

THE INVISIBLE WOMAN: AVAILABILITY AND CULPABILITY IN REPRODUCTIVE HEALTH JURISPRUDENCE

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Women's health is widely assumed to be a significant consideration in reproductive rights cases. Court decisions relating to contraception, abortion, and childbirth demonstrate that while this assumption may have historical validity, consideration of women's health is often truncated in recent reproductive rights jurisprudence. This occurs, in part, through the application of one or both of two recurring tools.

First, judges regularly—and often inaccurately—cite the theoretical availability of alternative reproductive health services as proof that women's health will not suffer even if a law curtailing reproductive rights is upheld. I label this the "availability tool." Second, when alternatives are not available, judges may blame women for the lack of available services or procedures. I call this the "culpability tool." Although the availability and culpability tools can be applied in a manner that appropriately considers women's health, often they are not. Thus, the availability and culpability tools contribute to the undervaluing of women's health in reproductive health jurisprudence.

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INTRODUCTION

“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 Specifically, the ability to control one’s fertility is a health issue: medical and surgical technologies that promote, prevent, or terminate pregnancy pose risks to women’s health,³ as do pregnancy and childbirth.⁴

1. HENRI-FRÉDÉRIC AMIEL, *AMIEL’S JOURNAL: THE JOURNAL INTIME OF HENRI-FRÉDÉRIC AMIEL* 104 (Mrs. Humphry Ward trans., MacMillan & Co. 2d ed. 1889) (1885).

2. See Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality 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 U.S. FOOD AND DRUG ADMIN., *BIRTH CONTROL GUIDE* (2009), <http://www.fda.gov/ForConsumers/ByAudience/ForWomen/ucm118465.htm> (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

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 women's health to further a political agenda.⁵

Reproductive health considerations have long been present in reproductive rights jurisprudence.⁶ Today, however, women's health is considered alongside an ever-increasing and ever-politicized array of highly charged competing interests, such as religious freedom, physicians' rights to practice as they see fit, and, most controversially, the rights, if any, of a fetus.⁷ As women's health competes with other interests of potentially constitutional dimensions, it triggers a legally and ideologically loaded confrontation that judges quite understandably may want to avoid.

An analysis of recent, major reproductive rights decisions involving contraception, abortion, or childbirth reveals that judges can—and do—avoid or abbreviate consideration of the impact a law may have on women's health by looking to the health care marketplace for available alternatives to the

tract infections, and toxic shock syndrome)); *see also infra* Part II.B(2) (including cases that discuss the risks of various abortion procedures).

"Women's health," as used in this Article, includes all mental or physical health considerations that can impact women's ability to fully participate in society, including the ability to choose whether, when, and how to become a mother, and to have access to the safest medical services necessary to effectuate that choice.

4. One in 4,800 women dies from "pregnancy-related causes" in the United States during their lifetime ranking it 41st in the world in maternal mortality. *See WOMEN DELIVER, MATERNAL MORTALITY SCORECARD (2007)*, [http://www.womendeliver.org/fact/MM_Country_Rankings_factsheet_\(A4\).pdf](http://www.womendeliver.org/fact/MM_Country_Rankings_factsheet_(A4).pdf) (citing Ireland as having the lowest mortality rate of 1 in 47,600, and noting that the study "almost certainly understate[s]" the problem).

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 women's reproductive health concerns are used disingenuously by pro-abortion rights advocates to argue for fewer abortion restrictions. *See Jason Linkins, McCain Mockingly Suggests that Concerns for a Mother's Health are Extreme*, HUFFINGTON POST, Oct. 15, 2008, http://www.huffingtonpost.com/2008/10/15/mccain-mockingly-suggests_n_135072.html.

6. *See, e.g., Stenberg v. Carhart*, 530 U.S. 914, 937–38 (2000) (discussing the fatal lack of a health exception in a "partial-birth" abortion ban); *Hodgson v. Minnesota*, 497 U.S. 417, 465–67 (1990) (discussing the potential health impact parental notification has on minor women's health); *Carey v. Population Servs. Int'l*, 431 U.S. 678, 690 (1977) (explaining that restrictions on the sale of "nonhazardous" contraception did not further a state interest in health); *Roe v. Wade*, 410 U.S. 113, 144–53 (1973) (discussing the health risks to women from illegal abortion and from pregnancy itself).

7. *See infra* Parts II–III.

threatened reproductive health service.⁸ If such alternatives are available, judges may cite them both as guarantors of women's continuing ability to access the service needed and as vindicators of women's reproductive health.⁹ I call this the "availability tool." The problem with the availability tool is this: when applied incorrectly, it focuses the analysis primarily, if not *solely*, on the *ends* desired (e.g., can women still terminate a pregnancy even in the face of an abortion procedure ban?) and neglects the importance of the *means* (e.g., whether the remaining abortion method is as safe or safer than the one banned).

When judges use the availability tool, the availability invoked may appear in one or more of several forms. It may take the form of the citation of statistics on the use of a specific product or service and the identification of potential substitutes.¹⁰ A judge may compare different services or even providers.¹¹ Regardless of the type of availability discussed, availability of alternatives often serves as a surrogate for a complete analysis of how the law at issue would impact women's health.

Hypothetically, the availability tool can be used to protect women's health—in fact, there are cases where courts do just that—but often the availability tool, as applied, is an analytical shortcut that shortchanges women. Consider a hypothetical jurisdiction where the only methods of birth control available are diaphragms, oral contraception, and intrauterine devices ("IUDs"). If a law banning diaphragms was passed, for example, a judge *incorrectly* applying the availability tool might uphold that law, citing women's ability to access the alternative birth control methods, oral contraceptives or IUDs, as evidence that a diaphragm ban would not impact women's health. However, a correct application of the availability tool should lead to the diaphragm ban's demise. The judge who correctly uses the availability tool would not stop at a mere citation of available alternatives as guarantors of women's health. The

8. See *infra* Part II. Compare Alex M. Azar II, Deputy Sec'y of Health and Human 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 A13 (citing sociologist Carole Joffe as questioning whether abortion is truly part of the health care industry or is instead part of a social movement).

9. See *infra* Part II.

10. See *infra* Part II.

11. See *infra* Part II.

judge should find that no true replacement for diaphragms is available for women in this hypothetical jurisdiction: oral contraceptives are contraindicated for women with certain cardiovascular risks, and IUDs are contraindicated for women with a history of pelvic infection and, perhaps, for women who want to have children in the future.¹² Theoretically, because the diaphragm can be a safer method for certain populations of women, the ban should fail if the tool is applied correctly. In fact, in this hypothetical, banning *any* of the three contraceptives would increase the health risks for some women by either making the most effective method of pregnancy prevention unavailable for those women (thus making pregnancy and its attendant risks more likely), imposing increased health risks presented by the non-banned methods themselves, or both.

As the hypothetical diaphragm ban shows, the proper application of the availability tool requires two steps: (1) identifying available, potential substitutes for the provider, product, or service in question; and then (2) analyzing whether those alternatives are *true* substitutes with equivalent or better health risk profiles. In other words, inquiring about the availability of alternatives is appropriate, but judges must also determine whether the available alternatives are adequate substitutes given all health considerations in order for the tool to be used in a way that vindicates women's health interests. An analysis of relevant jurisprudence shows that judges often use the availability tool, as it is identified and described in this Article, incorrectly: judges complete step one of the tool but neglect step two, thus failing to complete the analysis.¹³ This is not to say that women's health is not mentioned or even briefly discussed in these cases—it often is—but the analysis of the impact on women's health is often perfunctory.¹⁴ In such decisions, judges frequently point to the presence of theoretically available alternative reproductive health services without per-

12. See KAREN J. CARLSON ET AL., THE NEW HARVARD GUIDE TO WOMEN'S HEALTH 319 (2004) ("IUDs are generally not considered a good choice of birth control for women who want to bear children in the future"); ALAN H. DECHERNEY ET AL., CURRENT DIAGNOSIS AND TREATMENT: OBSTETRICS & GYNECOLOGY 581–90 (10th ed. 2007) (describing the relatively minor risks of diaphragms; the comparatively major risks of oral contraceptives, especially for women with diabetes and certain cardiovascular diseases; and the rare but serious risk of uterine complications presented by IUDs, especially in certain women).

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

14. See *infra* Part II.

forming a nuanced analysis of the impact a legal restriction may have on women's health (either generally or on a specific class of women).¹⁵

The availability tool cannot be used in all cases. Most notably, it should be useless when there is no available alternative for the product, procedure or practitioner being regulated. However, when alternatives are not available, judges may suggest that women themselves are culpable for a perceived failure to access reproductive health services at a time when alternatives may have been 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.¹⁶ In these cases, which include abortion and court-ordered cesarean section decisions, the weight of the woman's health interest—even when discussed—is downplayed because the woman is presented as having voluntarily waived previously available options.¹⁷

Childbirth-related controversies provide an ideal backdrop for the application of the culpability tool. When a laboring woman refuses to have a cesarean section despite her physician's contrary advice, that physician may seek a court order requiring the woman to have the surgery against her will, and the judge may cite the woman's alleged failure to find an obstetrician willing to support her preferred delivery method as evidence her decision is wrong, thus portraying the lack of available delivery options as her own fault.¹⁸ This application of the culpability tool fails to adequately account for the risks to the woman's health that a cesarean section poses (regardless of any culpability on her part), and it also fails to examine whether the pregnant woman's inability to locate a provider willing to supervise her chosen delivery method was truly because her request was medically unsound or stemmed from market-based issues such as the limited availability of obstetrical care in a particular location.

15. See *infra* Part II.

16. See *infra* Part III (discussing how some courts cite a woman's choice not to terminate a pregnancy as the basis for accepting state regulation of the pregnancy).

17. See *infra* Part III.

18. See *infra* Part III.

Hypothetically, the culpability tool could function to protect women's health. Such could be the case in the unlikely event where a woman makes a medical decision that is truly unwise and is certain to result in her death and fetal death, for example. But, in this unlikely scenario, the court would still have to wrestle with a woman's strong autonomy interest.¹⁹

This Article (1) identifies and labels the operation of the availability and culpability tools in several significant reproductive rights decisions; (2) describes how those tools are applied in different reproductive health contexts (preventing pregnancy, terminating pregnancy, and obtaining obstetrical services); and (3) questions whether the use of these tools impacts women's health, either beneficially or detrimentally. This analysis demonstrates that although the tools have the ability to vindicate women's health, more often their use results in the undervaluing of women's health relative to competing interests. Thus, the availability and culpability tools, as typically applied, contribute to the de-emphasis of women's health in significant reproductive rights decisions.

This Article neither claims that the tools are universally present in all reproductive health cases nor asserts that their presence explains the outcome of all reproductive health cases.²⁰ Rather, it identifies, labels, and describes the tools' recent and repeated use by federal and state courts, suggests that their historic and current use will continue to impact judicial analysis of women's reproductive health issues, and finally examines the true utility of the tools going forward.

Part I of this Article provides an overview of the significant role reproductive rights play in women's push for equality, briefly tracing the evolution of reproductive health law and policy from the early twentieth century to present.

Part II discusses the availability tool. Section A argues that *Planned Parenthood v. Casey* created a jurisprudential environment in which the availability tool (and its counterpart,

19. See *infra* Part III.

20. The number and type of reproductive rights cases is vast. For this Article, I examined recent precedent representative of three phases in many women's reproductive lives: pregnancy prevention (federal cases involving pharmacists' refusal to dispense contraception), pregnancy termination (federal cases involving abortion providers or procedures), and childbirth (state 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 some of the most significant—and binding—recent reproductive rights decisions.

the culpability tool) can thrive. Next, it explains how the availability tool functions in actual controversies, showing that the manner of application significantly impacts whether women's health is adequately valued. Section B focuses on cases in which provider availability is threatened, and Section C examines cases in which procedure availability is threatened.

Part III describes the culpability tool and how it holds women responsible for their alleged role in the narrowing of their reproductive health care options. Section A identifies and describes the two most common reproductive-health-related choices women make that may subsequently be used against them via the culpability tool. Section B examines cesarean section case law, demonstrating that the culpability tool often functions in a way that may unfairly assign blame to women, truncates women's health analyses, and ultimately leads courts to undervalue women's health interests relative to competing interests.

Part IV discusses whether there is a legitimate, ongoing use for the availability and culpability tools. From a normative perspective, Section A finds that the availability and culpability tools can theoretically be used in ways that adequately value women's health but asserts that the requisites for proper application are onerous and often not followed by courts. Section B sets forth the minimum criteria for the tools to operate successfully in real cases involving women's reproductive health issues.

I. THE SIGNIFICANCE OF WOMEN'S REPRODUCTIVE HEALTH

Women's ability to safely control their reproductive capacity has long been central to women's struggle for equality.²¹ 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 shall become a mother."²² Then and now, birth control was seen by many as necessary to enable women's full participation

21. See ALEXANDER SANGER, *BEYOND CHOICE: REPRODUCTIVE FREEDOM IN THE 21ST CENTURY* 71 (2004).

22. See *id.* at 33. See generally RICKIE SOLINGER, *PREGNANCY AND POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA* (2005) (describing the history of reproductive politics).

in society.²³ And when women experienced an unplanned pregnancy, many accessed abortion services—legal or not.²⁴

Throughout the twentieth and twenty-first centuries, as women's ability to regulate their reproductive lives grew, so did the recognition that such control impacted women's equality.²⁵ The legal recognition of the right to access contraception for married persons in 1965 and for unmarried couples in 1972 enabled women to improve their status in both the private and public sphere by allowing them to plan childbearing and enter the paid labor force.²⁶ 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.²⁷

Legal recognition of abortion rights soon followed. In 1973, *Roe v. Wade* established the legal right to have an abortion. In doing so, the foundational case cited the significance of women's health literally dozens of times, discussing both the health risks posed by pregnancy itself as well as by abortion.²⁸

23. 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 reproductive capacity from ancient Greece to present).

