknowledging the fact that "division of medical opinion about the matter at most means uncertainty, a factor that signals the presence of risk, not its absence," the Court's ultimate holding, that a health exception was necessary to protect women, showed that a proper application of the tool is possible even in complex factual scenarios, where the utility of the banned procedure is in question.¹³⁷ We will see later, in *Gonzales*, a contrary application of the availability tool, where the Court's resolution of a similar question of availability resulted in a truncated women's health analysis.

The availability tool is also used in *Stenberg* to determine whether the Nebraska ban itself -- even with a health exception -- posed an "undue burden" on women's right to access abortion.¹³⁸ Whether the law constituted an "undue burden" was resolved by the fact that the procedures banned by the Nebraska "partial-birth" abortion ban included not only D&X, but also D&E, the most common abortion procedure used.¹³⁹ There was no patent analysis of the ban's impact on women's health, however the availability tool functioned in the background, unstated yet visible to those who look for it.¹⁴⁰

¹³⁷ See *Stenberg*, 520 U.S. at 937. Arguably, the Court could have forgone use of the availability tool and its corollary comparison of D&X to other procedures and simply analyzed whether the alternative procedures were safe. It chose, instead, to rely on the availability-based comparison. In future cases, however, the Court shifted its approach. See *also id.* at 931 (noting that abortion regulations cannot pose significant health risks to women, whether the risk originates from the regulation of an abortion method or from the pregnancy itself).

¹³⁸ See *id.* at 938 (noting Nebraska's stipulation that if the ban applied to first-trimester procedures it would constitute an "undue burden").

¹³⁹ See *id.* at 945 (noting that the ban would allow the state to prosecute physicians who use D&E, "the most commonly used method for performing pre-viability second-trimester abortions").

¹⁴⁰ Arguably, the Court's analysis of the health exception also operates in the background of the "undue burden" decision, where the Court was unable to determine the extent to which D&X, D&E and induced labor were competing procedures, further truncating any

To understand the potential impact of the ban, the Court first determined what, exactly, the Nebraska statute prohibited: a major point of contention in the case.¹⁴¹ Parties fundamentally disagreed over whether the Nebraska ban applied solely to D&X abortions or to the more common, first-trimester D&E procedure as well.¹⁴²

The Court found that the Nebraska ban did, in fact, ban D&Es and therefore constituted an “undue burden” on women’s ability to terminate a pregnancy.¹⁴³ Although the Court’s decision was based largely on statutory interpretation, the holding was also dictated by the implied use of the availability tool to analyze the impact a procedure ban would have on access to abortion services (and the health issues that are inextricably intertwined with access).¹⁴⁴

The *Stenberg* decision striking down the Nebraska ban as an “undue burden” on women’s right to access abortion emphasized the high percentage of abortions the Nebraska ban would impact. By criminalizing not only D&X, but also “the most commonly used pre-viability second trimester” procedure, D&E, the ban would have left women seeking an abortion unduly burdened.¹⁴⁵ By discussing commonality, the Court implied that a ban impacting the majority of abortions at a certain gestational point in pregnancy would be unduly burdensome because there are inadequate available alternative procedures available to woman.¹⁴⁶ The availability tool

potential health consideration in the “undue burden” analysis. *See id.* at 934-35 (listing some of the potential advantages of D&X).

¹⁴¹ *See id.* at 940 (applying *Casey* to find that an exception was “necessary” to protect the health of the pregnant woman).

¹⁴² *See Rovner, supra* note 120 (explaining the term and confirming that both sides of the abortion debate disagree as to what, exactly, the term describes); Woodward, *supra* note 120, at 441 (while discussing that “partial-birth” abortion is not a medically recognized term for an official procedure, saying “‘Partial-birth’ is a political battle cry, not medical terminology.”).

¹⁴³ *See Stenberg*, 520 U.S. at 940.

¹⁴⁴ *See id.* at 923-30, 935 (citing the relative risks and benefits of potential alternative procedures and the district court’s holding that such procedures were not as safe as the potentially banned procedure).

¹⁴⁵ *See id.* at 945.

¹⁴⁶ The unstated presence of the availability tool has been noted by scholars as well. *See, e.g.,* Stephanie D. Schmutz, *Infanticide or Civil Rights for Women: Did the Supreme Court Go Too Far in Stenberg v. Carhart*, 39 HOUS. L. REV. 529, 565 (2002) (suggesting that “the Nebraska statute does not create an undue burden on a woman’s right to choose an abortion because she can still choose to have a D&E abortion instead of a D&X or partial-birth abortion.”). Interestingly, in *Stenberg*, the Court both emphasizes the importance of commonality of use and also downplays it. *See Stenberg*, 520 U.S. at 934-938 (saying the

is functioning in the background of *Stenberg*, even in its “undue burden” analysis.¹⁴⁷ As Justice O’Connor specified in her concurring opinion, “If there were adequate alternative methods for a woman *safely* to obtain an abortion before viability, it is unlikely that prohibiting the D&X procedure alone would ‘amount in practical terms to a substantial obstacle to a woman seeking an abortion.’”¹⁴⁸ Therefore, *Stenberg* shows that the availability tool is not only useful when looking at health exceptions, but also when looking at the impact a law may have on the right to access abortion -- and, as *Casey* suggested -- the health concerns that might be subsumed within that access analysis. This will be significant in later cases: as we will see, even when the health exception’s constitutional fate seems grim, the availability tool operates.

Stenberg did not stem the tide of “partial-birth” abortion legislation.¹⁴⁹ It simply sent proponents back to the legislative drawing board with jurisprudential guidance as to what type of legislation the Court was likely to find constitutionally acceptable.¹⁵⁰ “Partial-birth” abortion was again brought to the Supreme Court in 2007, this time in the guise of a federal “partial-birth” abortion ban.

In *Gonzales v. Carhart*, the Court considered a “partial-birth” abortion ban with issues similar to those in *Stenberg*: the ban lacked an exception to protect the health of the pregnant woman, and it was unclear what procedure or procedures, exactly, the ban prohibited.¹⁵¹ To determine the legal import of each of the issues, the Court focused on whether alternative procedures existed. Specifically, it relied on the availability of multiple second-trimester abortion procedures to hold that banning “partial-birth” abortion was not a substantial burden on women.¹⁵² Moreover, the

procedure’s relative rarity is “not highly relevant” then discussing the fact that a ban on a more common procedure would be an “undue burden”).

¹⁴⁷ See *id.* at 934-35 (listing some of the potential advantages of D&X); see also *Richmond Medical Center for Women v. Herring*, 527 F.3d 128, 148 (4th Cir. 2008) (declaring a law criminalizing partial birth abortion unconstitutional as it effectively prohibited the overwhelming majority of second trimester abortions).

¹⁴⁸ See *Stenberg v. Carhart*, 520 U.S. 914, 951 (2000) (O’Connor, J. concurring) (emphasis added).

¹⁴⁹ See *infra* notes 150-167 and accompanying text (discussing subsequent “partial-birth” abortion ban litigation).

¹⁵⁰ See *generally* *Gonzales v. Carhart*, 127 S. Ct. 1610, 1639 (2007) (finding that a health exception was unnecessary).

