

A ROAD MAP THROUGH THE SUPREME COURT’S BACK ALLEY

CLARKE D. FORSYTHE* & BRADLEY N. KEHR**

“As today’s decision indicates, medical technology is changing, and this change will necessitate our continued functioning as the nation’s ‘*ex officio*’ medical board with powers to approve or disapprove medical and operative practices and standards throughout the United States.”¹

“It is certainly difficult to understand how the Court believes that the physician-patient relationship is able to accommodate any interest that the State has in maternal physical and mental well-being in light of the fact that the record in this case shows that the relationship is non-existent.”²

—Justice Sandra Day O’Connor (1983)

I. INTRODUCTION

A decade after *Roe v. Wade*³ and *Doe v. Bolton*,⁴ Justice O’Connor pointed out that the Supreme Court had assumed the role of the National Abortion Control Board. Before effective abortion clinic regulations can be drafted or implemented, the constraints of the Supreme Court’s abortion doctrine—that Justice O’Connor only partially outlined—must be thoroughly understood. In the wake of *Gonzales v. Carhart*,⁵ clinic regulations need to be reasonably designed to protect maternal health. If clinic regulations are going to meet that standard, the short- and long-term risks of abortion need to be better understood.

Professor Calhoun wants to “bring pro-lifers and pro-choicers together to prevent future Gosnells.”⁶ While preventing “future Gosnells” is a worthy goal, we question several of his assumptions. A majority of people—including pro-lifers and pro-choicers—already support health and safety regulations for abortion procedures. The aim should be effective protection for women’s physical and psychological health, not merely the bargain-basement goal of stopping the

* Senior Counsel of Americans United for Life and author of *POLITICS FOR THE GREATEST GOOD: THE CASE FOR PRUDENCE IN THE PUBLIC SQUARE* (Intervarsity Press 2009). Copyright 2011 by Clarke D. Forsythe. All rights reserved.

** Georgetown University Law Center, J.D. Candidate, 2012. Acknowledgement: The authors are grateful to Denise Burke and Evangeline Jones for comments on an earlier draft.

1. *City of Akron v. Akron Ctr. for Reprod. Health, Inc.*, 462 U.S. 416, 456 (1983) (O’Connor, J., dissenting) (quoting *Planned Parenthood v. Danforth*, 428 U.S. 52, 99 (1976) (White, J., concurring in part and dissenting in part)), *overruled by* *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

2. *Id.* at 473.

3. 410 U.S. 113 (1973).

4. 410 U.S. 179 (1973).

5. 550 U.S. 124 (2007).

6. See Samuel W. Calhoun, *Stopping Philadelphia Abortion Provider Kermit Gosnell and Preventing Others Like Him: An Outcome That Both Pro-choicers and Pro-lifers Should Support*, 57 VILL. L. REV. 1, ___ (2012).

worst practitioners. The main obstacle to effective health and safety regulations is not a lack of majority support, but rather the Supreme Court's abortion doctrine, which was misguided in its inception and has been contradictory in its application. As we hope to show, clinic regulations are fully justified by the substandard conditions in clinics and by the inherent risks of abortion procedures.

II. THE IMPACT OF *ROE V. WADE* & *DOE V. BOLTON*

The Supreme Court, in its 1973 abortion decisions—*Roe v. Wade* and *Doe v. Bolton*—swept away the abortion laws of all fifty states.⁷ The Court virtually exempted abortion from the state public health systems by declaring it to be the only medical procedure that is a constitutional right, and by holding that there is no compelling interest in regulations that protect maternal health in the first trimester.

Congress could not fill the vacuum. Congress exercised virtually no power over abortion before *Roe* unless it was tied to an enumerated power, such as the Mail or the Spending Clause.⁸ Since *Roe*, Congress's power over abortion is still disputed.⁹ Since Congress's constitutional authority to fill the gap is doubtful, and the state and local governments have been disabled by the Court, no level of government has clear authority to act without federal court approval.