24. See SANGER, *supra* note 21, at 19–47 (tracing reproductive rights debates prior to the eighteenth century through today); SOLINGER, *supra* note 22, at 118 (stating that 25–40 percent of all pregnancies were terminated during the depression).

25. See Naomi Cahn & Anne T. Goldstein, *Roe and Its Global Impact*, 6 U. PA. 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.”); Reva B. Siegel, *Sex Equality Arguments for Reproductive Rights: Their Critical Basis and Evolving Constitutional Expression*, 56 EMORY L.J. 815, 819 (2007) (arguing 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).

26. See JUDITH F. DAAR, REPRODUCTIVE TECHNOLOGIES AND THE LAW 104–17 (2006) (discussing the impact of *Griswold v. Connecticut*, 381 U.S. 479 (1965), legalizing contraceptives for married couples and *Eisenstadt v. Baird*, 405 U.S. 438 (1972), legalizing contraception for individuals); 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, 317 (2006) (concluding through empirical analysis of employment data that contraceptive availability catapulted women into the workplace). *But see* GARY S. BECKER, A TREATISE ON THE FAMILY 106–07 (1981) (asserting that birth control was merely part of the reason why fertility rates declined in the United States).

27. See NARAL Pro-Choice America, Issues: Birth Control, http://nalar.org/issues/birth_control/ (last visited Feb. 9, 2009).

28. See *Roe v. Wade*, 410 U.S. 113, 153 (1973) (“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.”).

Now, approximately one-third of all women in the United States have an abortion at some point in their lives.²⁹

The Supreme Court has resisted efforts to overturn *Roe*, even saying that “[t]he 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.”³⁰ But the Court faces a crush of litigation over the contours of reproductive rights, and ultimately has allowed substantial government restrictions to be placed on their exercise.³¹

Despite the limited legal protections afforded by reproductive rights jurisprudence and the medical advances in reproductive health technology, women today still face substantial reproductive health risks.³² Pregnant women in the United States are subject to significant pregnancy-related morbidity and mortality.³³ Contraceptives, even when accessible, still pose health risks³⁴ and development of new contraceptives is

29. See GUTTMACHER INSTITUTE, IN BRIEF: FACTS ON INDUCED ABORTION IN THE UNITED STATES (2008), http://www.guttmacher.org/pubs/fb_induced_abortion.html (explaining that 50 percent of women having abortions are younger than twenty-five and 60 percent of all abortions are sought by women who have one or more children).

30. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 856 (1992).

31. 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. For an in-depth analysis of this issue, see B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277 (2007), which argues that a general right to make autonomous medical decisions is found in Supreme Court jurisprudence.

32. See June Carbone, *If I Say “Yes” to Regulation Today, Will You Still Respect Me in the Morning?*, 76 GEO. WASH. L. REV. 1747, 1748–50 (2008) (asserting that African-Americans have greater rates of reproductive health illness, likely because of less access to medical care). 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).

33. See WOMEN DELIVER, *supra* note 4 (discussing maternal mortality worldwide); see also *infra* Part III (discussing various childbirth-related health issues). See generally HEIDI MURKOFF & SHARON MAZEL, WHAT TO EXPECT WHEN YOU’RE EXPECTING (4th ed. 2008) (detailing the myriad of health issues that can be caused or complicated by pregnancy).

34. See KATHARINE T. BARTLETT & DEBORAH L. RHODE, GENDER AND LAW: THEORY, DOCTRINE, COMMENTARY 855–56 (4th ed., Aspen Publishers 2006) (discussing the history of tort litigation surrounding the risks of various birth control technologies and emphasizing problems with Dalkon Shield intrauterine devices); BOSTON WOMEN’S HEALTH BOOK COLLECTIVE, OUR BODIES, OURSELVES: A NEW EDITION FOR A NEW ERA 326–80 (35th Anniversary ed. 2005) (arguing that birth control is often approved by the Food and Drug Administration before its long-term health effects are understood and detailing the health risks of every major contraceptive technology); David Voreacos & Patricia Hurtado, *J&J Pays \$1.25*

slow.³⁵ Continuing limitations on the availability of abortion providers and procedures curtail women's ability to safely plan whether and when to have a child.³⁶ In short, inadequate access to safe, affordable reproductive health care continues to result in a tangible loss of liberty for women.³⁷

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. It is difficult to decouple women's health from the polarizing moral and political controversies surrounding their reproductive capacity—controversies that any person—judge or not—may understandably want to avoid. As the cases discussed below demonstrate, the availability and culpability tools facilitate such avoidance.

II. AVAILABILITY

The availability of alternative reproductive health services and products is cited in myriad reproductive rights cases, in varying manners and to varying degrees.³⁸ For example, in

Million to Settle Suit Over Death of 14-Year-Old, BLOOMBERG, 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 a contraceptive patch).

35. 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 United States is in the “backwaters” of contraceptive development).

36. 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 residents showing that 79 percent opposed abortion when the rationale for the decision was concern over the effect of childbearing on a woman's career).

37. See *Planned Parenthood of Se. Pa. 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.”); see also Rebecca J. Cook, *Human Rights and Reproductive Self-Determination*, 44 AM. U. L. REV. 975, 984 (1995) (noting that women's participation in society outside the home continues to be balanced against their reproductive capacity).

38. It is worth noting that the reproductive health care market's operation is not completely understood from an economic standpoint. See Deborah Haas-

pharmacist refusal controversies, in which pharmacists decline to dispense contraceptives (whether by prescription or over-the-counter) for religious or personal reasons, the presence of other pharmacies or pharmacists may be cited to show that the refusal of any one provider to dispense birth control will not impact women's health.³⁹ But the availability of large numbers of competing providers or procedures is not required to use the availability tool: in areas of more limited availability, such as abortion, reliance on the availability tool is identifiable.⁴⁰ In each area of reproductive health jurisprudence, the manner in which the availability tool is employed may differ, but the result is almost always the same: consideration of women's health is truncated based on an unstated yet apparent assumption that the availability of other health services will protect women from any significant adverse impact from the regulation in question.⁴¹ Although they do exist, cases in which the availability tool appropriately analyzes women's health interests appear to be few and far between.

Part II describes the modern jurisprudential underpinnings of the availability tool and how its application impacts reproductive health jurisprudence. Section A discusses *Planned Parenthood v. Casey*⁴² and how both its rhetoric and its adoption of the "undue burden" standard invited further reliance on the presence of availability in reproductive rights analysis.⁴³ Sections B and C analyze judicial use of the availability tool—specifically, how judges use references 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 availability tactics to discuss their collective import in reproductive rights jurisprudence.

Wilson & Kristen Lindberg, *Regulation and the Optimal Size and Type of Abortion Provider*, 31 APPLIED ECON. 409, 409 (1999).

39. See *infra* Part II.B.

40. See *infra* Part II.B.

41. 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 reasons.

42. 505 U.S. 833.

43. See *infra* Part II.A.

A. *Availability Facilitated: Planned Parenthood v. Casey*

Casey's impact on reproductive rights jurisprudence is irrefutable.⁴⁴ The 1992 case simultaneously addressed a panoply of abortion restrictions:⁴⁵ it affirmed *Roe v. Wade's* general protection of a woman's right to have an abortion,⁴⁶ rejected *Roe's* trimester framework for judging the constitutionality of abortion restrictions,⁴⁷ and adopted the "undue burden" standard for adjudicating reproductive rights disputes.⁴⁸ *Casey's* impact reverberates today: by explicitly linking women's reproductive health to women's participation in the economy and by introducing the undue burden standard, *Casey* arguably facilitated 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,"⁴⁹ husband notification,⁵⁰ parental consent regulations,⁵¹ a mandatory waiting period prior to receiving abortion services,⁵² and the extensive regulation of facilities

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

45. See *Casey*, 505 U.S. at 844.

46. *Id.* at 869–71.

47. *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).

48. *Id.* at 874–79 ("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.").

49. *Id.* at 881–83 (explaining that "informed consent" requires that a woman be provided with state-authored materials prior to terminating a pregnancy and holding that the law was a constitutionally permissible expression of the state's preference against abortion).

50. *Id.* at 887–98 (finding that the husband notification requirement posed a substantial obstacle for women facing domestic violence, thus violating their constitutional rights).

51. *Id.* at 899–900 (upholding the parental consent requirement and noting that such a requirement had been upheld in several prior U.S. Supreme Court cases).

52. *Id.* at 886–87 (describing the twenty-four hour "waiting period" as potentially increasing women's exposure to anti-abortion protester harassment and being particularly burdensome for rural or poor women, but upholding the regulation).

where abortions were provided.⁵³ Most significantly, *Casey* presented the Court with the opportunity to overturn *Roe*.⁵⁴

In 1973, *Roe* established a woman's constitutional right to have an abortion and outlined the trimester framework for judging the constitutionality of abortion regulations.⁵⁵ In the first trimester of a woman's pregnancy, the pregnant woman and her physician controlled the decision to terminate a pregnancy; during the second trimester, the state could regulate abortion for the purpose of protecting women's health; and post-viability, the state could outlaw abortion as long as it provided an exception for the life and the health of the pregnant woman.⁵⁶ *Roe* centered on the premise that the health of the pregnant woman was of paramount concern, regardless of whether the risks at issue related to the abortion or to health concerns stemming from the pregnancy itself.⁵⁷

Although *Casey* preserved *Roe*'s holding protecting a woman's constitutional right to have an abortion,⁵⁸ it rejected the trimester framework in favor of 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 of a nonviable fetus."⁵⁹ Using this new standard, *Casey* upheld all of the regulations at issue in the case save for the husband-notification requirement (and its related record-keeping requirements).⁶⁰ *Casey*'s impact has extended far beyond the original controversy in question. Its undue burden test markedly altered the way in which jurists approach questions of women's health, including facilitating the application of the availability tool.

53. *Id.* at 900–01 (upholding various record-keeping requirements, but finding those related to husband notice unconstitutional).

54. "Liberty finds no refuge in a jurisprudence of doubt. Yet nineteen years after our holding that the Constitution protects a woman's right to terminate her pregnancy . . . that definition of liberty is still questioned." *Id.* at 844 (citation omitted).

55. *Roe v. Wade*, 410 U.S. 113 (1973) (establishing the framework by which state regulation of abortion was judged until the *Casey* decision).

56. *Id.* at 163.

57. *See id.* at 113; *see also* CELESTE MICHELLE CONDIT, *DECODING ABORTION RHETORIC: COMMUNICATING SOCIAL CHANGE* 99–100 (1990) (quoting Sara Wedington, *Roe*'s attorney, as asserting that pregnancy "is perhaps one of the most determinative aspects of [a woman's] life," disrupting her body, education, employment, and family).

58. *See Casey*, 505 U.S. at 845–46.

59. *See id.* at 872–77.

60. *Id.* at 900–01.

Although judges applied the availability tool in reproductive health cases prior to *Casey*, *Casey* further enables its application.⁶¹ First, it explicitly ties the availability of reproductive health services to women's ability to participate in the public sphere. Second, *Casey*'s undue burden test de-emphasizes women's health as an interest. *Casey*, therefore, simultaneously emphasizes access and puts the importance of women's health on uncertain terms. Moreover, under the undue burden standard, issues of access to reproductive services and health can be treated simultaneously, making it easy to assume—correctly or incorrectly—that access and health questions should be treated as interchangeable and analyzed accordingly.

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 views of themselves and their places in society, in reliance on the *availability* of abortion in the event that contraception should fail. The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.⁶²

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 protects women's autonomy. Although this rhetoric may be pleasing to some, it fails to separate the significance of women's sheer ability to access reproductive health services from their ability to access them as safely as possible.

Arguably, the shift from the *Roe* trimester framework to the *Casey* undue burden standard signaled a de-emphasis of women's health in reproductive health jurisprudence. *Roe*'s protection of women's health was two-fold: its framework centered on whether abortion regulations were "promoting" the state interest in women's health and, additionally, required an exception for the protection of women's health as other interests became compelling.⁶³ *Casey*'s undue burden test aban-

61. See *infra* note 137 and accompanying text.

62. *Casey*, 505 U.S. at 856 (emphasis added).

63. *Roe v. Wade*, 410 U.S. 113, 164–65 (1973).

doned the notion that protecting women's health should be a central state interest. Under the undue burden standard, some burden on the woman is acceptable: the total burden on a woman is simply judged to be substantial or not.⁶⁴ The question is, then, how much of a burden on a woman's health must exist for it to be "substantial"? Do women have a right to the *safest* procedure or service or simply a *safe* procedure, however (and by whomever) that is defined?⁶⁵ This question has direct bearing on the operation of the availability tool because it goes to how close of a "fit" an available alternative has to be in order to be considered sufficient to protect women's health. The change from the trimester framework to the undue burden standard, therefore, makes it easier to misapply the availability tool.⁶⁶

Under the undue burden standard, health issues can be considered side-by-side with issues of access, so health concerns can—correctly or incorrectly—be compensated for by the presence of competition, ensuring that no health burden rises to the level of being "substantial" or "undue."⁶⁷ As will be seen in cases discussed below, 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 assuage concerns that a regulation burdens women's health. It is worth noting, however, that the tool sometimes demonstrates the lack of available and suitable alternatives and thus compels a law's downfall.⁶⁸

64. See Gillian E. Metzger, *Unburdening the Undue Burden Standard: Orienting Casey in Constitutional Jurisprudence*, 94 COLUM. L. REV. 2025, 2033 (1994) (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).