¹⁵¹ See *id.*

¹⁵² In a somewhat unexpected twist on the availability tool, the decision also cites the presence of contrasting medical information and opinions on the medical necessity of D&X to support its ultimate holding that alternative abortion procedures vitiated any impact the

availability of alternative procedures is specifically cited as negating any potential health issues for women the ban may have posed, thus making *Gonzalez* the first case in which the Supreme Court upheld an abortion restriction without a corollary health exception.¹⁵³

Gonzales typifies how a court, when it conflates the analysis of access and health, as *Casey* allows, and uses the availability tool, can easily shortchange women's health in its analysis. At the outset of the *Gonzales* decision, the Court signaled that availability of alternative procedures would be significant to its analysis. The Court juxtaposed a graphic description of D&X with a description of all abortion procedures that are potential substitutions for D&X,¹⁵⁴ when those procedures are used and any potential risks they pose to women's health.¹⁵⁵ The inclusion of available alternatives at this point in the decision is not explained, just merely set forth.

The *Gonzales* Court immediately distinguished the federal "partial-birth" abortion ban from the Nebraska ban in *Stenberg*, finding that the federal ban only applied to some second-trimester abortions, unlike the Nebraska ban, which the court had found banned the more commonly used first-trimester D&E procedure.¹⁵⁶ This difference between the two cases is key because it directly impacts how the availability tool is used. Given that the federal ban was significantly narrower in scope than the Nebraska, the likelihood that the federal procedure ban could be compensated for by the presence of alternative procedures was higher.

ban could have on women's health. *See id.* at 1636 (citing competing medical opinions on the necessity of D&X, in part, because "[a]lternatives are available").

¹⁵³ *See* National Partnership for Women and Families, *The Supreme Court and Abortion Access*, http://www.nationalpartnership.org/site/DocServer/supreme_court_and_abortion_access_aug_26_2008.pdf?docID=3881 (saying that the *Gonzales* Court abandoned the health exception requirement, which had been in place for 33 years).

¹⁵⁴ The court refers to D&X as "intact D&E." *See generally Gonzales*, 127 S. Ct. at 1621 (noting the different nomenclature used to describe a "partial-birth" abortion). For the purposes of consistency, the term D&X is used in this paper.

¹⁵⁵ *See id.* at 1623 (describing alternative second-trimester abortion methods as: medical induction, which is used in 5 percent of abortions prior to 20 weeks gestation and 15 percent in those after 20 weeks; hysterotomy and hysterectomy, which are used in emergent situations only because of increased health risk to the pregnant woman and together account for less than 1 percent of all second-trimester abortions).

¹⁵⁶ *See id.* at 1629 (postulating that the different diction in the federal ban was Congress' attempt to avoid the legal issues with the Nebraska ban).

As was the case in *Stenberg*, the *Gonzales* Court had to determine whether the absence of a health exception rendered the statute facially unconstitutional. The *Gonzales* Court noted the same issue that faced it in *Stenberg*: there was no medical consensus regarding whether D&X was a necessary procedure to protect the health of the woman seeking an abortion. To the contrary, the issue of whether D&X is the “safest” second-trimester abortion method was hotly contested.¹⁵⁷ the Court noted the “documented medical disagreement [over] whether the Act’s prohibition would ever impose significant health risks on women.”¹⁵⁸ But it departed from its prior treatment of the health exception issue: unlike *Stenberg*, where the Court resolved the question in favor of women’s health, the *Gonzales* Court did not address the health exception as a stand-alone issue. Instead, the Court conflated the resolution of the health exception issue with the broader undue burden analysis.¹⁵⁹ In doing so, the *Gonzales* Court used the availability tool to resolve both the health exception and undue burden issues simultaneously.

The Court held that the federal “partial-birth” abortion ban did not constitute an “undue burden” on women -- even without an exception to protect the health of pregnant women -- specifically because the Court found that there were alternative abortion procedures available to women.¹⁶⁰ The *Gonzales* Court noted the continued availability of D&E and saline amniocentesis and held that the lack of the health exception was constitutional specifically because “[a]lternatives are available to the prohibited procedure. ... Here the Act allows, among other means, a commonly used and generally accepted method, so it does not construct a substantial obstacle to the abortion right.”¹⁶¹ The Court overtly relied on the presence of other procedures to hold the act constitutional.¹⁶²

¹⁵⁷ See *id.* at 1636-37.

¹⁵⁸ See *id.* at 1636.

¹⁵⁹ See *id.* at 1638 (conflating the necessity of a health exception with the analysis of whether the ban was an “undue burden” on access)

¹⁶⁰ See *Gonzales v. Carhart*, 127 S. Ct. 1610, 1637 (2007) (distinguishing the case from *Planned Parenthood v. Danforth*, 428 U.S. 52 (1976), in which the court struck down a ban on the saline amniocentesis abortion method, which was then the most common second-trimester abortion method, and saying, “alternatives are available to the prohibited procedure.”).

¹⁶¹ See *id.* at 1637 (noting court decisions that cite the relative safety of D&E and the modification to the D&X procedure that could be made so as not to fall under the federal ban).

¹⁶² In reaction to the Court’s decision, the American College of Obstetricians and Gynecologists released a statement saying, in part, “‘Today’s decision to uphold the Partial-Birth Abortion Ban Act of 2003 is shameful and incomprehensible to those of us who have dedicated our lives to caring for women,’ said Douglas W. Laube, MD, MEd,

The *Gonzales* Court failed, however, to determine whether the alternative procedures -- frequently used or not -- have the same health risk-benefit profile as the banned procedure. Noticeably absent from *Gonzales* is a procedure-by-procedure comparison of women's health risks and benefits.¹⁶³ Rather than looking at each procedure and comparing their risk-benefit profile, the Court overtly assumes that the availability alone of other procedures protects women's health.¹⁶⁴ The Court infers from the frequency with which the non-banned procedures are used that all women's health is protected by their presence. But frequency of use alone does not prove that D&E and saline amniocentesis are true alternatives for D&X and are appropriate for all women, regardless of underlying health. In other words, *Gonzales* defined "available alternatives" in terms of access, instead of in terms of health -- exactly the type of availability analysis error facilitated by *Casey*.

Strikingly, the *Gonzales* Court itself acknowledged that there was medical support for the argument that the banned procedure was necessary for some women's health but, for inexplicable reasons, departed from *Stenberg* to find that the medical disagreement over whether the ban would pose "significant" health risks to women was obviated by the presence of "safe alternatives."¹⁶⁵ The use of "safe" in lieu of "as safe" or "safest," shifted the burden of proving absence of risk from the government to women, who arguably now have to prove the presence of risk. Use of the phrase "safe alternatives" instead of "as safe" or "safest" signals the Court's acceptance of laws that impose health risks on women seeking abortion -- unless those risks rise to the undefined level of being "substantial."

Gonzales provides an example of a misapplication of the availability tool. It at once heralds the availability of safe alternatives to the banned

ACOG president. "It leaves no doubt that women's health in America is perceived as being of little consequence." ACOG, *ACOG Statement on the U.S. Supreme Court Decision Upholding the Partial Birth Abortion Ban Act of 2003*, (April 18, 2007), http://www.acog.org/from_home/publications/press_releases/nr04-18-07.cfm.

¹⁶³ Juxtapose the majority opinion with the dissent. *See Gonzales*, 127 S. Ct. at 1641-46 (attacking the majority's reliance on alternative methods and including detailed health and safety information on the methods presented as "competing" with D&X and seeking to advance women's "autonomy") (Ginsberg, J., dissenting. Stevens, J., Souter, J. and Breyer, J. joining).