A. *No Record in Roe or Doe*

The Court created the vacuum without any trial record in either *Roe* or *Doe*. The factual records in *Roe* and *Doe* were non-existent—consisting merely of a complaint, an affidavit (unsigned by Jane Roe, signed by Mary Doe), and motions to dismiss.¹⁰ In both cases, the three-judge district courts proceeded to

7. See, e.g., Laurence H. Tribe, *Foreword: Toward a Model of Roles in the Due Process of Life and Law*, 87 HARV. L. REV. 1, 2 (1973) (“And in *Roe v. Wade* and *Doe v. Bolton*, when the Court had its most dramatic opportunity to express its supposed aversion to substantive due process, it carried that doctrine to lengths few observers had expected, imposing limits on permissible abortion legislation so severe that no abortion law in the United States remained valid.” (footnotes omitted)).

8. See, e.g., *Ex parte Jackson*, 96 U.S. 727, 736 (1877) (applying act of Congress regulating mail and banning “any article or thing designed or intended for the . . . procuring of abortion”).

9. See, e.g., David B. Kopel & Glenn H. Reynolds, *Taking Federalism Seriously: Lopez and the Partial-Birth Abortion Ban Act*, 30 CONN. L. REV. 59 (1997) (examining whether Partial-Birth Abortion Ban Act is legitimate exercise of congressional power); Robert J. Pushaw, Jr., *Does Congress Have the Constitutional Power to Prohibit Partial-Birth Abortion?*, 42 HARV. J. ON LEGIS. 319 (2005) (asserting Congress had authority under Commerce Clause to pass Partial-Birth Abortion Ban Act); Jordan Goldberg, Note, *The Commerce Clause and Federal Abortion Law: Why Progressives Might Be Tempted to Embrace Federalism*, 75 FORDHAM L. REV. 301 (2006) (arguing progressives should take approach other than Commerce Clause to support abortion rights because conservative court could restrict rights under clause).

10. See *Doe v. Bolton*, 319 F. Supp. 1048 (N.D. Ga. 1970), *modified*, 410 U.S. 179 (1973); *Roe v. Wade*, 314 F. Supp. 1217 (N.D. Tex. 1970), *aff'd in part, rev'd in part*, 410 U.S. 113 (1973). See generally 1-3 ROY M. MERSKY & GARY R. HARTMAN, A DOCUMENTARY HISTORY OF THE LEGAL ASPECTS OF ABORTION IN THE UNITED STATES:

hold two-hour oral hearings in which the judges addressed procedural and jurisdictional issues more than substantive constitutional or medical questions. There were no factual hearings. No witnesses testified. No testimony was given. No medical data was reviewed. There was no opportunity for cross-examination. And then, without any intermediate appellate review in either case, the Supreme Court granted review.

The Justices took *Roe* and *Doe* under the misapprehension that they were merely dealing with the application of *Younger v. Harris*¹¹—decided sixty days before the Court took *Roe* and *Doe*—which prohibited federal court intervention in pending state criminal proceedings. If the Court had merely addressed the jurisdictional issues, it would not have needed a full evidentiary record on the complex historical, legal, and medical issues that the Court eventually addressed. The expectation of dealing only with jurisdictional issues may explain why the Justices took not one but two cases with no evidentiary record. At some point—possibly during the conference after the first arguments on December 16, 1971—a majority decided that they had jurisdiction and proceeded to address the abortion issue without a record, instead of more prudently granting review to other pending abortion cases with better records.¹²

The lack of an evidentiary record should have been a red flag to the Justices. Hearing such cases violated long-standing principles of not deciding constitutional questions without a full record.¹³ However, a bloc of four Justices—

ROE V. WADE (1993). In the first oral argument in *Roe*, the Texas Assistant Attorney General stated, “The record that came up to this Court contains the amended petition of Jane Roe, an unsigned alias affidavit, and that is all.” Transcript of Oral Argument at 16, *Roe*, 410 U.S. 113 (No. 70-18) [hereinafter *Roe* Oral Argument], available at <http://www.aul.org/roe-v-wade-transcripts>. Additionally, during the first oral argument in *Doe*, the Georgia Assistant Attorney General said, “That, again, is not in the record because there was no evidence presented.” Transcript of Oral Argument at 17, *Doe*, 410 U.S. 179 (No. 70-40) [hereinafter *Doe* Oral Argument], available at <http://www.aul.org/doe-v-bolton-transcripts>.