65. See *id.* (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").

66. See Caitlin E. Borgmann, *Winter Count: Taking Stock of Abortion Rights After Casey and Carhart*, 31 FORDHAM URB. L.J. 675, 699–700 (2004) (suggesting that *Casey* "subsumed" the medical exception within the undue burden test, rather than requiring two separate analyses). *Stenberg v. Carhart*, 530 U.S. 914, 923–38 (2000), suggested that a separate analysis was required in some cases. Metzger, *supra* note 64, at 706. However, as we will see in later cases, courts continue to conflate the health and undue burden analyses and do so with the aid of the availability tool. See *infra* Parts II.B–C.

67. See SANGER, *supra* note 21, 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).

68. See *generally* *infra* Parts II.B–C.

Casey's impact is not limited to cases in which the undue burden standard applies. Its tandem consideration of health and availability provides a roadmap for the use of the availability tool in non-abortion reproductive health cases as well. For example, in a recent case involving pharmacists who wanted the right to refuse to provide contraception to women, both the district and appellate court weighed women's health against other asserted interests, including freedom of religion.⁶⁹ In that case, courts used the perceived availability of reproductive health services to recast women's health as a non-constitutional "convenience" interest, a tactic analogous to the sublimation of women's health to state interests in *Casey's* undue burden analysis.⁷⁰

Examining individual reproductive health cases provides a window into how the availability tool functions. Decisions show that references to availability appear in two primary forms: courts cite the presence of competing reproductive health *providers* and *procedures* as counteracting the potential health risks posed by restrictions on reproductive health care.

B. The Availability of Alternative Providers

When a law impacts the number of reproductive health service providers, judges can use the availability tool to determine whether that law burdens women's health. For example, in a hypothetical case where a judge must analyze the constitutionality of a law banning midwives from performing abortions, a judge perfunctorily applying the availability tool might cite the general availability of competing providers, such as physicians, to show that the ban on midwife providers will not have a deleterious impact on women's health. A more nuanced application of the availability tool could find that such a ban could threaten the health of certain women, namely rural women served primarily by midwives due to a lack of available obstetricians. The extent to which alternative providers are available and thus adequately protect women's health is at issue in contraception- and abortion-related cases applying the availability tool. Whether related to pregnancy prevention or termination, these cases show that accurate identification of available alternative providers determines whether the avail-

69. See generally *infra* Parts II.B–C.

70. See *infra* notes 103–05 and accompanying text.

ability 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 (whether by prescription or over-the-counter) and the range of contraception options.⁷¹ The variety of contraception options likely reflects widespread support for this particular reproductive health technology.⁷² Support for contraception is not universal, however. This is particularly the case with emergency contraception,⁷³ post-intercourse contraception used either when pre-intercourse contraception is not used or when it fails.⁷⁴

71. The U.S. hormonal contraceptives market, including oral contraceptives and hormonal IUDs, is valued at approximately \$2.5 billion annually. See Aude Lagorce, *Schering AG Storms Birth Control Market*, FORBES, July 11, 2003, 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>.

72. See Press Release, 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).

73. Emergency contraception is often referred to as "the morning after pill." See *id.* Regular prescription hormonal contraceptives can be used post-intercourse as emergency contraception. Planned Parenthood, Emergency Contraception (Morning After Pill), <http://www.plannedparenthood.org/health-topics/emergency-contraception-morning-after-pill-4363.htm> (follow "How Do I Use Emergency Contraception?" hyperlink) (last visited Mar. 3, 2009) (listing more than twenty pills that can be used as emergency contraception). Common brand-name emergency contraceptives include Plan B and Plan B OneStep. See Duramed Pharmaceuticals, Inc., Plan B One-Step Consumer: What is Plan B One-Step?, <http://www.planbonestep.com/what-is-plan-b.aspx> (last visited Sept. 27, 2009). Although Plan B is a brand name, it is also sometimes used colloquially as a general descriptor for all post-intercourse contraception.

74. See Press Release, Harris Interactive, *supra* note 72 (finding that only 58 percent of respondents think emergency contraception should be "easily available," but also finding that only 62 percent think pharmacists should not be allowed to refuse to dispense it). Contraceptive-related controversies have not been confined to only Plan B, however. Traditional oral contraceptives have also been the subject of pharmacist refusal. See CRISTINA PAGE, HOW THE PRO-CHOICE MOVEMENT SAVED AMERICA: FREEDOM, POLITICS AND THE WAR ON SEX 1–2 (2006) (retelling the stories of several women who were refused contraceptives at pharmacies across the country).

According to the U.S. Food and Drug Administration, Plan B, perhaps the most well-known form of emergency contraception,

works like a birth control pill to prevent pregnancy mainly by stopping the release of an egg from the ovary. It is possible that Plan B may also work by preventing fertilization of an egg (the uniting of sperm with the egg) or by preventing attachment (implantation) to the uterus (womb), which usually occurs beginning 7 days after release of an egg from the ovary. Plan B will not do anything to a fertilized egg already attached to the uterus. The pregnancy will continue.⁷⁵

Given that emergency contraception such as Plan B functions by interrupting a biological sequence of events, it is crucial that it be taken as soon as possible after intercourse.⁷⁶ Plan B may be available from a variety of sources, including pharmacies, where it is kept behind the counter. No prescription is necessary for women ages seventeen and over, but a prescription is necessary for women sixteen and younger.⁷⁷ By one account, Plan B is responsible for almost half of the decline in the number of abortions between 1994 and 2000.⁷⁸

Some pharmacists believe that emergency contraception such as Plan B functions as an abortifacient, rather than a con-

75. See U.S. Food and Drug Admin., Plan B: Questions and Answers (Dec. 14, 2006), <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm109783.htm>.

76. See *id.* (“Data shows Plan B is more effective the sooner treatment is started following unprotected sex.”); PAGE, *supra* note 74, at 99–100 (noting that the chance of pregnancy if taken within 24 hours of intercourse is 0.4 percent, and the likelihood increases to 2.7 percent if taken between 24 and 72 hours after intercourse).

77. In 2009, a federal court ordered the FDA to permit pharmaceutical companies to make Plan B available without a prescription to 17-year-old young women. *Tummino v. Torti*, 603 F. Supp. 2d 519, 550 (E.D.N.Y. 2009). Subsequently, multiple formulations of Plan B (as well as a generic version) were approved for over-the-counter use by women ages 17 and older. U.S. Food and Drug Admin., FDA Approves Plan B One-Step Emergency Contraceptive; Lowers Age for Obtaining Two-Dose Plan B Emergency Contraceptive without a Prescription (July 16, 2009), <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM109775>; Press Release, Watson Pharmaceuticals, Inc., Watson Pharmaceuticals Receives FDA Approval For Generic Plan B for Over-the-Counter Use (Aug. 28, 2009), <http://ir.watson.com/phoenix.zhtml?c=65778&p=RssLanding&cat=news&id=1325502>.

78. See Rachel K. Jones et al., *Contraceptive Use Among U.S. Women Having Abortions in 2000–2001*, 34 PERSP. ON SEXUAL & REPROD. HEALTH 226 (2002), available at <http://www.guttmacher.org/pubs/journals/3429402.pdf> (discussing the decline between 1994 and 2000).

traceptive and therefore refuse to dispense emergency contraception, saying that it violates their religious or personal beliefs.⁷⁹ Many women, on the other hand, argue that such refusal jeopardizes their ability to use the drug in a timely manner, thus diminishing their chance to prevent an unplanned pregnancy.⁸⁰ Pharmacist refusal has sparked heated reactions on both sides of the debate, prompting several states (and pharmacy boards) to confront the issue: some protect pharmacists' ability to refuse and others limit it.⁸¹ Although pharmacist refusal has the potential to impact women's health, litigation over pharmacist refusal tends to focus on the conflict between an employer and the religious rights of a pharmacist.⁸²

Access to emergency contraception and its relative impact on women's health was squarely before a court, however, in one recent case. *Stormans, Inc. v. Selecky* was brought by pharmacists and a pharmacy in an effort to stop the enforcement of

79. An abortifacient is a substance that causes pregnancy to end prematurely and causes an abortion. MERRIAM-WEBSTER'S COLLEGIATE DICTIONARY (11th ed. 2003). One group of pharmacists who opposes abortion and describes Plan B as an abortifacient is Pharmacists for Life International. See generally Pharmacists for Life International, Plan B [Emergency Abortion Pill] FAQs, <http://www.pfli.org/main.php?pfli=planbfaq> (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). For purposes of this Article, I focus on pharmacist refusal; however, other pharmacy workers may also refuse to participate in work they find objectionable.

80. For more information, see National Women's Law Center, The Pharmacy Refusal Project, <http://www.nwlc.org/details.cfm?id=2185§ion=health> (last visited Feb. 9, 2009) (detailing the pharmacist refusal issue and providing instructions to women who have been refused).

81. See National Women's Law Center, Pharmacy Refusals: State Laws, Regulations, and Policies (July 2009), <http://www.nwlc.org/pdf/pharmacyrefusalpoliciesjuly2009.pdf> (describing pharmacist refusal laws by state).

82. *Stormans, Inc. v. Selecky*, 524 F. Supp. 2d 1245 (W.D. Wash. 2007) [hereinafter *Stormans I*], appears to be unique because of the presence of the women intervenors, who pressed women's health as an issue requiring court attention. Cf. *Menges v. Blagojevich*, 451 F. Supp. 2d 992 (C.D. Ill. 2006) (examining whether an Illinois law which limited pharmacist refusal violated pharmacists' rights); *Noesen v. Med. Staffing Network*, 232 Fed. App'x 581 (7th Cir. 2007) (dismissing action by refusing pharmacist under Title VII). In administrative actions brought against pharmacists, however, women's health may be considered. See, e.g., *In re Disciplinary Proceedings Against Neil T. Noesen*, RPH, Proposed Final Decision and Order, Case No. LS0310091PHM, at 7, 19 (Wis. Pharmacy Examining Bd. 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 that "[e]very pregnancy has the potential for morbidity or mortality").

Washington state regulations that restrict pharmacists' ability to refuse to dispense Plan B due to their religious or moral objections.⁸³ The Washington regulations forbade pharmacists from discriminating against patients, destroying or refusing to return prescriptions, violating patient privacy, or harassing or intimidating customers, and put the burden on the pharmacy to protect customers from refusal by ensuring that all customers have access to medication even if a pharmacist refused.⁸⁴ Washington sought to restrict pharmacist refusal in the interest of "promoting [women's] health by ensuring access to Plan B."⁸⁵

Stormans generated multiple opinions. The courts used the availability tool in every decision, and, in every decision, the tool truncated the women's health analysis to some degree.⁸⁶ In *Stormans I*, a group of women—some of whom had been refused Plan B by pharmacists previously—intervened in an attempt to ensure that the regulations were enforced, thus protecting their ability to obtain emergency contraception.⁸⁷ The women intervenors were unsuccessful: the district court granted a preliminary injunction to the pharmacists pending a full trial on the basis that the regulation could violate the pharmacists' free religious exercise right, in effect permitting some pharmacist refusal.⁸⁸ In so doing, the court misapplied the availability tool by failing to fully analyze whether the alternative providers they cited were true substitutes for the refusing pharmacists. The women seeking access to emergency

83. *Stormans I*, 524 F. Supp. 2d at 1248–49.

84. *Id.* at 1251–53.

85. *See id.* at 1263 (asserting a secondary interest of "preventing sex discrimination").

86. *See infra* notes 87–110 and accompanying text.

87. In addition to HIV-medication-related intervenors, five women who were concerned with pharmacist refusal as it pertained to Plan B intervened: one woman who faced a hostile pharmacist at a pharmacy that did not carry Plan B, was 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 who was refused by a pharmacist, but another pharmacist at the same pharmacy provided the Plan B; one woman who used Plan B twice—once after a sexual assault—and both times got it from Planned Parenthood because she had heard stories of pharmacist refusals elsewhere; one woman who did not use Plan B, but found two out of five local pharmacies unwilling to provide it; and one woman who participated in the suit because she agreed with its goals. *See Stormans I*, 524 F. Supp. 2d at 1254–55; *see also Stormans, Inc. v. Selecky*, 526 F.3d 406, 409 (9th Cir. 2008) [hereinafter *Stormans II*] (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).

88. *Stormans I*, 524 F. Supp. 2d at 1266.

contraception lost again in *Stormans II*, when the appellate court declined to stay the district court injunction, thereby ostensibly permitting some pharmacist refusal pending appeal.⁸⁹ The court relied heavily on the *Stormans I* rationale, again misapplying the availability tool.⁹⁰ The women intervenors prevailed in *Stormans III*, however, when the Ninth Circuit reversed the order granting the preliminary injunction, vacated the injunction, and remanded the matter to the district court for further proceedings.⁹¹ The holding did not center on women's health: the court found that the district court applied the wrong legal standard and that the resultant injunction in the pharmacists' and pharmacy's favor was overbroad.⁹² The Ninth Circuit did, however, discuss women's health. It cited the potential harm to women posed by delayed access to Plan B.⁹³ Here, too, the court applied the availability tool, actually identifying deficiencies in the prior courts' application, but then, quite inexplicably, made similar missteps in its own use of the tool.⁹⁴ At all levels of litigation, the *Stormans* controversy is illustrative of the problems inherent in the availability tool.