¹⁶⁴ Competition is widely presumed to benefit health care consumers. *See, e.g., Azar II*, *supra* note 8 (saying, "The more free competition there is in ... health care ... the more innovation and health the world will enjoy.").

¹⁶⁵ *See Gonzales*, 127 S. Ct. at 1637-39 (holding the ban constitutional where there is uncertainty over its necessity and there are "safe alternatives").

procedure while admitting that there is significant medical authority suggesting that the ban could be harmful to women's health. The decision looks to the commonality of alternative procedures instead of their relative safety for women. *Gonzales*, then, demonstrates how the tool, when used imprudently, undercuts women's health.

When one looks at court reliance on the availability of providers and procedures together, it is apparent that the availability tool can be used to decide a wide variety of women's health issues. Moreover, as is seen in the context of pharmacist refusal and abortion, the tool can be used by both proponents and opponents of regulations that curtail women's reproductive rights.¹⁶⁶ Regardless of the factual scenario, the end result depends largely on the court's characterization of what constitutes available alternatives.

Gonzales and *Stenberg* (and, for that matter, all of the cases discussed) leave us with a significant question: what is the standard used to determine whether a procedure or a provider is "available"?¹⁶⁷ Must the alternative procedure or provider be a perfect replacement for the one impacted by the law in question, or is there some leeway in the fit? As will be discussed in Part IV, the answer to this question determines whether the availability tool functions to adequately value women's health interests or to undercut them.

III. CULPABILITY

The utility of the availability tool depends upon the presence of at least a modicum of alternatives, which leads to an obvious question: what can judges facing women's health issues do when alternative procedures or providers are unavailable? It appears that even in the absence of robust

¹⁶⁶ Another area that may be fruitful to examine regarding the function of the availability tool is coverage of contraceptives by health insurance. Known by women's rights advocates as "equity in prescription insurance coverage," "EPIC" cases also contain indicators that judges use the availability tool. *Compare In re Union Pac. R.R. Employment Practices Litigation*, 479 F.3d 936 (8th Cir. 2007) (the majority citing the existences of several types of birth control with and without prescription as evidence that there was no Title VII violation) *with* *Ericson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266 (W.D. Wash. 2001) (holding that lack of coverage constitutes sex-based discrimination, as a lack of contraceptive coverage prevents women from participating fully in the labor market). This issue merits further exploration but is beyond the scope of this paper.

¹⁶⁷ It is worth noting that the concept of convenience, which was present in the *Storemans* pharmacist refusal case, also emerges in *Gonzales*. *Gonzales v. Carhart*, 127 S. Ct. 1610, 1638 (2007) ("When standard medical options are available, mere convenience does not suffice to displace them.").

competition, judges can refocus a case on a time when alternatives were available. To do so, they look to see if women, themselves, are culpable for the absence of available alternatives.

Culpability on a general level is ever-present in reproductive health. The notion that women are morally culpable if they become pregnant through consensual sex is a thread that runs through contraception, abortion and childbirth-related cases.¹⁶⁸ Failure to prevent pregnancy or to terminate it at the time and in the manner most acceptable by society is a woman's fault. The culpability tool is used to locate whether this type of fault is present in a specific case because of the actions of a specific woman.

Reference to a woman's culpability in reproductive health jurisprudence represents the availability tool's last gasp for life. The lack of viable alternative women's reproductive health services should render the availability tool useless. But some judges find a way to present the woman as responsible specifically for the lack of availability in her own case and the narrowing of choices that resulted. In other words, if the woman had made a decision at an earlier time, access to the health service needed would have been available. Or, if she had made a decision reflective of the existing medical consensus, no health issue would exist.

The culpability tool is less universal and decidedly more subjective than the traditional availability tool. The availability tool is presented in reproductive health jurisprudence as neutral and prospective: it looks at the present state of the market and how a regulation will impact availability going forward. As described earlier, the availability tool can be used by two groups of jurists examining the same set of facts to come to two different legal conclusions. The culpability tool, on the other hand is retrospective and inherently judgmental: it is a search for the time in the past when a

¹⁶⁸ In recent cases, the court has also implied women's culpability in a more gratuitous fashion. See *id.* at 1634 ("While we find no reliable data to measure the phenomena, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained ... Severe depression and loss of esteem may follow.") The general culpability in *Gonzales* has no availability-related function. Likewise, rape and incest exceptions to abortion bans make the general implication that women who had consensual sex are morally culpable if they become pregnant. See Judith A.M. Scully, *Book Review: Breaking the Abortion Deadlock: From Choice to Consent*, 8 UCLA WOMEN'S L. J 125, 133 (1997) (discussing, as examples of this argument, the federal "Hyde Amendment," which disallows Medicaid funding except in cases of rape, incest or threat to the pregnant woman's life, and *Doe v. Bolton*, 410 U.S. 179, 208 (1973), which discussed consensual versus nonconsensual pregnancies). This general use of culpability is not related to the narrowing of availability but undoubtedly facilitates the use of the more specific culpability tool to which I refer.

woman made a choice that narrowed her own health care options -- and thus narrowed the competition she could access.¹⁶⁹

The culpability tool is especially apparent as the availability of reproductive health services decreases. The tool is used in abortion cases, where both the number of providers and procedures can be limited.¹⁷⁰ Culpability is also used in compelled cesarean section cases, where a woman disagrees with her physician's insistence on delivery by cesarean section, so the physician seeks a court order compelling the woman to submit to a cesarean section for the benefit of the fetus.¹⁷¹ In each of these cases, when the culpability tool is used, the court simultaneously blames the woman for the predicament she faces and returns the analysis to availability.¹⁷²

When judges use the culpability tool, they refer to the narrowing of alternatives stemming from a woman's decisions at one (or both) of two points in time. The first point at which a woman voluntarily narrows her options is at viability, when she makes a choice to continue her pregnancy.¹⁷³ The second point in time at which a woman voluntarily

¹⁶⁹ Judicial interventions into a woman's pregnancy-related decision-making are necessarily judgmental because, by their very nature, such interventions undermine a woman's autonomy. See Charity Scott, *Resisting the Temptation to Turn Medical Recommendations into Judicial Orders: A Reconsideration of Court-Ordered Surgery for Pregnant Women*, 10 GA. ST. U. L. REV. 615, 642-44 (1994) (explaining that autonomy "entails the subjective, rather than objective, decision-making"). The difficulty the medical establishment -- and presumably the judiciary -- has dealing with pregnant woman is based on the fact that she "refutes one of western culture's most powerfully held truths -- the concept of one individual per one body." See Suzanne K. Ketler, *The Rebirth of Informed Consent: A Cultural Analysis of the Informed Consent Doctrine After Schreiber v. Physicians Insurance of Wisconsin*, 95 NW. U. L. REV. 1029, 1040 n.78 (2001).

¹⁷⁰ Judicial intervention in pregnancies is not limited to cesarean sections. See generally Scott, *supra* note 169, at 621-27 (discussing interventions including blood transfusions and "purse string" operations).

¹⁷¹ See *infra* notes 181-207 and accompanying text.

¹⁷² Recall also the double (culpability) bind in *Storemans*: in order to have a cause of action, a woman must have "failed" to access Plan B, but given that access is a matter of "convenience," if she had failed to access Plan B, she would have been culpable for her own failure to find a provider and thus not worthy of protection.