Stormans I and *II* are particularly emblematic of the availability tool's potential pitfalls, as both misapply the tool and in so doing negate the health interests of both the individual women intervenors and Washington women generally. First, according to *Stormans I* and *II*, the intervening women failed to demonstrate that women's health was threatened by pharmacist refusal because all of the women who attempted to get Plan B eventually were successful in procuring the drug.⁹⁵ Presumably, these particular women neither became pregnant

89. *Stormans II*, 526 F.3d at 408.

90. *Id.*

91. *Stormans, Inc. v. Selecky*, Nos. 07-36039, 07-36040, 2009 WL 3448435, at *27 (9th Cir. Oct. 28, 2009) [hereinafter *Stormans III*] (holding that the district court applied the incorrect standard of review, failed to balance hardships, and failed to consider the public interest). *Stormans III* vacated and superseded a previous Ninth Circuit decision, but the analysis most relevant to women's health largely stayed the same. See *Stormans, Inc. v. Selecky*, 571 F.3d 960 (9th Cir. 2009).

92. *Stormans III*, 2009 WL 3448435, at *27.

93. *Id.* at *24.

94. See *infra* notes 108–10 and accompanying text.

95. "There is no evidence that any woman who sought Plan B was unable to obtain it." *Stormans II*, 526 F.3d at 409. The district court said 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 provide access to Plan B. *Stormans I*, 524 F. Supp. 2d 1245, 1266–67 (W.D. Wash. 2007).

because of any delay in receiving contraception nor did they suffer other health effects from the refusal they had already suffered. Therefore, via the availability tool, both decisions implied that the present controversy did not implicate these individual women's health and that the presence of multiple providers would protect the women from any future health issues caused by pharmacist refusal.⁹⁶ Thus, application of the availability tool effectively truncated a more in-depth analysis of the potential health implications presented by delayed or denied access to the drug (including pregnancy). Second, the courts in both *Stormans I* and *II* used the availability tool to negate pharmacist refusals' potential to harm to *all* Washington women. Both decisions cited statistics on pharmacy availability to demonstrate, ostensibly, that no woman in the state of Washington faced a health risk from pharmacist refusal: the courts implied that the sheer number of pharmacies that stocked Plan B prevented the health risks posed by pharmacist refusal from coming to fruition.⁹⁷ According to these courts, a survey showed that out of 121 pharmacies that responded to a survey, ninety-three "typically" stocked emergency contraceptives while twenty-eight did not.⁹⁸ Despite the fact that the survey showed that nearly one in four Washington pharmacies did not stock Plan B, the courts cited the survey ostensibly to

96. Neither court considered the fact that the ability to access Plan B from alternative providers in the past does not guarantee the ability to access it in the future, nor does a previous physical harm-free delay in getting Plan B guarantee a harm-free delay in the future. For a further discussion of the potential errors in use of the availability tool in *Stormans*, see *infra* Part IV.

97. *Stormans II*, 526 F.3d at 408–09; *Stormans I*, 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 drugs from the internet. See U.S. Food and Drug Admin., *The Possible Dangers of Buying Medicines Over the Internet* (Feb. 27, 2009), <http://www.fda.gov/ForConsumers/ConsumerUpdates/ucm048396.htm>.

98. *Stormans I*, 524 F. Supp. 2d at 1260 (“A survey of approximately 135 pharmacies conducted by the Board during the rulemaking process (October 2006) revealed that of the 121 respondents, 93 typically stocked emergency contraceptives while 28 did not. Of those who did not, 18 cited low demand and three relied on an ‘easy alternative source.’ Only two pharmacies said they did not stock emergency contraceptives because of religious or personal reasons.”); see also *Stormans II*, 526 F.3d at 408.

show the adequate availability of Plan B and failed to adequately discuss the risks delayed access may present.⁹⁹

In *Stormans I* and *II*, the statistics cited indicated which pharmacies *stocked* Plan B, not the willingness of individual pharmacists at those pharmacies to *dispense* it. This is a crucial distinction: one of the plaintiff pharmacists in *Stormans* who was seeking the right to refuse to dispense Plan B was the sole pharmacist at a pharmacy that apparently stocked the contraceptive.¹⁰⁰ This fact scenario shows that, although a pharmacy stocks Plan B, it may not necessarily have a pharmacist willing to provide it or transfer it to someone who will.¹⁰¹ 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.¹⁰²

According to the courts, women’s health was not truly at issue in *Stormans I* and *II*: the women’s interest was simply that they “understandably may not want to drive farther than the closest pharmacy” to get Plan B.¹⁰³ By recasting the women’s interest as one that “ha[d] more to do with convenience and heartfelt feelings than with actual access to certain medications,”¹⁰⁴ the courts rendered unnecessary any meaningful analysis of the potential health implications posed

99. *Stormans II*, 526 F.3d at 408–09; *Stormans I*, 524 F. Supp. 2d at 1260.

100. *See Stormans I*, 524 F. Supp. 2d at 1253–54 (noting that the pharmacy could not afford to hire a second pharmacist, thereby implying that the refusing pharmacist had been working—and presumably refusing to provide Plan B—alone at this pharmacy).

101. Pharmacist Neil Noesen, in another case, refused to transfer contraceptive prescriptions to competing pharmacies, rendering the availability of alternative providers meaningless to the women he served. *In re Disciplinary Proceedings Against Neil T. Noesen, RPH*, Case No. LS0310091PHM, at 19 (Wis. Pharmacy Examining Bd. Feb. 2005), available at <http://www.naralwi.org/assets/files/noesendecision&finalorder.pdf>.

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

103. *See Stormans I*, 524 F. Supp. 2d at 1263.

104. *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 provide access to contraceptives, specifically characterizing the potential delay in receiving Plan B as a health risk: “unwanted pregnancies and all that accompanies it.” *Stormans II*, 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).

by pharmacist refusal.¹⁰⁵ It also placed women in a classic double bind: in order to have a cause of action, women must have “failed” to access Plan B altogether, but given that access is a matter of “convenience,” if a woman had failed to access Plan B, she would have been culpable for her failure to find a provider.¹⁰⁶ By emphasizing the purported availability of alternative Plan B providers, both courts negated the health concerns posed by the intervening women, who had previously been refused Plan B, ultimately finding that there was no showing that intervenors would face irreparable harm if the injunction remained in effect pending appeal.¹⁰⁷

The application of the availability tool in *Stormans I* and *II* shortchanged women’s reproductive health individually, as to the intervenors, and collectively, as to Washington State women. The appeal of the injunction—heard in *Stormans III*—would show both the promise of the availability tool and its pitfalls.

In *Stormans III*, the Ninth Circuit reversed the district court’s injunction and ruled in the women intervenors’ favor. In doing so, it questioned the superficial inculcation of availability by prior courts, but then itself proceeded to misapply the availability tool.¹⁰⁸ *Stormans III* noted the sparse record relied on by prior courts, and said that the survey relied upon in the prior decisions only provided information on whether pharmacies *stocked* Plan B and provided no information on whether providers would *dispense* it.¹⁰⁹ But after what appears to be a recognition of the availability tool’s pitfalls, *Stormans III* made a classic misapplication of the tool. In its analysis of whether the district court injunction that applied to *all* pharmacists and pharmacies was overbroad, the court said that a narrower injunction allowing only the plaintiff pharmacy and

105. Compare *Stormans II*, 526 F.3d at 408–09 (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 twenty-four hours), with *Stormans II*, 526 F.3d at 416–17 (Tashima, J., dissenting in part) (describing the potential for unwanted pregnancies due to delayed access to Plan B).

106. See *Stormans I*, 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 CHAMALLAS, INTRODUCTION TO FEMINIST LEGAL THEORY 8–10 (2d ed. 2003) (discussing the significance of identifying double binds); see also *infra* Part III (discussing the culpability tool).

107. See *Stormans II*, 526 F.3d at 408; *Stormans I*, 524 F. Supp. 2d at 1266–67.

108. See *Stormans III*, Nos. 07-36039, 07-36040, 2009 WL 3448435, at *2, *26 (9th Cir. Oct. 28, 2009).

109. *Id.* at *2, *21.

pharmacists to refuse would not harm women because of the availability of “numerous alternative pharmacies,” doing so without adequately examining whether those alternative pharmacies staffed pharmacists willing to *dispense* Plan B, were open comparable hours, or accepted comparable health insurance.¹¹⁰ The *Stormans III* court uses the availability of theoretical alternatives as a proxy for a thorough examination of women’s health interests—the same type of error committed by the *Stormans I* and *II* courts. Although *Stormans III* ostensibly protected women’s health by reversing the lower court decision, its incomplete application of the availability tool arguably paves the way for similar analytical missteps by the district court on remand.

The *Stormans* litigation is a prime example of how the availability tool operates in modern reproductive rights cases. As will be discussed more thoroughly below, *Stormans* demonstrates the attention to detail necessary to appropriately analyze potential substitutions for a threatened service and how such detail may be neglected. Perhaps most significantly, the most recent chapter in the case—*Stormans III*—shows the allure of the availability tool, even to jurists who recognize that it is not a panacea when evaluating women’s reproductive health controversies.

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 by a law. In these cases, the availability of alternative providers may be cited to signal that a regulation is not an unconstitutional burden on a woman’s ability to access abortion services and, by implication, is not an impermissible burden on women’s health.¹¹¹

110. *See id.* at *26.

111. 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 & REPROD. HEALTH 6, 10 (2008). The number of providers for later gestation abortion appears to be declining. *See id.* at 15. However, 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).

The availability tool is not used in all abortion-related cases, but when a law threatens to decrease the number of providers, the use of the availability tool may emerge.¹¹² In these cases, the exit of a 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 resultant increased costs, delay, and health risks.¹¹³ Some courts have held, however, that such travel is not an undue burden on women and that the existence of multiple abortion providers, even if not geographically convenient, protects women's right to access abortion.¹¹⁴ In these cases, access to competing providers may impliedly guarantee 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.¹¹⁵ The regulations at issue in *Greenville Women's Clinic* were extensive, mandating detailed record-keeping by abortion providers, regulating facility construction,

112. See, e.g., *Women's Med. Profl Corp. v. Baird*, 438 F.3d 595, 604–05 (6th Cir. 2006) (holding that an abortion facility's likely closure stemming from regulatory requirements 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) (saying 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).

113. For an example of these arguments and how they were received by one court, see *Greenville Women's Clinic v. Bryant*, 66 F. Supp. 2d 691, 735 (D.S.C. 1999) (holding that increased cost, delay or distance to an abortion provider each constitutes an "undue burden"), *rev'd*, 222 F.3d 157 (4th Cir. 2000).

114. See *Women's Med. Profl 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).

115. Compare *Greenville Women's Clinic*, 222 F.3d at 160 (restricting the applicability of the regulations to facilities where five or more first-trimester abortions were performed per month), with *Greenville Women's Clinic*, 66 F. Supp. 2d at 735 (holding that increased cost, delay or distance to an abortion provider each constitutes an "undue burden").

and imposing onerous building requirements.¹¹⁶ Implementing these types of regulations increases provider costs, which in turn can lead to increased costs (and concomitant delay while raising the funds) for patients. Closure of a provider may result. Such was the case in *Greenville Women's Clinic*.¹¹⁷

Greenville Women's Clinic demonstrates that the application of the availability tool turns on how a court defines "available alternatives." Although the district and appellate courts in this case came to opposite decisions on whether the regulations at issue posed an undue burden on women, both used the availability tool to arrive at their result. The district court cited a lack of competing abortion providers in a specific geographic area to demonstrate that access to abortion services would be inadequate to protect women's health if the regulations were upheld.¹¹⁸ The appellate court held a contrary view of availability: the appellate court cited what it saw as the presence of competing providers as proof that the law would not impact women's health.¹¹⁹

The district court opinion made women's health the central issue throughout the analysis, including in its evocation of availability.¹²⁰ The court used the availability tool, ultimately finding that, if the law was allowed to stand, thus forcing a provider to close, the lack of available alternative providers in certain areas of the state would jeopardize women's health.¹²¹ Its decision centered on the *Roe*-based premise that the regulations at issue must protect maternal health in order to pass

116. *Greenville Women's Clinic*, 222 F.3d at 160–62 (describing a ten-part regulatory scheme). These regulations are 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 (Nov. 1, 2007), <http://reproductiverights.org/en/document/targeted-regulation-of-abortion-providers-trap-avoiding-the-trap>.

117. 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 provider and whether it decided to remain open).

118. 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).

119. 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).

120. See *Greenville Women's Clinic*, 66 F. Supp. 2d at 731.

121. See *id.* at 735–36 (noting the foreseeable closure of an abortion clinic and finding that increasing the distance a woman has to travel to obtain an abortion constitutes a substantial obstacle).

constitutional scrutiny.¹²² The district court compared the health risks of abortion and the health risks of pregnancy, noting that early abortion has a mortality rate twenty-five times lower than carrying a pregnancy to term.¹²³ 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. In other words, the opinion resists the conflated analysis invited by *Casey*.

The district court decision marched through an analysis of the increased costs the regulations would prompt, ultimately finding that such increases threatened women's health. The regulations would force physicians to impose fee increases ranging from a nominal additional cost to an increase of almost \$400 per procedure.¹²⁴ The district court said that these costs would likely force one provider out of business, and the alternative of asking women to travel more than seventy miles to another provider was insufficient either to protect their right to access abortion services or to protect their health.¹²⁵ Delay in accessing abortion is a health risk, and regulations that increase costs or drive providers out of business cause delay.¹²⁶ This, according to the district court, is why the regulations at issue constituted an undue burden for South Carolina women seeking an abortion.¹²⁷ In other words, the presence of distant

122. *See id.* at 725–31 (citing *Casey's* requirement that abortion regulations should protect women's health and calling the regulations "at best medically unnecessary and at worst contrary to accepted medical practice").

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

124. *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).

125. *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); *see also* Kay et al., *supra* note 111, at 324 (noting that abortion services are unevenly distributed and that the vast majority of all unmet abortion needs are concentrated in rural areas).

126. *See Greenville Women's Clinic*, 66 F. Supp. 2d 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 a 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.").

127. *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").

providers did not constitute adequate availability of alternatives. Although distant providers were able to provide substitute services, the inevitable delay arising from their distance posed other health risks, thus preventing such providers from being characterized as adequate substitutes for the provider facing closure.

In the eyes of the appellate court, however, the loss of an abortion provider was a permissible by-product of the law: “no evidence suggests that [women] could not go to the clinic in Charleston, some seventy miles away.”¹²⁸ The presence of what the appellate court saw as alternative providers filled the gap that might be created by the potential loss of providers due to increased, regulatorily imposed costs.¹²⁹ Moreover, to the appellate court, the increased costs were also “speculative” and “modest.”¹³⁰ There was no substantive discussion of the impact that increased costs and potential delays would have on accessing abortion services or, ultimately, on women’s health in the relevant community.¹³¹ Therefore, according to the appellate court, the impact on women’s health, if any, was speculative.¹³²

Greenville Women’s Clinic is a significant case when examining the availability tool because (1) it demonstrates the reliance on the availability tool by two courts deciding the same question that came to entirely different results regarding the constitutionality of abortion restrictions, and (2) it confirms the significance of judicial characterization of available alterna-

128. *Greenville Women’s Clinic v. Bryant*, 222 F.3d 157, 165 (4th Cir. 2000). The court repeated this statement, at no time fully addressing the health issues 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” (citing *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992))). The dissent said sending women to an abortion provider seventy miles away was inadequate to protect women’s right to access abortion services or their health. *Id.* at 202 (Hamilton, J., dissenting) (characterizing the majority’s treatment of rural women as “with cavil”). See also Kay et al., *supra* note 111, at 330 (noting that travel distance is negatively correlated with the use of abortion services).

129. We will see later, in the context of vaginal births after prior cesarean section, that courts may cite the unavailability of a service—specifically providers willing to supervise vaginal births after cesarean sections (“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).

130. 222 F.3d at 159. From the outset of the appellate opinion, the pertinent issues were framed much differently by the appellate court, which did not emphasize women’s health, but instead focused on the impact the regulations would have on women’s “decisions to obtain an abortion.” *Id.* at 162.

131. The court blamed the lack of analysis on the Plaintiffs’ use of a facial challenge to the law instead of a “concrete” challenge. See *id.* at 165–71.

132. *Id.*

tives.¹³³ First, unlike autonomy-based arguments, which are used by abortion rights advocates, or fetal life arguments, which are only useful to abortion rights opponents, *Greenville Women's Clinic* shows that the availability tool is hypothetically useful to both sides in reproductive health cases. The availability tool crosses abortion's moral and political divides. Second, as did the courts in *Stormans*, *Greenville Women's Clinic* demonstrates that how a court defines "available alternative" may prove outcome-determinative when the availability tool is used. The relevant portion of the *Stormans* analysis focused on pharmacies that stocked Plan B as available alternatives instead of focusing on pharmacies with willing dispensers of Plan B.¹³⁴ Likewise, in *Greenville Women's Clinic*, whether the tool was applied neutrally or as a means to an end, each decision turned in part on whether the court characterized a provider located more than seventy miles away as an "available" alternative provider.¹³⁵

Provider-based applications of the availability tool are not the tool's only use. 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.¹³⁶ In these cases, the availability of multiple providers is of no consequence, as it is allegedly 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 alternative procedures to resolve any potential impact on women's health.

C. *The Availability of Alternative Procedures*

Judges may rely on the presence of available *procedures* when using the availability tool, just as they rely on the pres-

133. See *supra* notes 115–32 and accompanying text.

134. See *supra* Part II.B(1).

135. See *supra* notes 115–32 and accompanying text.

136. Compare NARAL Pro-Choice America, Fast Facts: 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 (last visited Sept. 27, 2009) (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> (last visited Sept. 27, 2009) (containing an exhaustive documentation of the "partial birth" abortion-related controversies).

ence of available *providers*.¹³⁷ If the availability tool is to be used correctly in these circumstances, a call for the elimination of a particular reproductive health procedure should first lead a court to determine whether there is an alternative procedure available that would be an adequate substitute for the procedure impacted by the law in question.¹³⁸ 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 risk-and-benefit profile. Not all judges applying the availability tool take this second step, which can lead to the undervaluing of women's health in reproductive health controversies.

"Partial-birth" abortion bans provide fertile ground for the application of the procedure-based availability tool. "Partial-birth" abortion is a descriptor used by the anti-abortion rights movement that has been applied to a wide variety of abortion procedures.¹³⁹ These bans restrict the range of abortion procedures available to pregnant women and, in so doing, raise questions regarding both access to abortion services and the corollary impact that 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 in procedure-ban cases is not outcome determinative—far from it. The resolution of each case turned in significant part

137. Procedure bans are less common than other forms of abortion regulation, but as the "partial-birth" abortion litigation demonstrates, arise nonetheless. *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. *Planned Parenthood of Cent. Mo. 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). *See also* *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 513–14 (6th Cir. 2006) (addressing the "off-label" use of the medical abortion-inducing drug mifepristone and noting "[t]he State does not point to any evidence which demonstrates that there is an alternative abortion procedure which is available after seven weeks' gestation which is as safe or safer than a mifepristone medical abortion for all medically foreseeable circumstances or conditions").

138. *See infra* notes 139–78 and accompanying text (discussing the litigation surrounding partial-birth abortion).

139. *See generally* Kenneth L. Woodward, *What's in a Name?* *The New York Times on "Partial-Birth Abortion"*, 19 *NOTRE DAME J.L. ETHICS & PUB. POLY* 427, 441 (2005) (discussing that "partial-birth" abortion is not a medically recognized term for an official procedure, saying "[p]artial birth' is a political battle cry, not medical terminology" (quoting *Frank Talk About Abortion*, *N.Y. TIMES*, Nov. 30, 2003, at WK8)).

on the Court's characterization of whether there was an available alternative to partial-birth abortion that would allow the ban at issue to survive constitutional scrutiny. 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.¹⁴⁰ A more recent case, *Gonzales v. Carhart*, upheld a similar partial-birth abortion ban, citing the availability of adequate alternative procedures.¹⁴¹

Stenberg centered on a Nebraska statute criminalizing the act of performing a partial-birth abortion.¹⁴² Proponents of the ban argued that the statute applied to a particular procedure, called dilation and extraction ("D&X," also known as "intact D&E").¹⁴³ Some describe D&X as a procedure during which a fetus is partially delivered, its skull collapsed, and the contents removed.¹⁴⁴ A physician who provided 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 commonly used abortion procedure, and a procedure typically used in early pregnancy.¹⁴⁵ Moreover, whatever procedure the law banned, it contained no exception for the health of the pregnant woman, in apparent contravention of *Roe*'s health-related mandates.¹⁴⁶

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 performed during the first tri-

140. See *Stenberg v. Carhart*, 530 U.S. 914, 923–38 (2000).

141. See *Gonzales v. Carhart*, 550 U.S. 124, 166–67 (2007) ("The Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman's health, given the availability of other abortion procedures that are considered to be safe alternatives.").

142. See *Stenberg*, 530 U.S. at 921–22.

143. *Id.* at 922–27 (explaining that D&X procedures are also known by some as intact D&E).

144. See *id.* at 927 (explaining that the fetus is not disarticulated in a "partial-birth" abortion).

145. *Id.* at 922.

146. *Id.* at 937–38 (noting that medical uncertainty as to the procedure's relative utility shows that potential risk to women's health is present, thus requiring a health exception).

mester of pregnancy, and the predominant technique used is vacuum aspiration.¹⁴⁷ Vacuum aspiration has an extremely low rate of complications; its mortality rate, according to the Court, is five to ten times lower than carrying a pregnancy to term.¹⁴⁸ During the second trimester, D&E is used for between ninety and 95 percent of all terminations, but this procedure does carry certain health risks.¹⁴⁹ D&X, on the other hand, is also used during the second trimester, but the frequency of its use is unknown.¹⁵⁰ The benefits of D&X over other procedures were disputed, but, according to some physicians, included lower infection and organ perforation rates for the pregnant woman and additional, specific benefits for women with certain health conditions.¹⁵¹

The application of the availability tool in *Stenberg* (and later in *Gonzales*) hinged on whether an alternative procedure for partial-birth abortion was necessary and, if so, was available. *Stenberg* required any alternative to be at least as safe as the procedure threatened, D&X.¹⁵² If no such procedure was available, a health exception to the partial-birth abortion ban was constitutionally mandated.¹⁵³

The availability tool eventually guided the *Stenberg* Court to find that the existence of an acceptable alternative to D&X was questionable—in other words, the medical evidence failed to establish whether any other available procedure provided the same service (termination of pregnancy) with the same or less health risk to pregnant women.¹⁵⁴ The Court reviewed extensive medical evidence and concluded that D&X may pose

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

148. *Id.* (discussing the various abortion procedures used at various gestations).

149. *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).

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

151. *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).

152. *See id.* at 934–38 (saying that D&X may be safer than alternatives so a health exception is mandated).

153. *Id.*

154. *See id.* (citing medical authority stating 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 which found that D&X was not necessary for the health of women “given the availability of other procedures”), *vacated*, 530 U.S. 1271 (2000).

fewer risks to certain pregnant women desiring to terminate a pregnancy than any alternative procedure.¹⁵⁵ As it was unclear whether an alternative procedure with the same or better health benefits was available, a health exception was required.¹⁵⁶

The *Stenberg* health exception analysis provides an example of how the availability tool can be used to appropriately analyze women's health issues in reproductive rights jurisprudence. The Court undertook a comparison of D&X with available alternative procedures—a comparison that did not 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.¹⁵⁷ Moreover, by acknowledging the fact that the “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 availability tool is possible even in complex factual scenarios where the health necessity of the banned procedure is in question.¹⁵⁸ The *Stenberg* Court went on to hold that the law also placed an “undue burden” on women's ability to access abortion, given that it banned both D&X and D&E.¹⁵⁹ As we will see later in *Gonzales*, which relied on a contrary application of the availability tool, the Court's resolution of a similar question of availability resulted in a truncated women's health analysis.

155. See *Stenberg*, 530 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).

156. *Id.* at 940; see also David D. Meyer, *Lochner Redeemed: Family Privacy After Troxel and Carhart*, 48 UCLA L. REV. 1125, 1161–62 (2001) (interpreting the *Stenberg v. Carhart* majority opinion as prohibiting any state-imposed increased medical risk to a woman seeking an abortion).

157. See *Stenberg*, 530 U.S. at 934–37.

158. See *id.* at 937; see also *id.* at 931 (noting that abortion regulations can pose significant health risks to women, whether the risk originates from the regulation of an abortion method or from the pregnancy itself).

159. *Id.* at 938 (application of the availability tool in this portion of the analysis was unnecessary given Nebraska's stipulation that if the ban applied to first-trimester procedures it would constitute an “undue burden”). However, Justice O'Connor suggested an application of the availability tool in her undue burden analysis: “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.’” *Id.* at 951 (O'Connor, J., concurring) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 884 (1992)).

Stenberg did not stem the tide of partial-birth abortion legislation: it simply sent ban proponents back to the legislative drawing board with jurisprudential guidance as to what type of legislation the Court was likely to find constitutionally acceptable.¹⁶⁰ The Supreme Court addressed partial-birth abortion again in 2007, this time as a federal partial-birth abortion ban.

In *Gonzales v. Carhart*, the Court considered a federal partial-birth abortion ban challenge based on legal 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 the ban prohibited.¹⁶¹ To determine the legal import of each of the issues, the Court again focused on whether alternative procedures existed. Specifically, it relied heavily on the availability of multiple second-trimester abortion procedures when holding that the federal partial-birth abortion ban was not an undue burden on women.¹⁶² *Gonzales* was the first case in more than three decades in which the Supreme Court upheld an abortion restriction without a corollary health exception.¹⁶³

Gonzales typifies how a court that improperly applies the availability tool can shortchange women's health. At the outset of the *Gonzales* decision, the Court signaled that availability of alternative procedures would be significant to its analysis. The inclusion of available alternatives at this point in the decision is not explained, just simply set forth. The Court juxtaposed a graphic description of D&X with a description of abortion procedures that could potentially substitute for D&X¹⁶⁴ and the

160. See *infra* notes 161–78 and accompanying text (discussing subsequent partial-birth abortion ban litigation).

161. *Gonzales v. Carhart*, 550 U.S. 124, 141–44 (2007).

162. See *id.* at 166–67 (“The Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman’s health, given the availability of other abortion procedures that are considered to be safe alternatives.”). The decision cites the presence of conflicting medical opinions on the medical necessity of D&X to support its ultimate holding that alternative abortion procedures vitiated any impact the ban could have on women’s health. See *id.* at 162–64.

163. See National Partnership for Women & Families, *The Supreme Court and Abortion Access* (Aug. 26, 2008), 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 thirty-three years).