¹⁷³ See, e.g., *Jefferson v. Griffen Spalding County Hospital Authority*, 274 S.E.2d 457, 458 (Ga. 1981) (citing the fact that the child was viable, and was thus entitled to the protection under *Roe* when ordering a woman with placenta previa to have a cesarean section). See also *In re A.C.*, 533 A.2d 611, 614 (D.C. Ct. App. 1987) (saying "as a matter of law, the right of a woman to an abortion is different and distinct from her obligations to the fetus once she had decided not to timely terminate her pregnancy") *reversed* 573 A.2d 1235 (D.C. Ct. App. 1990) (holding, after the compelled cesarean section and death of the

narrows her options is when she makes a reproductive health care choice that is perceived to be unsupported by health care providers.¹⁷⁴ Either or both of these events can be used to suggest a woman's culpability in her present health care situation, facilitating an abbreviated or non-existent discussion of her health.

One example of the first narrowing point, the reference to a woman's choice to continue her pregnancy after viability, can be found in *Casey*.¹⁷⁵ The *Casey* court, asserting that allowing increased regulation of abortion post-viability was an issue of "fairness," said that "[i]n some broad sense it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing fetus."¹⁷⁶ In other words, *Casey*, when unpacked, makes plain two ideas. First, by referring to state intervention post-viability as a matter of "fairness," it suggests that an element of judgment, perhaps even judgment that is moralistic, is appropriate with regard to women's reproductive decisions. Second is *Casey's* idea that the woman herself is responsible for any state intervention she faces later in the pregnancy if she doesn't terminate the pregnancy pre-viability, when alternatives still existed.¹⁷⁷

pregnant woman, that a substituted judgment process should have been used where the woman was in a coma).

¹⁷⁴ See, e.g., *Pemberton v. Tallahassee Regional Medical Center*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999) (citing the pregnant woman's inability to find a provider for her desired service); *Jefferson*, 274 S.E.2d at 459-60 (citing the woman's refusal to have a cesarean section even though her fetus was likely to die and her health was seriously threatened); *In re A.C.*, 573 A.2d at 1263 (discussing *In re Madyun*, appended to *In re A.C.*, in which the court accused the parents of ignoring medical advice when refusing to consent to a cesarean); *WVCS Hospital v. Doe*, Civil Action No. 3-E-2004, Special Injunction Order and Appointment of Guardian, (Ct. Common Pleas, Luzerne Cty, PA Undated) (citing refusal to abide by doctor's recommendation to deliver by cesarean section, ordering a cesarean section and not discussing any women's health issues).

¹⁷⁵ The culpability statements in *Casey* are somewhat surprising because they arise in the context of pre-viability abortion regulations. First-trimester abortion is a fairly available service, therefore, discussion of culpability is not necessary to bring the judicial conversation back to the realm of availability. However, *Casey's* implications were broader: it was the Supreme Court's broader outlines of the future of abortion jurisprudence. As such, its signal to the world -- that women will be held culpable for the results of their decisions -- makes sense from an objective standpoint.

¹⁷⁶ See *Planned Parenthood v. Casey*, 505 U.S. 833, 870 (1992). See also Scott, *supra* note 169, at 638 (explaining that if a woman declines to terminate a pregnancy, she creates legal duties for her future child that are stronger than the duties she generally owes to others).

¹⁷⁷ The state can intervene in pregnancy in many additional ways. See generally Note, *Rethinking (M)otherhood: Feminist Theory and State Regulation of Pregnancy*, 103 HARV. L. REV. 1325 (1990) (discussing forced blood transfusions; detention of the mother to stop potentially harmful behavior by the pregnant woman such as drug use; detention to force

Given that this narrowing point is, actually, the point at which a woman exercises a constitutionally protected right -- the right to bear a child -- using it to curtail her health interest is problematic at best.¹⁷⁸

The second narrowing point referenced in reproductive health decisions is the time at which a woman makes a reproductive health care choice perceived to be unsupported by the health care system. Because availability is often considered a protector of women's health, judges may hold women responsible if they choose not to take advantage of existing services.¹⁷⁹ Moreover, judges may be inclined to accept the risk assessment made by physicians, as opposed to women themselves, in cases where a woman's desire conflicts with that of her doctor, further emphasizing the woman's culpability for her situation.¹⁸⁰

One vivid example of a situation in which availability of reproductive health services may be lacking and where a significant clash of legal interests is present is at childbirth. Some women have been court-ordered to undergo cesarean sections, despite their desire to deliver vaginally.¹⁸¹ It is not hyperbolic to say that compelled cesarean sections (or

potentially beneficial behavior by the pregnant woman, such as medical treatment. State intervention can be civil or criminal in nature).

¹⁷⁸ See *supra* Part IV (discussing the misapplications of the culpability tool).

¹⁷⁹ It appears that the culpability tool is more likely to be used in cases where the women's health interests are subrogated to fetal rights arguments. However, given that these cases are difficult to locate, this observation cannot be taken as proof of a pattern.

¹⁸⁰ Judges may buy into the "technological imperative," a presumption that the risk assessments of medical professionals are superior to the risk assessments made by pregnant woman. See Scott, *supra* note 169, at 659. The presumption that women cannot accurately assess the risk posed to them (and their fetus), is based on the assumption that the level of stress a laboring woman faces renders her unable to make rational choices. See Marguerite A. Driessen, *Avoiding the Melissa Rowland Dilemma: Why Disobeying a Doctor Should Not Be A Crime*, 10 MICH. ST. U. J. MED. & L. 1, 40-41 (2006) (discussing the ironic fact that the same judges who may view women as irrational decision makers at the time of delivery oversee hundreds of thousands of medical malpractice lawsuits per year); Ketler, *supra* note 169, at 1045 (arguing that a related assumption is the labor and birth follow a natural course, thus leaving no room for the exercise of maternal choice).

¹⁸¹ The frequency of compelled cesarean sections is difficult to estimate because of the nature of the proceedings that often lead to them: rushed, oral proceedings resulting in brief, difficult-to-locate state trial-level court orders. Moreover, courts have expressed substantive concerns over the attendant proceedings. See, e.g., *In re A.C.*, 573 A.2d 1235, 1248 (D.C. Ct. App. 1990) (noting the procedural shortcomings in compelled cesarean section proceedings, including inadequate notice and representation of parties, substandard arguments and opportunities for appeal: "Certainly courts dealing with other kinds of medical decision-making conflicts have insisted both upon much more rigorous procedural standards and upon significantly more information.") The American College of Obstetricians and Gynecologists says that judicial intervention in birth choice undermines

the threat of one) has led to dramatic scenarios: a woman being forcibly restrained, sedated and carted into an operating room as her screaming partner was forcibly restrained;¹⁸² a woman facing compelled cesarean section “escaping” from the hospital and attempting birth in hiding with no medical support;¹⁸³ a woman’s alleged refusal to consent to a cesarean section resulting in criminal charges against her;¹⁸⁴ and, in one case, the trauma of a forced cesarean leading to the father’s suicide.¹⁸⁵ The stakes are high for all involved in a potential compelled cesarean section, including the judge.