164. *Id.* at 134–40. The court refers to D&X as “intact D&E.” See generally *Gonzales*, 550 U.S. at 136–37 (noting the different nomenclature used to describe a partial-birth abortion). For the purpose of consistency, the term D&X is used throughout this paper.

commonality of each procedure. At this point in the decision, the Court mentions generally and in passing the potential risks to women's health from some alternatives.¹⁶⁵

The *Gonzales* Court immediately distinguished the federal partial-birth abortion ban from the Nebraska ban in *Stenberg*, finding that the federal ban was substantially narrower in scope than the Nebraska ban.¹⁶⁶ The Court's different interpretation of the scope of the bans in each of the two cases directly impacts how the availability tool is used. Given the federal ban's significantly narrower scope, the likelihood that the federal procedure ban could be compensated for by the presence of alternative procedures should have been greater.

As was the case in *Stenberg*, the *Gonzales* Court had to determine whether the absence of a health exception rendered the statute unconstitutional. The *Gonzales* Court noted the same issue that faced it in *Stenberg*: although medical evidence supporting the necessity of D&X existed, there was no medical consensus regarding whether the availability of D&X was necessary to protect the health of women seeking an abortion. To the contrary, the issue of whether D&X is the "safest" second-trimester abortion method was hotly contested.¹⁶⁷ The Court noted the "documented medical disagreement [over] whether the Act's prohibition would ever impose significant health risks on women."¹⁶⁸ 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 conflated the resolution of the health exception issue with the broader undue burden analysis permitted by *Casey*.¹⁶⁹ The *Gonzales* Court then used the availability tool to resolve both the health exception and undue burden issues simultaneously.

165. *See id.* at 139–40 (describing alternative second-trimester abortion methods as: medical induction, used in 5 percent of abortions prior to twenty weeks gestation and 15 percent in those after twenty weeks; and hysterotomy and hysterectomy, which together account for less than 0.1 percent of all second-trimester abortions and are only used in emergency situations because of health risks to the pregnant woman).

166. *Id.* at 150 (finding that the ban covered D&X, or "intact D&E," not "the D&E procedure in which the fetus is removed in parts" and postulating that the different diction in the federal ban was Congress' attempt to avoid *Stenberg*-like issues).

167. *See id.* at 162–65.

168. *Id.* at 162.

169. *See id.* at 165–67 (conflating the necessity of a health exception with the analysis of whether the ban was an undue burden on access).

The Court held that the federal partial-birth abortion ban did not constitute an “undue burden,” even without an exception to protect the health of pregnant women, because the Court found that available alternative abortion procedures obviated any medical uncertainty as to the banned procedure’s necessity to women.¹⁷⁰ The *Gonzales* Court relied on the continued availability of D&E and other alternate procedures, saying, “[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.”¹⁷¹ It then went on to hold that a health exception was unnecessary, saying that when

standard medical options are available, *mere convenience* does not suffice to displace them; and if some procedures have different risks than others, it does not follow that the State is altogether barred from imposing reasonable regulations. The Act is not invalid on its face where there is uncertainty over whether the barred procedure is ever necessary to preserve a woman’s health, given the availability of other abortion procedures that are considered to be *safe* alternatives.¹⁷²

The *Gonzales* Court misapplied the availability tool in a predictable manner: it failed to adequately analyze whether the substitute procedures—frequently used or not—had the same or better health risk-benefit profile as the banned procedure for women who might need it. The *Gonzales* Court cited medical support for the argument that the banned procedure was necessary for the health of some women,¹⁷³ although it subsequently found that the presence of “safe alternatives” obviated the ban’s increased risks to women’s health.¹⁷⁴ The use of “safe” in lieu of “as safe,” “safer,” or “safest” effectively signaled the Court’s acceptance of laws that impose health risks on

170. *Id.* at 164–65 (distinguishing the case from *Planned Parenthood of Cent. Mo. 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).

171. *Id.* (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).

172. *Id.* at 166–67 (emphasis added).

173. *Id.* at 161–63.

174. *Id.* (holding the ban constitutional where there is uncertainty over its necessity and there are “safe alternatives”).

women seeking abortion and overtly allowed substitutes without defining the “fit” necessary. In response to the Court’s decision, the American College of Obstetricians and Gynecologists released a statement calling the ruling “shameful and incomprehensible” and observing that “[i]t leaves no doubt that women’s health in America is perceived as being of little consequence.”¹⁷⁵

Noticeably absent from the *Gonzales* majority opinion is a detailed, procedure-by-procedure comparison of women’s health risks and benefits as was presented in the dissent.¹⁷⁶ Rather than discussing the comparative health risks and benefits of all procedures, the majority assumes that the availability of an alternative procedure protects women’s health. The Court apparently infers from the frequency with which the non-banned procedures are used that, in the absence of the banned procedure, the alleged alternatives will protect all women’s health.¹⁷⁷ But frequency of use alone does not prove that the asserted alternatives are as safe as the banned procedure for women. Just as in the hypothetical diaphragm ban, where women diaphragm users were told that oral contraceptives and IUDs were “available alternatives” despite the fact that they may be medically contraindicated for some women, *Gonzales* erroneously defined “available alternatives” in terms of women’s continued ability to access abortion, instead of looking for the safest “available alternatives” for all women’s health.

Gonzales is an example of the misapplication of the availability tool and its potential to undercut women’s health. The case at once heralds the availability of safe alternatives to the banned procedure while admitting that there is medical authority suggesting that the ban could be harmful to women’s

175. Press Release, American College of Obstetricians and Gynecologists (“ACOG”), ACOG Statement on the US Supreme Court Decision Upholding the Partial-Birth Abortion Ban Act of 2003 (Apr. 18, 2007), http://www.acog.org/from_home/publications/press_releases/nr04-18-07.cfm (quoting Douglas W. Laube, MD, MEd, ACOG president).

176. *Compare Gonzales*, 550 U.S. at 176–80 (Ginsburg, J., dissenting. Stevens, Souter, & Breyer, JJ., joining) (providing detailed information on the population of women for which the banned procedure may be safest and the safety advantages) *with id.* at 161–67 (majority opinion) (acknowledging the potential benefits of the banned procedure for some women, but focusing on the disagreement in the medical community).

177. *See Gonzales*, 550 U.S. at 164–65 (majority opinion) (distinguishing that case from *Planned Parenthood of Cent. Mo. 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, “[a]lternatives are available” to D&X).

health.¹⁷⁸ It is a perplexing retreat from the more vigorous application of the availability tool in *Stenberg*.

When one looks at judicial reliance on the availability of providers and procedures together, it is apparent that courts can use the availability tool to analyze a wide variety of women's reproductive health controversies. As is seen in the context of pharmacist refusal and abortion, application of the tool may protect or undermine women's health.¹⁷⁹ These decisions show that regardless of the factual scenario, the end result depends largely on the court's characterization of what constitutes an available alternative.

The availability tool cases discussed leave us with significant questions: what standard is used to determine whether a procedure or a provider is truly an available alternative?¹⁸⁰ 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 these questions may determine 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 potential alternatives, which leads to an obvious question: what can judges facing women's health issues do when there are no alternatives? Abortion and

178. Strangely, while downplaying the medical necessity of D&X, the majority also instructed that women who needed a D&X for health reasons could simply have the fetus terminated by injection prior to the D&X. *Id.* at 164. The dissent noted that the injection “poses tangible risk and provides no benefit to the woman.” *Id.* at 180 n.6 (Ginsburg, J., dissenting) (quoting *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 1028 (D. Neb. 2004), *aff'd*, 413 F.3d 791 (8th Cir. 2005)).

179. 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 health advocates as “equity in prescription insurance coverage” (“EPIC”), EPIC cases contain indicators that judges may use the availability tool. *Compare In re Union Pac. R.R. Employment Practices Litig.*, 479 F.3d 936, 939–43 (8th Cir. 2007) (citing the existence of several types of birth control available with and without prescription as evidence that there was no Title VII violation), *with Erickson v. Bartell Drug Co.*, 141 F. Supp. 2d 1266, 1271–72 (W.D. Wash. 2001) (holding that lack of coverage constitutes sex-based discrimination).

180. The concept of convenience, which was present in the *Stormans* pharmacist refusal case, also emerges in *Gonzales*. *See Gonzales*, 550 U.S. at 166–67 (“When standard medical options are available, mere convenience does not suffice to displace them . . .”); *Stormans II*, 526 F.3d 406, 408 (9th Cir. 2008); *Stormans I*, 524 F. Supp. 2d 1245, 1263, 1266–67 (W.D. Wash. 2007).

childbirth-related cases suggest that even in the absence of robust competition, judges may look to see if women themselves are culpable for the absence of available alternatives in the health care marketplace.

Culpability on a general level is ever-present in reproductive health controversies: the notion that women are culpable if they become pregnant unless through rape or incest is a thread that runs through contraception, abortion, and childbirth-related cases.¹⁸¹ The culpability tool, however, goes beyond morality: it is used to determine whether the lack of available reproductive health choices in a specific case was the result of a woman's own (bad) choice.

A. *Availability's Last Dying Gasp*

Reference to a woman's culpability in reproductive health jurisprudence may represent 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 present the woman as responsible for the lack of available options in her own case and for the narrowing of choices that resulted. In other words, if the woman had made a different decision at an earlier time, access to the health service desired would have been available. Or, if she had taken advantage of available options (and had made a decision reflective of the existing medical consensus), no controversy would exist.

The culpability tool is less apparent and decidedly more subjective than the 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

181. In several cases, the Court has also implied women's culpability in a more gratuitous fashion. *See, e.g., Gonzales*, 550 U.S. at 159 ("While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained. Severe depression and loss of esteem can follow." (internal citation omitted)). The general culpability in *Gonzales* has no availability-related function and is more akin to blame. Likewise, rape and incest exceptions to abortion bans generally imply that women who had consensual sex are morally culpable if they become pregnant. *See Doe v. Bolton*, 410 U.S. 179, 208 (1973) (discussing consensual versus nonconsensual pregnancies); Judith A.M. Scully, Book Review, 8 *UCLA WOMEN'S L.J.* 125, 133 n.18 (1997) (reviewing EILEEN L. MCDONAGH, *BREAKING THE ABORTION DEADLOCK: FROM CHOICE TO CONSENT* (1996)) (discussing, as an example of this argument, the federal "Hyde Amendment," which disallows Medicaid funding of an abortion except in cases of rape, incest, or threat to the pregnant woman's life).

a regulation will impact availability going forward (and, if correctly applied, whether the alternatives are true substitutes). As described earlier, two groups of jurists examining the same set of facts can use the availability tool to come to two different legal conclusions depending upon how closely potential alternatives are scrutinized. The culpability tool, on the other hand, is retrospective and inherently judgmental: it is a search for the time in the past when a woman made a choice that narrowed her own health care options—and thus narrowed the alternatives she could access in the future.¹⁸²

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.¹⁸³ Judges also use the culpability tool in compelled cesarean section cases, where a woman disagrees with her physician's insistence on child delivery by cesarean section, so the physician seeks a court order compelling the woman to deliver via surgery.¹⁸⁴ 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 the availability of alternatives at an earlier point in time.¹⁸⁵

Decisions show that when judges use the culpability tool, they often 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 ostensibly voluntarily narrows her options is at viability, when she makes a choice to continue her pregnancy rather than to abort.¹⁸⁶ The second point in

182. Regardless of whether such actions protect women's health, judicial intervention into a woman's pregnancy-related decision calls into question a woman's judgment and may undermine her 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 (1994) (explaining that "autonomy entails the expression of subjective, rather than objective, decisionmaking").

183. See *infra* notes 188–91 and accompanying text.

184. See *infra* Part III.B. Judicial intervention in pregnancies is not limited to cesarean sections. See generally Scott, *supra* note 182, at 626–30 (discussing interventions including blood transfusions and "purse string" operations).

185. Recall the double (culpability) bind in *Stormans*: 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 legal protection. See *supra* notes 104–06.

186. See, e.g., *Jefferson v. Griffin Spalding County Hosp. Auth.*, 274 S.E.2d 457, 458 (Ga. 1981) (citing the fact that the child was viable and was thus entitled

time at which a woman voluntarily narrows her options is when she makes a reproductive health care choice that the court perceives to be unsupported by health care providers.¹⁸⁷ Either or both of these events can be used to suggest a woman's culpability in her present health care situation, facilitating an abbreviated discussion of her health or an avoidance of the topic of health altogether.

One example of the first narrowing point, a woman's choice to continue her pregnancy, can be found in *Casey*. 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 child."¹⁸⁸ 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 chooses not to terminate the pregnancy pre-viability, when alternatives to continuing the pregnancy still

to 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. 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 has decided not to timely terminate her pregnancy"), *vacated*, 573 A.2d 1235, 1237 (D.C. 1990) (holding, after the compelled cesarean section and death of the pregnant woman, that a substituted judgment process should have been used where the woman was in a coma). Note that some compelled cesarean section cases are pre-*Casey*, suggesting that although *Casey* facilitates the availability and culpability tools, the tools are likely even more deeply rooted. See, e.g., *In re A.C.*, 573 A.2d 1235.

187. See, e.g., *Pemberton v. Tallahassee Mem'l Reg'l Med. Ctr., Inc.*, 66 F. Supp. 2d 1247, 1249 (N.D. Fla. 1999) (citing the pregnant woman's inability to find a provider for her desired service); *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); *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 threatened); *WVHCS-Hosp., Inc. v. Doe*, No. 3-E-2004, 1-2 (Pa. Ct. Com. Pl. Jan. 14, 2004), <http://advocatesforpregnantwomen.org/WVHCSBabyDoevJaneandJohnDoe.pdf> (restraining the parents from not consenting to a cesarean based on the hospital's verified complaint that they refused despite being advised on health risks to the pregnant woman and fetus presented by vaginal delivery).

188. *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 870 (1992); see also Scott, *supra* note 182, 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).

existed.¹⁸⁹ Given that the first 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 and unconstitutional at worst.¹⁹⁰ To imply otherwise is to imply that by exercising a constitutional right to have a child, a woman subjects herself wholesale to the coercive powers of the state, an implication that would render the very existence of the right itself meaningless.¹⁹¹

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 women choose not to take advantage of existing services. 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, another indicator that the woman is culpable for her situation.¹⁹²

B. Culpability and Compelled Cesarean Sections

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 childbirth. Some women have been court-ordered to undergo cesarean sections,

189. 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, 1325–28 (1990) [hereinafter, Note, *Rethinking (M)otherhood*] (discussing forced blood transfusions; detention of the mother to stop potentially harmful behavior by the pregnant woman, such as drug use; detention to force potentially beneficial behavior by the pregnant woman, such as medical treatment; and that state intervention can be civil or criminal in nature).

190. *See infra* Part IV (discussing the misapplications of the culpability tool).

191. “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.” *Eisenstadt v. Baird*, 405 U.S. 438, 453 (1972).

192. 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 182, at 659; *see also* 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).

despite their desire to deliver vaginally.¹⁹³ It is not hyperbolic to say that compelled cesarean sections (or the threat of them) have led to dramatic scenarios: a woman being forcibly restrained, sedated, and carted into an operating room as her screaming partner was forcibly removed;¹⁹⁴ a woman facing compelled cesarean section “escaping” from a hospital and attempting birth in hiding;¹⁹⁵ a woman’s alleged refusal to consent to a cesarean section resulting in criminal charges being filed against her;¹⁹⁶ and, in one case, the trauma of a forced cesarean leading to the father’s suicide.¹⁹⁷ In a recent case, a woman who refused a cesarean section and gave birth vaginally to a healthy child subsequently lost custody of her child, based initially on her refusal to have a cesarean section.¹⁹⁸ The stakes are high for all involved in a potential compelled cesarean section.

193. The frequency of compelled cesarean sections is difficult to estimate because of the nature of the proceedings, which may be oral, rushed, and which may result in cryptic state trial-level court decisions. See, e.g., *In re A.C.*, 573 A.2d 1235, 1248 (D.C. 1990) (noting the procedural shortcomings in compelled cesarean section proceedings, including inadequate notice and representation of parties, substandard arguments, and the absence of opportunities for appeal). The American College of Obstetricians and Gynecologists says that judicial intervention in birth choice undermines women’s autonomy and their trust in their medical providers, potentially causing them to deliver without medical care. See Driessen, *supra* note 192, at 42–43; see also 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).

194. Driessen, *supra* note 192, at 36–37 (describing the compelled cesarean section of a Nigerian woman, whose husband later killed himself).

195. The result of court-ordered cesarean sections is that the extent of reproductive rights is necessarily conditioned on the physical 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 182, at 667 (noting that surrendering her rights is not the result of any illegal activity).

196. Driessen, *supra* note 192, at 2–3 (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).

197. See *id.* at 36–37 (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).

198. *N.J. Div. of Youth and Family Servs. v. V.M.*, 974 A.2d 448, 449 (N.J. Super. Ct. App. Div. 2009).

The culpability tool may be attractive to judges in child-birth-related cases, where childbirth methods can be in dispute because competition to provide childbirth services at the time of labor may be low. Even though the number of obstetricians may be large in any particular geographic area, for practical purposes, once in labor, a woman's ability to access a new physician is limited. At the time of delivery, many physicians are unwilling to treat a woman who was not previously their patient, and assistance from a new doctor may be even less likely when there are complications surrounding the delivery.¹⁹⁹ Even if a provider willing to provide the woman's preferred childbirth method is hypothetically available, there may not be time to access that alternative provider. This fact 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 analyze the woman's health interest. Instead, judges rely on the woman's culpability in the absence of competition rather than focusing simply on health ramifications posed by any court decision.

Pemberton v. Tallahassee Memorial Regional Medical Center exemplifies how the culpability tool functions in the area of compelled cesarean sections.²⁰⁰ In *Pemberton*, a pregnant

199. Difficulty finding a doctor later in pregnancy is reported anecdotally by many women. See, e.g., Roy Wood, *High-Risk Pregnancy Fuels Fears*, CINCINNATI POST, Sept. 13, 2005, at A12 (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); Dana DiFilippo, *Changing Your OB-GYN: The Challenges of Switching Doctors*, PARENTS.COM, <http://www.parents.com/pregnancy/labor-delivery/support/changing-ob-gyn/?page=2> (last visited June 13, 2009) (asserting that doctors are reluctant to take new patients if they are advanced in their pregnancy).

200. 66 F. Supp. 2d 1247 (N.D. Fla. 1999). For a similar example, see *In re Madyun*, a case involving a pregnant teenager who, after laboring for more than 2 days, was told by physicians that she needed a cesarean section to avert possible infection. *In re Madyun*, Misc. No. 189-86 (D.C. July 26, 1986) reprinted in *In re A.C.*, 573 A.2d 1235, 1260 app. (D.C. 1990). Madyun, who was Muslim, expressed religious objections to having a cesarean section. *Id.* at 1260 app. 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 app. The baby was born with no infection. Driessen, *supra* note 192, at 34. The *Madyun* case is discussed extensively in *The Colonization of the Womb*, by Nancy Ehrenreich. 43 DUKE L.J. 492, 524-35, 556-64 (1993); see also *In re A.C.*, 533 A.2d 611, 614 (D.C. 1987) (citing both viability and medical opinion-based culpability); *WVHCS-Hosp., Inc. v. Doe*, No. 3-E-2004, 1-2 (Pa. Ct. Com. Pl. Jan. 14, 2004), <http://advocatesforpregnantwomen.org/WVHCSBabyDoeJaneandJohnDoe.pdf> (restraining a pregnant woman and her husband from refusing a cesarean section without discussing women's health risks in a perfunctory court order in response to a motion by a hospital); *id.* at 3

woman who had a prior cesarean section tried unsuccessfully to find a physician who would attend her in a vaginal delivery.²⁰¹ She decided to give birth at home with no medical assistance but during labor went to the hospital emergency room solely for hydration.²⁰² The attending physician declined to provide the requested services, instead contacting supervising physicians, all of whom thought that a cesarean section was necessary.²⁰³ Meanwhile, Pemberton left the hospital.²⁰⁴ At that point, the hospital attorney instituted court proceedings to compel Pemberton to have a cesarean section, to which a judge agreed.²⁰⁵ Law enforcement was dispatched to Pemberton's home, and she was returned to the hospital against her will via ambulance.²⁰⁶ After a bedside hearing, a judge ordered Pemberton to have a cesarean section, and doctors performed the procedure against her will.²⁰⁷ After the birth of her child, Pemberton sued the hospital for violating her constitutional rights.²⁰⁸

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 health care options when she chose not to terminate her pregnancy.²⁰⁹ 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.²¹⁰ Moreover, Pemberton sought health care that was not supported by providers: a vaginal delivery after a prior cesarean section.²¹¹ The court said that the lack of competition

(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).

201. *Pemberton*, 66 F. Supp. 2d at 1249 (explaining that Pemberton's prior cesarean section was accomplished via a vertical incision, which presents a risk of uterine rupture during subsequent deliveries).

202. *Id.*

203. *Id.*

204. *Id.* (stating she departed "against medical advice" and "surreptitiously").

205. *Id.* at 1250 (The doctors testified that vaginal birth posed a substantial risk of death to the fetus.).

206. *Id.*

207. *Id.*

208. *Id.* at 1249 (asserting substantive and procedural due process rights violations).

209. *See id.* at 1251–52.

210. *See id.*

211. *See* John Zweifler et al., *Vaginal Birth After Cesarean in California: Before and After and Change in Guidelines*, 4 ANNALS FAM. MED. 228 (2006) (noting that after the adoption of restrictive vaginal birth after cesarean, or "VBAC,"

to provide Pemberton with vaginal delivery services was “hardly surprising” given the estimated 2 percent risk of uterine rupture (and 50 percent risk of fetal death if rupture occurred).²¹² 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 VBAC services she desired.

The operation of the culpability tool in *Pemberton* allowed the court to truncate its analysis of women’s health. The decision suggests that Pemberton was responsible for the lack of available providers; thus her interests were more easily subrogated to those of the fetus.²¹³ The nine-page decision focuses almost exclusively on the health of the “baby,” relegating the pregnant woman’s health—and the significant health risks presented by cesarean sections—to a few parenthetical references and one brief footnote.²¹⁴ The court’s response to Pemberton’s assertion that the forced cesarean section presented risks to her health was flippant: “Medical procedures rarely are [without risk].”²¹⁵ The court inferred from one expert’s failure

guidelines in 1999, the number of VBACs declined more than 10 percent, but neonatal and infant mortality rates failed to improve); David Dobbs, *VBAC Backlash: Why Are Hospitals Forbidding Women Who Have Had C-sections the Right to Have Vaginal Births?*, SLATE, Dec. 28, 2004, <http://www.slate.com/id/2111499/> (describing the trend of hospitals banning VBACs).

212. See *Pemberton*, 66 F. Supp. 2d at 1253 (noting a 2 to 2.2 percent risk of rupture, according to one physician).

213. See Note, *Rethinking (M)otherhood*, *supra* note 189, at 1339–40 (noting that a pregnant woman is seen as self-interested, thus her opinion is easily ignored by courts).

214. See *Pemberton*, 66 F. Supp. 2d at 1253 (saying “there is a very substantial risk of uterine rupture and resulting death of the baby (as well as serious injury to the mother)”; *id.* at 1254 (stating “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)”; *id.* at 1256 (noting “a vaginal birth in these circumstances would have presented a substantial risk of uterine rupture and resulting death of the baby, as well as a substantial risk to the health of the mother”); Rita Rubin, *Study Examines Moms’ C-Section Complications*, USA TODAY, Jan. 20, 2009, http://www.usatoday.com/news/health/2009-01-20-c-sections_N.htm (citing a study finding, between 1998–99 and 2004–05, a “90% increase in blood transfusions;” “a 50% increase in . . . blood clots in the lungs;” and a “20% increase in rates of kidney failure, respiratory distress syndrome, shock and the need for a ventilator”).

215. See *Pemberton*, 66 F. Supp. 2d at 1254 n.18. 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.

to quantify them that the risks are minimal.²¹⁶ The court did not analyze the risks the cesarean section posed to Pemberton, despite the fact that cesarean sections present such significant health risks that reducing their frequency is a goal of the federal government.²¹⁷

While *Pemberton* typifies judicial 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 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 instead on a detailed analysis of women's health issues at the time of delivery.²¹⁸ *In re Baby Boy Doe*, for example, exhaustively details the risks, both minor and major, a woman faces when she undergoes a cesarean section²¹⁹—and, in doing so, goes out of its way to disclaim the pregnant woman of any fault or responsibility she bears for her situation.²²⁰ 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.²²¹ This makes sense: why would a court emphasize a woman's

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

217. *See* Centers for Disease Control & Prevention, *Vaginal Birth After Cesarean Birth—California, 1996–2000*, 51 MORBIDITY & MORTALITY WKLY. REP. 989, 996 (2002) (citing the reduction of cesarean sections as a “national health objective” for first-time deliveries and vaginal deliveries after prior cesarean sections).

218. *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).

219. *See id.* at 328–29 (discussing that the mortality rate for cesarean sections is double that of vaginal delivery, involves increased recovery time and pain, and may damage other maternal organs).

220. *See id.* at 332 (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” (quoting *Stallman v. Youngquist*, 531 N.E.2d 355, 360 (Ill. 1988))).

221. *See id.*; *In re A.C.*, 573 A.2d 1235, 1237–53 (D.C. 1990) (majority not using the culpability tool and finding in the woman's favor); *id.* at 1256 (Belson, J., concurring in part and dissenting in part) (citing a woman's choice to bear a child as voluntarily putting herself in a “special class” of persons upon whom another's life depends totally). Similar reliance on an autonomy rationale is suggested in a recent U.S. District Court for the District of Columbia decision addressing allegations that the District of Columbia government forced institutionalized persons to have abortions. *See Does I through III v. Dist. of Columbia*, 593 F. Supp. 2d 115, 125 (D.D.C. 2009).

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.

Reference to a women's purported culpability is truly the last, dying gasp of the availability tool. It is an attempt to return to the rhetoric of availability, even in the absence of available alternatives. Regardless of how it is applied, however, by virtue of the fact that it seeks to use an availability tool-based analysis even when alternatives may be utterly lacking, the culpability tool's mere existence reinforces the significance of available alternatives to the analysis of women's reproductive health issues in reproductive health jurisprudence.

IV. THE TOOLS' UTILITY: THEORETICAL V. ACTUAL

The question remains as to whether either the availability tool or the culpability tool—or both—can be useful when analyzing restrictions on reproductive health products, providers, or services. As Part A discusses, theoretically, the tools have an undeniable appeal: if something is taken away, the visceral reaction is to immediately look to see if it can be replaced. But as Part B concludes, the complexities of actually determining whether a suitable substitute exists may overwhelm the tools' utility.

A. Theoretical Utility

Theoretically, the availability and culpability tools may be applied in a way that adequately protects women's reproductive health. The availability tool presumes that when a law eliminates a reproductive health provider or procedure women must be able to replace that provider or procedure with an alternative. Thus, the availability tool contains an underlying assumption that the reproductive health services currently on the market are either necessary to protect women's health, protected by law, or both. Likewise, the culpability tool assumes that doctors should be permitted to protect women's health by inserting their judgment when another medical decision could result in physical harm to the woman.