The culpability tool may come into play when childbirth methods are in dispute because competition to provide childbirth services at the time of labor may be very low. Even though the number of obstetricians may be large in any particular geographic area, for practical purposes, once in labor, the ability of a woman to access a new physician is limited. Many, if not most, physicians are unwilling to attend a woman who is not their patient at the time of delivery, and assistance from a new doctor may be even less likely when there are complications surrounding the delivery.¹⁸⁶ And even if

women’s autonomy and their trust in their medical providers, potentially causing them to deliver without medical care. *See* Driessen, *supra* note 180, at 42-43. Many cesarean sections occur after the threat of legal action, so are technically consensual. *See* Michael J. Myers, *ACOG’s Vaginal Birth After Cesarean Standard: A Market Restraint Without Remedy?*, 49 S.D. L. REV. 526, 527-28 (2004) (observing that women are often dissuaded from having a vaginal delivery, which provides revenues of approximately \$6,000 to \$8,000 per procedure, while cesarean sections provide between \$14,000 and \$17,000 each).¹⁸² *See, e.g.*, Driessen, *supra* note 180, at 36 (describing the compelled cesarean section of a Nigerian woman, whose husband later committed suicide).

¹⁸³ The result of court-ordered cesarean sections is that the extent of reproductive rights is necessarily conditioned on the place in which they are exercised: if a pregnant woman chooses to use traditional medical facilities, she surrenders her autonomy at the hospital door. *See* Scott, *supra* note 169, at 667 (surrendering her rights is not the result of any illegal activity, the author notes).

¹⁸⁴ *See, e.g.*, Driessen, *supra* note 180, at 1-3 (discussing the arrest of a woman for first-degree murder after the woman delayed consenting to a cesarean section despite being told by her physician that the health of twin fetuses was in jeopardy. One was stillborn.).

¹⁸⁵ *See id.* at 36 (discussing the court-ordered cesarean section of a Nigerian woman, pregnant with triplets who had refused the surgery out of fear that a repeat cesarean section would not be available in Nigeria for subsequent pregnancies. The hospital lied to the woman and husband, saying they could attempt a vaginal delivery, only to present them with the court order when she arrived in labor. The woman, screaming, was forcibly restrained and sedated. The husband was forcibly removed from the hospital by security guards and subsequently killed himself.).

¹⁸⁶ Difficulty finding a doctor later in pregnancy is reported anecdotally by many women. *See, e.g.*, *Pregnancy: Healthcare*, ClubMom, <http://www.clubmom.com/display/286152?aCatId=1295&questionId=279164> (reporting that one woman called eight doctors and only two would consider seeing her after 30 plus

a provider willing to provide the woman's preferred childbirth method is hypothetically available, there may not be time to access that alternative provider. That suggests that a judge facing a request for a court-ordered cesarean section should not be able to rely on the presence of available alternatives to vindicate the woman's health interests. Instead, judges rely on the woman's culpability in the absence of competition rather than separately analyzing the health ramifications.

Pemberton v. Tallahassee Memorial Regional Medical Center exemplifies how the culpability tool functions in the area of compelled cesarean sections.¹⁸⁷ In *Pemberton*, a pregnant woman who had a prior cesarean section tried unsuccessfully to find a physician who would attend her in the vaginal delivery of what was expected to be a large infant.¹⁸⁸ She decided to give birth at home with no medical assistance but ended up in the hospital emergency room in need of hydration.¹⁸⁹ The attending physician declined to provide the requested medical services, instead contacting supervising physicians, all of whom determined that a cesarean section was necessary.¹⁹⁰ Meanwhile, Pemberton left the hospital.¹⁹¹ At that point, the

weeks pregnancy, another saying that doctors will not take women after 36 weeks because of liability concerns). See Roy Wood, *High-Risk Pregnancy Fuels Fears*, CINCINNATI POST, Sept. 13, 2005 (reporting that one woman had to call nearly one dozen doctors before finding someone willing to care for her during her last month of pregnancy). Common sense dictates that the ability to locate a new doctor shortly before or during labor would be more onerous.

¹⁸⁷ 66 F. Supp. 2d 1247 (N.D. Fla. 1999). For a similar example, see *In re Madyun*, a case involving a pregnant teenage woman who, after laboring for more than 2 days, was told by physicians that she needed a cesarean section to avert possible infection. 573 A.2d 1235 (D.C. Ct. App. 1990). Madyun, who was Muslim, expressed religious objections to having a cesarean section. *Id.* The court, citing the fact that the child was viable, and that, in wanting a vaginal delivery, Madyun was acting in direct contravention of medical experts, ordered a cesarean section. *Id.* at 1262-63. The baby was born with no infection. See Driessen, *supra* note 180, at 34. See also *WVCS Hospital v. Doe*, Civil Action No. 3-E-2004, Special Injunction Order and Appointment of Guardian, (Ct. Common Pleas, Luzerne Cty, PA Undated) (citing refusal to abide by doctor's recommendation to deliver by cesarean section, ordering a cesarean section and not discussing any women's health issues) and Motion for Special Injunction Order and Appointment of Guardian, at 3 (citing *Roe v. Wade* and the right of the "full term viable fetus" to have decisions made for its health independent of its parent's wishes and omitting any discussion of the pregnant woman's health); *In Re A.C.*, 533 A.2d at 614 (citing both viability and provider-based culpability).

¹⁸⁸ See *Pemberton v. Tallahassee Regional Medical Center*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999) (explaining that Pemberton's prior cesarean section was accomplished via a vertical incision, which presents a risk of uterine rupture during subsequent deliveries).

¹⁸⁹ See *id.*

¹⁹⁰ See *id.* (explaining that her prior cesarean section was done with a vertical incision, making subsequent cesarean sections more dangerous).

hospital attorney instituted court proceedings to compel Pemberton to have a cesarean section, to which a judge agreed.¹⁹² Law enforcement was dispatched to Pemberton's home, and she was returned to the hospital via ambulance against her will. After a bedside hearing, Pemberton was ordered to be given a cesarean section, and the procedure, against her will, was performed.¹⁹³ After the birth of her child, Pemberton sued the hospital for violating her constitutional rights.¹⁹⁴

In its decision, the court used the culpability tool before finding in the hospital's favor. First, in the court's eyes, Pemberton voluntarily limited her healthcare options when she chose not to terminate her pregnancy.¹⁹⁵ The *Pemberton* court cited *Roe* and stated that Pemberton sought only to limit her childbirth options, not to forgo having a child altogether, implying that her post-viability reproductive health care choices were somehow less weighty because she chose to continue her pregnancy.¹⁹⁶ Moreover, Pemberton sought health care that was not supported by providers: a vaginal delivery after a prior cesarean section.¹⁹⁷ The court said that the lack of competition to provide Pemberton with vaginal delivery services was "understandable" given the estimated 2 percent risk of uterine rupture (and 50 percent risk of fetal death if rupture occurred).¹⁹⁸ In other words, there were no providers for the service because it was simply an inappropriate service to request. Therefore, the court held Pemberton culpable for the lack of access to the services she desired.

The operation of the culpability tool in *Pemberton* allowed the court to truncate its analysis of women's health. Given that the pregnant woman is responsible for the lack of available providers, her interests are more

¹⁹¹ See *id.* (describing her departure as "against medical advice" and "surreptitiously").

¹⁹² See *id.* at 1250 (the doctors testified that vaginal birth posed a substantial risk of death to the fetus).

¹⁹³ See *id.*

¹⁹⁴ See *id.* at 1249 (asserting substantive and procedural due process rights violations).

¹⁹⁵ See *id.* at 1251-52 (noting that Pemberton "affirmatively desired to deliver" the child, not terminate the pregnancy).

¹⁹⁶ See *id.*

¹⁹⁷ See David Dobbs, *VBAC Backlash*, SLATE.COM (Dec. 28, 2004),

<http://www.slate.com/id/2111499/> (describing the trend of hospitals banning VBACs);

John Zweifler et al., *Vaginal Birth After Cesarean in California: Before and After and Change in Guidelines*, 4 ANNALS OF FAM. MED. 228 (2006) (noting that after the adoption of restrictive VBAC guidelines in 1999, the number of VBACs declined more than ten percent, but neonatal and infant mortality rates failed to improve).

¹⁹⁸ See *Pemberton*, 66 F. Supp. at 1253 (noting a 2 to 2.2 percent risk of rupture, according to physicians).

easily subrogated to those of the fetus.¹⁹⁹ The nine-page decision focuses almost exclusively on the health of the “baby,” relegating women’s health issues to a few parenthetical references and one brief footnote.²⁰⁰ The court’s response to Pemberton’s assertion that the forced cesarean section was not without risk to her health was flippant: “Medical procedures rarely are [without risk].”²⁰¹ The court said there are risks to the pregnant woman but inferred from one expert’s failure to quantify them that the risks are minimal.²⁰² There was no discussion of the risk the cesarean section presented to Pemberton, despite the fact that cesarean sections present such health risks that federal agencies are actively working to reduce them.²⁰³

While *Pemberton* typifies a straightforward use of the culpability tool, it would be disingenuous to suggest that the culpability tool always results in a *Pemberton*-like analysis. The culpability tool’s application is not as uniform as the availability tool’s application. First, the culpability tool is not always used, even in cases where access to given reproductive health services is severely limited. Some cases, including compelled cesarean section cases, forgo the culpability tool altogether and focus on a detailed analysis of women’s health issues at the time of delivery.²⁰⁴ *In re Baby Boy Doe*, for example, exhaustively details the risks, both minor and major, a

¹⁹⁹ See *Rethinking (M)otherhood*, *supra* note 177, at 1339-40 (noting that a pregnant woman is seen as self-interested, thus her opinion is easily ignored by courts).

²⁰⁰ See *Pemberton*, 66 F. Supp. 2d at 1253-56 (saying “there is a very substantial risk of uterine rupture and resulting death of the baby (as well as serious injury to the mother)”; “based on the evidence disclosed by this record, this was an extraordinary and overwhelming case; no reasonable or even unreasonable argument could be made in favor of vaginal delivery at home with the attendant risk of death to the baby (and concomitant grave risk to the mother)”; “a vaginal birth in these circumstances would have presented a substantial risk of uterine rupture and resulting death of the baby, as well as substantial risk to the health of the mother”).

²⁰¹ See *id.* at 1254. Note the court’s use of the word “procedure” to describe a cesarean section, which is a major surgery that requires the opening of the abdominal cavity and movement of major organs.

²⁰² See *id.* Nowhere in the decision are the risks of a cesarean section described or discussed.

²⁰³ See Centers for Disease Control and Prevention, *Vaginal Birth After Cesarean Birth – California, 1996-2000*, MORBIDITY AND MORTALITY WEEKLY (Nov. 8, 2002) (declaring the reduction of cesarean sections to be a “national health objective”).

²⁰⁴ See generally *In re Baby Boy Doe*, 632 N.E.2d 326 (Ill. App. Ct. 1994) (conducting a detailed analysis of the impact cesarean sections have on women’s health and holding that a woman’s choice to refuse a cesarean section must be honored even when it will harm the fetus).

woman faces when she undergoes a cesarean section²⁰⁵ -- and, in doing so, goes out of its way to disclaim the pregnant woman of any fault or responsibility she bears for her situation.²⁰⁶ Although the number of identifiable compelled cesarean section cases is too small to make definitive generalizations, it appears that the cases that forgo the culpability tool instead emphasize women's health and autonomy.²⁰⁷ This makes sense: why would a court emphasize a woman's culpability if it wants to find in her favor? This returns us to one of the initial observations about the culpability tool -- it is judgmental -- and suggests that whether the tool is used at all may depend on the end result desired by the judge.

Reference to women's culpability is truly the last, dying gasp of the availability tool -- an attempt to use rhetoric of availability, even in the absence of alternatives. As such, the functioning of the culpability tool is less uniform and less predictable than that of the availability tool. Regardless, by virtue of the fact that it seeks to use reference to available alternatives as a tool at a time when alternatives may be utterly lacking, the culpability tool's mere existence reinforces the importance of available alternatives to judicial analysis of women's reproductive health cases.

IV. THE TOOLS' UTILITY: THEORETICAL V. ACTUAL

Theoretically, the availability tool protects women's reproductive health. It presumes that, when a law eliminates a reproductive health provider or procedure, that provider or procedure must be replaced with an alternative. Thus, the availability tool contains an underlying assumption that the reproductive health services currently on the market are either necessary for women's health, protected by law or both. Likewise, the culpability tool assumes that doctors should be permitted to protect women's health when women attempt to make a decision that may actually result in physical harm. When theory translates into practice, however, the availability and culpability tools often fall short.

²⁰⁵ *See id.* at 396 (discussing that the mortality rate for cesarean sections is double that of vaginal delivery; the increased recovery time and pain; and possible damage to other maternal organs).

²⁰⁶ *See id.* at 400 (saying it is the mother's actions that form the environment for the fetus, and "[t]hat this is so is not a pregnant woman's fault, it is a fact of life.").

²⁰⁷ *See id.*; *In re A.C.*, 573 A.2d 1235, 1256 (D.C. Ct. App. 1990) (majority not using the culpability tool and finding in the woman's favor, but Belson, J. concurring in part and dissenting in part citing woman's choice to bear a child as voluntarily putting herself in a "special class" of persons upon whom another's life depends totally).

While theoretically each tool has the potential to operate correctly (in that they correctly identify the impact a law may have on women's health), in reality, such application is difficult. The availability tool, for example, would work in an abortion procedure ban when there existed another procedure that had the exact same health risk-benefit profile as the banned procedure. If the judge in that hypothetical case cited the existence of the alternative procedure as protecting women's health in spite of the ban, he or she would be correct regardless of whether the judge adequately analyzed the substitute procedure's health risks and benefits. The culpability tool would "work" in a case where a pregnant woman facing 100 percent certainty of death if she chose vaginal delivery was compelled to have a caesarian section. "Work," in this case, means that the judge's hypothetical reference to her choice to continue her pregnancy post-viability and the refusal of doctors to assist her suicidal vaginal birth could be cited by the judge to find her culpable in her situation, thereby allowing the judge to subrogate the woman's interests to that of her doctor, partner, unborn fetus, etc. At this point, however, significant autonomy, privacy and sex-based equality interests would have to be adjudicated. As the cases show, these extreme scenarios are not the factual scenarios faced by most women or most judges.²⁰⁸

A significant question about the availability and culpability tools' operation remains: are judicial recitations of availability accurate? If the answer to that inquiry is "no," then use of the availability and culpability tools may actually pose risks to women's health, as judges may be overestimating access to reproductive health providers and procedures. If availability is underestimated, state interests may be inadequately protected.