Each tool, then, has the potential to assist judges in analyzing the impact a law or decision may have on women's health and deciding whether that impact can be adequately

mitigated. The availability tool, for example, could function correctly and uphold an abortion procedure ban if there existed either an alternative procedure with the exact same health risk-benefit profile as the banned procedure or an available procedure that provided superior health protection to that of the banned procedure. The culpability tool would “work” in a case where a court compelled a pregnant woman to have a cesarean section in the face of 100 percent certainty of death if she chose vaginal delivery. “Work,” in this case, means that the judge’s hypothetical reference to a woman’s choice to continue her pregnancy post-viability and doctors’ refusal to assist in a misguided vaginal delivery could be cited by the judge to find the woman culpable, thereby allowing the judges to compel her to undertake a better, safer course of action.

While the tools may advance women’s health in some hypothetical scenarios, application of the availability tool and culpability tool do not address other significant legal interests—they can take jurists and litigators only so far. Whenever a woman is forced to use a reproductive health provider, product, or service not of her choosing—regardless of the availability of alternatives—significant privacy, sex-based equality, and autonomy interests are triggered and must be addressed.²²²

The availability and culpability tools do not provide an analytical framework for adjudicating autonomy issues, which are frequently part of women’s reproductive health cases. Recently, for example, a New Jersey woman who refused to have a cesarean section (and subsequently delivered a healthy baby vaginally) initially lost custody of her child based in part on her “irrational” refusal to consent to a cesarean.²²³ Although the culpability tool could have functioned in this case in order to help the judge decide whether the cesarean section would pro-

222. See *supra* Parts II–III (discussing contraception, abortion, and childbirth cases).

223. Although the appellate majority opinion did not address the issue of whether the refusal to consent to a cesarean could be used as evidence of child abuse because it found sufficient alternative evidence of abuse, the concurrence squarely addressed the autonomy issues presented in the case and said women’s decisions about whether to undergo invasive procedures such as cesareans should not be used as bases for abuse and neglect. *N.J. Div. of Youth & Family Servs. v. V.M.*, 974 A.2d 448, 465 (N.J. Super. Ct. App. Div. 2009). The trial court opinion in this case was unavailable at the time of publication, so precisely whether and how the culpability tool is used remains unknown, but the facts suggest its operation.

protect the woman's health, the tool would not have helped the judge address the obvious autonomy issues presented.

B. Actual Utility

When we move from hypothetical to actual reproductive health cases, two minimum criteria must be satisfied if the availability or the culpability tool is to be used to analyze women's health issues. First, the analysis must accurately determine the availability of alternatives. Without accurate analysis and identification of potential alternatives, the use of the availability and culpability tools may actually pose risks to women's health, as judges may overestimate access to safe reproductive health care. Second, courts must apply the availability and culpability tools neutrally, not as a means to a desired end. Without satisfying both of these requirements, the availability tool and culpability tool may undervalue women's health relative to competing interests.

1. 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 understand the situation of the women seeking (or who might seek) the procedure or provider and the landscape of alternatives. This can be an exceedingly challenging task, especially if judges are considering a facial challenge to a law. In reproductive health matters, the constitutionality of a law should be determined not by whether the law threatens the health of the majority of women but by whether it threatens the minority, whose health concerns may be rarer but significant.²²⁴ So, for example, a judge should not only consider the women in Seattle seeking Plan B but also the predicament of rural women in Washington in order to truly address women's health. An accurate application of the availability tool

224. *Planned Parenthood v. Casey* provides an excellent example of this point. There the husband notification provision was struck because a minority of women—domestic violence victims—would have suffered unduly from its requirements. 505 U.S. 833, 894 (1992) (finding that notification was an “undue burden” even though it may only impact less than 1 percent of women seeking abortions).

presupposes the availability of complete factual information for analysis.

Moreover, 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 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 proposed replacement may leave women’s health inadequately protected.

Instances of misidentified or incorrectly analyzed availability of alternatives are readily identifiable in reproductive rights jurisprudence. Take, for example, *Stormans, Inc. v. Selecky*, the case involving pharmacist refusal.²²⁵ Recall that in *Stormans*, at issue was whether allowing pharmacists to refuse to dispense contraceptives would harm women’s health, and whether requiring pharmacists to so dispense violated their religious freedom.²²⁶ The *Stormans I* and *II* courts found in favor of the pharmacists, relying upon a survey that showed that out of 121 pharmacies, ninety-three typically stocked emergency contraceptives while twenty-eight did not.²²⁷ According to *Stormans II*, 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.²²⁸

The availability cited in *Stormans I* and *II*, however, was a red herring. The number of pharmacies that *stocked* Plan B was not the issue, the willingness of individual pharmacists to *provide* Plan B to specific women was.²²⁹ It makes no difference to a woman needing Plan B that the pharmacy’s shelves are stocked with Plan B if no pharmacist on duty will give it to her. *Stormans I* and *II* failed to address the type of availability truly at issue in the case—the presence of individual pharmacists willing to *dispense* Plan B—and although *Stormans III*

225. See *supra* Part II.B(1) (discussing the case as an example of provider-based availability tool use).

226. See *supra* Part II.B(1).

227. 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. *Stormans II*, 526 F.3d 406, 408–09 (9th Cir. 2008).

228. See *id.*

229. See *id.*

may have recognized this problem, it inexplicably failed to heed it in its analysis.

Moreover, although the statistics cited in the *Stormans* cases show that a majority of pharmacies stocked Plan B, almost one-quarter of the pharmacies did not.²³⁰ For the availability tool to function effectively, on remand, the lower court must perform a detailed analysis of the entire factual landscape, including, for example, 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. The Ninth Circuit's decision in *Stormans III* hinted at the importance of some of these factors, but it did not clearly articulate their significance.²³¹

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 the reproductive health care market on a local level. For example, providers may only be present in a particular state for one or two days per month, some providing only certain abortion services.²³² Does the existence of occasional, fly-in service providers adequately protect women's health when a full-time, in-state provider faces closure due to increased regulations? And what is the impact on women's health if the "available" provider, relied upon in a case to protect women's health, leaves practice?²³³ The courts must closely scrutinize potential available alternative providers (or services).

Moreover, as *Gonzales* demonstrates, significant medical controversy can exist over whether a particular women's reproductive health procedure is irreplaceable because of its specific health benefits.²³⁴ When a procedure regulation or ban is con-

230. *Stormans III*, Nos. 07-36039, 07-36040, 2009 WL 3448435, at *21 (9th Cir. Oct. 28, 2009).

231. *Id.* at *2, *21 (noting the lack of statistics on refusing pharmacists); *id.* at *26 (noting the availability of hypothetical alternative providers within a five-mile radius).

232. See generally SUSAN WICKLUND, THIS COMMON SECRET: MY JOURNEY AS AN ABORTION DOCTOR (2007) (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).

233. See Jones et al., *supra* note 111, at 6 (noting the declining number of abortion providers in recent years).

234. *Gonzales v. Carhart*, 550 U.S. 124, 186–87 (2007).

sidered, a court must resist the urge to simplify what is an admittedly complex analysis of medical facts by relying on the purported availability of a substitute for the threatened procedure unless the court first undertakes its own nuanced comparison of the threatened procedure and its hypothetical substitute.

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 health care landscape. The need for expert medical testimony is almost guaranteed. Economists may also be needed to fully understand the relevant market. The application of the tools can only be as good as the information provided to the court.

Similar problems arise when judges use the culpability tool. When the culpability tool is used, no alternatives are present, so the inquiry concerns not whether there is an alternative but why no alternatives are available. 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.²³⁵ 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.²³⁶ 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.²³⁷ For this reason, courts must abandon the viability-culpability argument.

Aside from the viability issue, whether a woman should *ever* be held culpable for a lack of available reproductive health

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

236. 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.

237. 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.").

care choices is a difficult question. Certainly the existence of available providers or services (or lack thereof) may provide a judge insight into whether a woman's choice is generally supported by the medical community and therefore whether it 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 other constraints, such as insurance- or hospital-based limitations on providers or services—not just that the service sought is somehow medically inappropriate for the woman to request.²³⁸

As the cesarean section cases show, situations may exist where the woman's choice of medical treatment is risky for her health or fetal health or both. As previously discussed, the question should then become whether the culpability tool should be used to override a woman's autonomy.²³⁹ What do we do when a woman is making a decision that is bad for her health or we find morally reprehensible? 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 both the women's reproductive health care marketplace and the facts at bar are thoroughly understood, the availability and culpability tools have the propensity to be applied incompletely—and perhaps dangerously—because they may facilitate an overestimation of the presence of available alternatives or facilitate mischaracterization of whether these alternatives are capable of protecting women's health.²⁴⁰

238. See Mary Forney, *Hospital Policy Pains Expectant Mom*, LAKE POWELL CHRON., Sept. 30, 2009, http://www.lakepowellchronicle.com/v2_news_articles.php?heading=0&story_id=1849&page=77 (telling the story of a hospital that prohibited vaginal deliveries after a prior cesarean section and one pregnant woman who was told refusing a cesarean at that hospital would lead to court action); Rita Rubin, *Battle Lines Drawn of C-Sections*, USA TODAY, Aug. 23, 2005, 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).

239. For a thorough discussion of autonomy generally, see 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).

240. One meaningful check on whether availability actually protects women's health in a particular circumstance is to examine women's ability to actually access those alternative services or providers.

2. Applying Tools Neutrally

The drive to accurately define what constitutes availability in any particular case assumes, of course, that courts are applying the availability and culpability tools neutrally in a search for the truth behind the availability of women's health services. That assumption may be incorrect. The tools may be entirely a means to an end.

Neutrality 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 a "safe" option sufficient?²⁴¹ How a judge defines the "fit" needed may simply reflect the desired outcome of a case.

Proper use of the availability and culpability tools may also be hindered by another erroneous belief: the belief that low availability is present when there is low demand, and therefore a reproductive health service perceived to be little-used is not deserving of protection. Such a belief in the context of reproductive health services is unsupportable. Statistics show that birth control is one of the most-used reproductive health services in a woman's lifetime;²⁴² abortion, although slowly declining in use, is still widely relied upon;²⁴³ and the availability of vaginal delivery, particularly after a prior cesarean, may be dwindling not due to women's desire, but because of regulatory and insurance constraints.²⁴⁴ Regardless of the frequency of use, these services must be as safe as possible for women lest they impair women's health and overall autonomy.

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, judges may refer to a pregnant woman as a "mother," a fetus may be referred to as a "baby," and a physi-

241. See *supra* Part II.C (discussing the use of the terms "safe" and "safest" in *Stenberg* and *Gonzales*).

242. NARAL Pro-Choice America, *supra* note 27 (saying 98 percent of women use birth control at some time in their lives).

243. There were an estimated 1.2 million abortions provided in 2005. See Jones et al., *supra* note 111, at 6.

244. See *supra* note 238 and accompanying text.

cian who provides abortions as an “abortion doctor.”²⁴⁵ In forced cesarean section cases, judges portray women as selfish and uncaring for questioning the opinions of their physicians, regardless of the woman’s motive or even the ultimate birth outcome.²⁴⁶ Strident rhetoric undermines the legitimacy of judicial decisions in all cases, but issues of legitimacy may be particularly magnified in women’s health cases, where the court’s role in disputes is routinely questioned. If the availability or culpability tool is surrounded by rhetoric that is openly hostile to one side, and if application of these tools operates the vast majority of the time to further restrict women’s health services, the neutrality of the application must necessarily be called into question.

Identifying the pitfalls of the availability and culpability tools does not necessarily render them useless. To the contrary, each of the tools may help organize the analysis of questions of law that are fraught not only with legal complexities but also with very real emotion. Like any tool or legal framework, courts must carefully apply the availability and culpability tools lest they morph into nothing more than shortcuts that undermine rather than facilitate the necessary analysis.

CONCLUSION

The availability tool and, to a more limited extent, the culpability tool have the potential to be useful in reproductive rights jurisprudence. These tools, however, must make up 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

245. See *Gonzales v. Carhart*, 550 U.S. 124, 186–87 (2007) (Ginsburg, J., dissenting) (noting that, in its rhetoric, “[t]he Court’s hostility to the right *Roe* and *Casey* secured is not concealed”).

246. See *In re Madyun*, Misc. No. 189-86 (D.C. July 26, 1986) reprinted in *In re A.C.*, 573 A.2d 1235, 1263 app. (D.C. 1990) (“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 infant.”).

but, in doing so, likely decreased availability.²⁴⁷ The next judge addressing a reproductive health controversy in that South Carolina area will have fewer providers to rely upon when deciding the case. Or consider *Gonzales*, which upheld a procedure ban on partial-birth abortion, leaving fewer substitute procedures.²⁴⁸ When the next federal procedural ban comes, will available alternatives exist for the court to use the availability tool to decide the controversy? For example, could a court uphold a total ban on surgical abortions based on the continuing availability of medical abortion? One day, might an argument suggesting that surgical abortion is 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 a medical abortion?

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 reproductive health services, one in which no available alternative exists not because of a woman's actions, but because of prolific government reproductive rights restrictions. It may be in this scenario, where neither the availability tool nor the culpability tool can function, that women—and their health—become visible again.²⁴⁹

247. See *supra* notes 112–35 and accompanying text.

248. See *supra* notes 161–78 and accompanying text.

249. 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).