Given that women's reproductive health cases deal with complex factual and medical scenarios, effective use of the availability and culpability tools can only take place when characterization of the availability is accurate and the tool is applied neutrally. Without both of these requirements being satisfied, the availability tool and culpability tool will continue to primarily function in a way that undervalues women's health relative to competing interests.

A. Identifying True Alternatives

To assess whether sufficient alternatives are available to protect women's reproductive health when a law threatens the continued availability of a reproductive health service, a judge must thoroughly

²⁰⁸ See *supra* Parts I-III (discussing contraception, abortion and childbirth cases).

understand the situation of the women seeking the product or provider and the landscape of alternatives.²⁰⁹ This is not a simple task. To the contrary, it is exceedingly complex. In reproductive health matters, the constitutionality of a law is determined not by whether the law threatens the health of the majority of women, but whether it threatens the minority, whose health concerns may be rarer, but more significant, their distance from providers greater, or their finances more precarious.²¹⁰

The cornerstone of the availability tool -- “availability” -- is undefined, thus it is left to judges to determine what available providers or procedures are sufficient to protect women’s health from the impact of the law in question. Judges who misidentify the relevant alternatives or who fail to do the in-depth examination necessary to determine whether there is a close enough “fit” between the threatened provider or procedure and its replacement may leave women’s health inadequately protected.

Instances of misidentified or mischaracterized availability are readily identifiable in reproductive rights jurisprudence. Take, for example, *Storemans v. Selecky*, the case involving pharmacist refusal.²¹¹ Recall that in *Storemans*, an issue was whether allowing pharmacists to refuse to fill contraceptives would harm women’s health -- and whether requiring pharmacists to so dispense violated their religious freedom.²¹² The court found in favor of the pharmacists, relying upon a survey that showed that out of 121 pharmacies, 93 typically stocked emergency contraceptives while 28 did not.²¹³ According to the appellate court, the presence of competing Plan B providers and the absence of any evidence of failure to access Plan B proved that there was no women’s health issue to be vindicated in the state of Washington.²¹⁴

²⁰⁹ A judge could take the availability tool even further by analyzing the impact that a regulation would have on the alternative provider’s entry into or exit from the market, but case law does not suggest this is typically done.

²¹⁰ *Casey* provides an excellent example of this point. The spousal notification provision was struck because a minority of women -- domestic violence victims -- would have suffered unduly from its requirements. 505 U.S. at 894 (finding that notification was an “undue burden” even though it may only impact less than 1 percent of women seeking abortions).

²¹¹ See *supra* Part IIA and accompanying text (discussing the case as an example of provider-based availability tool use).

²¹² See *id.*

²¹³ Of the pharmacies that did not stock Plan B, 18 cited low demand, three relied on an “easy alternative source,” and two cited religious or personal reasons. *Storemans v. Selecky*, 526 F.3d 406, 408-09 (9th Cir. 2008).

²¹⁴ See *id.*

The availability cited in *Storemans* was a red herring. It did not, in reality, prove that pharmacist refusal would not impact women's health. *Storemans* failed to address the type of availability at issue in the case: the presence of individual pharmacists willing to dispense Plan B. The statistics cited by the court focused on the number of pharmacies that stocked the drug, not pharmacists willing to dispense it.²¹⁵ At issue in the case was the willingness of individual pharmacists to dispense Plan B, not the willingness of pharmacies to stock Plan B.²¹⁶ It makes no difference to a woman needing Plan B if the pharmacy's shelves are stocked with Plan B if no pharmacist on duty will give it to her.

Moreover, although the statistics cited show that a majority of pharmacies stocked Plan B, almost one-quarter of the pharmacies did not. The court did not analyze the geographic distribution of the non-stocking pharmacies to see if they were clustered, thus threatening Plan B access for women in specific geographic areas. For the availability tool to function effectively in *Storemans*, the court needed to do a detailed analysis of the geographic distribution of the pharmacies that stocked Plan B (and those that did not), taking into consideration their location in relation to other providers (in the event of a refusal), item price, insurances accepted, hours open and, most significantly, the presence of individual pharmacists willing to dispense Plan B. Only then, could the *Storemans* court have determined whether the available alternatives protected women's health.²¹⁷ As that was not done, and as the court failed to identify true available alternatives -- pharmacists who would not refuse to dispense Plan B -- in its analysis, women's ability to prevent pregnancy, and thus their health, may be at risk post-*Storemans*.

The availability tool runs into similar problems in the abortion context. In abortion cases, determining the true availability of competing providers requires detailed analysis of available abortion services. Some providers may only be present in a state for one or two days per month, some providing only certain services.²¹⁸ Does the existence of these occasional, fly-in service providers adequately protect women's health when a full-time, in-state provider faces closure due to increased

²¹⁵ See *id.*

²¹⁶ See *id.*

²¹⁷ It is incumbent upon the advocate to define the level of availability so the jurist does not define it her or himself.

²¹⁸ See generally SUSAN WICKLUND, THIS COMMON SECRET: MY JOURNEY AS AN ABORTION DOCTOR (2008) (giving a first-hand account of traveling to multiple states per month to provide abortion services and detailing what services she would and would not provide).

regulations? And what is the result to women's health if the "available" provider relied upon in a case to protect women's health leaves practice?²¹⁹

The availability tool is only useful if enough facts are developed to allow the judge to understand both the threatened provider, service or product, and its replacement. This requires the parties to develop a complete factual record and present a sophisticated analysis of the competitive landscape. The need for expert medical testimony is almost guaranteed. Economists may also be needed to fully understand the relevant market. If such a record is not present, the judge should not endeavor to apply the availability tool. The analysis can only be as good as the information provided to the court. And that information is a prerequisite for determining if theoretical availability even exists, let alone is adequate.

Similar problems arise when judges use the culpability tool. The tool allows women to be blamed for their failure to access services at a time when there was widespread availability. According to some judges, the first time women narrow their own options is prior to viability, when women can abort their pregnancy but choose not to, thus subjecting them to state intervention.²²⁰ The result is that women are placed in the ultimate double bind -- they must access available services by terminating their pregnancy prior to viability or continue the pregnancy, making only those health choices supported by the particular providers or by a judge.²²¹ This line of reasoning is legally unsupportable. Describing women as culpable, in part, for their choice to continue a pregnancy penalizes them for exercising their constitutional right to have a child.²²² *Roe* gave states a negative right -- the right to prohibit most abortion post-viability -- but it did not grant the state a positive right to compel women to make certain health decisions post-viability. For this reason, the viability-culpability argument is an incorrect statement of the law and must be abandoned by courts using the culpability tool.

²¹⁹ See Jones et al., *supra* note 96, at 6 (noting the declining number of abortion providers in recent years).

²²⁰ See *supra* Part III and accompanying notes (discussing the operation of the culpability tool).

²²¹ Significantly, the availability and culpability tools fail to account for certain women's inability to access providers and services, specifically women with limited financial means.

²²² See *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972) ("If the right of privacy means anything, it is the right of the individual, married or single, to be free from unwarranted governmental intrusion into matters so fundamentally affecting a person as the decision whether to bear or beget a child.").

Whether women should be held culpable for a perceived lack of available alternatives is a much more difficult question. Certainly, the existence or lack of availability may provide a judge keen insight into whether a woman's choice is good or bad for her health. However, the lack of available medical services must be closely examined because the inability to access services may indicate the existence of economic constraints on providers or services -- not just that the service sought is somehow medically inappropriate for the woman.²²³

However, as the culpability tool hypothetical described, there may be situations where the woman's choice of medical treatment is bad for her health or, if she is pregnant, bad for the health of the unborn fetus. The question then becomes whether the culpability tool should be used to override a woman's autonomy.²²⁴ The presence of significant autonomy issues where the culpability tool is used should provoke caution in its users: the culpability tool can be the first step in a legal analysis, but a careful balancing of other interests -- autonomy included -- is the culpability tool's necessary corollary.

Unless the relevant availability of women's reproductive health care is thoroughly understood, the tools will function inaccurately -- and perhaps dangerously -- because they may facilitate an overestimation of the presence of available alternatives or allow mischaracterization of whether these alternatives are capable of protecting women's health.²²⁵ Moreover, superficial inculcations of availability are easily malleable and can be used as a means to a desired legal end.

B. Applying Tools Neutrally

The drive to accurately define what constitutes availability in any particular case assumes, of course, that the availability and culpability tools are being used neutrally in a search for the truth behind the availability of

²²³ See Rita Rubin, *Battle Lines Drawn of C-Sections*, USA TODAY, Aug. 23, 2005, available at http://www.usatoday.com/news/health/2005-08-23-csection-battle_x.htm (citing the fact that vaginal deliveries after cesareans are often not available to women because of legal and insurance concerns, not medical risk).

²²⁴ For a thorough discussion of autonomy generally see generally Dr. Kim Treiger-Bar-Am, *In Defense of Autonomy: An Ethic of Care*, 3 N.Y.U. J. L. & LIBERTY 548 (2008) (discussing the right to privacy as inherent in autonomy).

²²⁵ One meaningful check on whether availability actually protects women's health in a particular circumstance may be to examine women's ability to access services.

women's health services. That assumption may be incorrect. The tools may be entirely a means to an end.

Bias can be an issue at the very outset of the availability tool's use, when a judge is called on to define the relevant alternatives in a case. Having identified theoretical alternatives for a threatened service, a judge must determine how closely the theoretical replacement "fits" with the service threatened. In other words, at the conclusion of the case, must women have the safest options available to them, as they did prior to the restriction at issue, or is the availability of just safe options sufficient?²²⁶ How a judge answers that question may determine how she or he defines the relevant alternatives and the necessary "fit" in a case.

Proper use of the availability and culpability tools may also be hindered by another potential bias: the belief that low availability is present when there is low demand, and therefore a reproductive health service is not deserving of protection. Such a belief in the context of reproductive health services is unsupported. Statistics show that birth control is one of the most used reproductive health services in a woman's lifetime;²²⁷ abortion, although slowly declining in use, is still widely relied upon;²²⁸ and the availability of vaginal delivery, particularly after prior cesarean, is dwindling not due to women's desire, but because of regulatory and insurance constraints.²²⁹

Finally, both tools are subject to politically oriented misuse. Increasingly, judges in reproductive rights cases are not hiding their political leanings in decisions. In abortion cases, in particular, a pregnant woman may be referred to as a "mother," a fetus may be referred to as a "baby" and a physician who provides abortions as an "abortion doctor."²³⁰ In forced cesarean section cases, women are portrayed as selfish and uncaring for questioning the opinions of their physicians, regardless of the

²²⁶ See *supra* Part IIC (discussing the use of the terms "safe" and "safest" in *Stenberg and Gonzales*).

²²⁷ National Abortion Rights Action League, *Birth Control*, http://nara.org/issues/birth_control (saying 98 percent of women use birth control at some time in their life).

²²⁸ There were an estimated 1.2 million abortions provided in 2005. See *Abortion in the United States*, *supra* note 96, at 6.

²²⁹ See *supra* note 197 and accompanying text.

²³⁰ See *Gonzales v. Carhart*, 127 S. Ct. 1610, 1650 (2007) (noting that, in its rhetoric, "The Court's hostility to the right *Roe* and *Casey* secured is not concealed.") (Ginsburg, J., dissenting).

woman's motive or the ultimate birth outcome.²³¹ If the availability or culpability tool is surrounded by such hostile rhetoric, and if the application operates to further restrict women's health services, the neutrality of the application must necessarily be called into question.

CONCLUSION

Women's health advocates have reason to wince at the general notion that the existence of multiple providers or services alone protects women's health.²³² But given the breadth of women's health issues that have been adjudicated at least in part through the use of the availability and culpability tools, advocates on both sides would be wise to understand its workings.

The availability tool -- and even the culpability tool, to a limited extent -- has the potential to be useful in reproductive rights jurisprudence. These tools, however, must be only one part of a holistic analysis of women's health, including inquiries into relevant autonomy, privacy and equity rights and a subsequent weighing against competing interests.

Regardless of the use -- or misuse -- of the availability and culpability tools, their utility may be finite. Ironically, when the availability tool is used to uphold regulations that decrease access to providers or procedures, its utility weakens. Take, for example, *Greenville Women's Clinic*, which upheld regulations on the basis of the continued presence of available providers, but in doing so likely decreased competition.²³³ The next judge addressing a reproductive health controversy in that South Carolina area will have fewer providers to rely upon when deciding that case. Or consider *Gonzales*, which upheld a procedure ban on "partial-birth" abortions, leaving fewer substitute procedures.²³⁴ When the next federal procedural ban comes, will there be any available alternatives for the court to use the availability tool to decide the controversy?²³⁵

²³¹ See *In re A.C.*, 573 A.2d 1235, 1263 (D.C. Ct. App. 1990) (citing *In re Madyun*, appended, as saying, "It is one thing for an adult to gamble with nature regarding his or her own life; it is quite another when the gamble involves the life or death of an unborn child.").

²³² See generally OUR BODIES OURSELVES, *supra* note 32 (providing an exhaustive overview of the U.S. health care system and how women are disproportionately impacted by its shortcomings).

²³³ See *supra* notes 100-115 and accompanying text.

²³⁴ See *supra* notes 151-167 and accompanying text.

²³⁵ For example, could a surgical abortion ban be upheld based on the continuing availability of medical abortion? Might an argument suggesting that surgical abortion is

Use of the availability tool may only delay the very type of case both sides of the reproductive rights debate strive to avoid -- one demanding the resolution of a direct conflict between women's health and the state's desire to restrict a women's health provider or procedure, one in which no available alternative exists not because of women's actions, but because of government reproductive rights restrictions. It may be in this scenario, where neither the availability tool nor the culpability tool can function,²³⁶ that women become visible again.²³⁷

necessary for those women who decided to abort after the gestational cutoff for medical abortion be met successfully with culpability-based arguments that those women waived their right to abort by not deciding within the timeline required to access medical abortion?²³⁶ See Pamela Bridgewater, *Reproductive Freedom as Civil Freedom: The Thirteenth Amendment's Role in the Struggle for Reproductive Rights*, 3 J. GENDER RACE & JUST. 401, 407 (2000) (noting that "reproductive rights advocacy grounded on the idea of choice fails to deal with the question of access and resources").

²³⁷ See Elizabeth A. Reilly, *The Rhetoric of Disrespect: Uncovering Faulty Premises Infecting Reproductive Rights*, 5 AM. U. J. GENDER & L. 147, 157-58 (1996) (saying women as independent people are invisible in the law, and that the law views women only through their reproductive capacity).