11. 401 U.S. 37 (1971). *Younger* was decided with *Samuels v. Mackell*, 401 U.S. 66; *Perez v. Ledesma*, 401 U.S. 82; *Dyson v. Stein*, 401 U.S. 200; *Byrne v. Karalexis*, 401 U.S. 216; and *Boyle v. Landry*, 401 U.S. 77. All were decided February 23, 1971.

12. See Letter from Harry Blackmun, Assoc. Justice, U.S. Supreme Court, to William Rehnquist, Chief Justice, U.S. Supreme Court (July 20, 1987) (on file with the Library of Congress, Harry Blackmun Papers, Box 151 and Box 1407, Folder 13) (“Potter pressed for *Roe v. Wade* and *Doe v. Bolton* to be heard and did so in the misapprehension that they involved nothing more than an application of *Younger v. Harris*. How wrong we were.”); see also LINDA GREENHOUSE, *BECOMING JUSTICE BLACKMUN: HARRY BLACKMUN’S SUPREME COURT JOURNEY* 80 (2005) (quoting letter from Justice Blackmun to Chief Justice Rehnquist); JAMES F. SIMON, *THE CENTER HOLDS: THE POWER STRUGGLE INSIDE THE REHNQUIST COURT* 85-86 (1995) (relating this account based on May 1991 interview with Justice Blackmun); BOB WOODWARD & SCOTT ARMSTRONG, *THE BROTHERS: INSIDE THE SUPREME COURT* 165-69 (1979) (relating this account from Justice William O. Douglas’s perspective).

13. See, e.g., *Renne v. Geary*, 501 U.S. 312, 321-22 (1991) (“We possess no factual record of an actual or imminent application of [the statute] sufficient to present the constitutional issues in ‘clean-cut and concrete form.’” (citation omitted)); *Kleppe v. New Mexico*, 426 U.S. 529, 546 (1976) (“We have often declined to decide important questions regarding ‘the scope and constitutionality of legislation’ . . . in the absence of ‘an adequate and full-bodied record.’” (citations omitted)); *Pub. Affairs Assocs. v. Rickover*, 369 U.S. 111, 113 (1962) (per curiam) (“Adjudication of such problems, certainly by way of resort to a discre-

Douglas, Brennan, Marshall, and Stewart—was eager to strike down the abortion laws during the sixteen weeks that the Court was “short-handed,” with seven Justices after the abrupt retirements of Justices Black and Harlan in September 1971, and before the two new “Nixon judges” could join the Court.¹⁴ All of the sociological and medical assumptions that provided the premises for the Justices’ statements in the abortion decisions were thus derived from the parties’ and amicus briefs filed with the Court. Among many other things, the record lacked any data on the short- and long-term risks of abortion, or how the new “abortion practice” might be regulated.

The Court in *Doe* eliminated a two-physician concurrence, a residency requirement, and a hospitalization requirement.¹⁵ Between 1967 and 1970, thirteen states amended their abortion prohibitions and allowed abortion under certain circumstances. Georgia adopted a hospitalization requirement based on the then-existing policy position of the American Medical Association (AMA).¹⁶ But the advocate for the Georgia plaintiffs urged the Court to strike down the hospitalization requirement, claiming that abortions in clinics were equally safe. The Court obliged, without any trial record of the experience under the Georgia

tionary declaratory judgment, should rest on an adequate and full-bodied record. The record before us is woefully lacking in these requirements.”); *Associated Press v. NLRB*, 301 U.S. 103, 132 (1937) (“Courts deal with cases upon the basis of the facts disclosed, never with nonexistent and assumed circumstances.”); *United States v. Blackwell*, 694 F.2d 1325, 1344-45, 1345 n.9 (D.C. Cir. 1982) (Robinson, J., concurring) (“Not only have any impediments to the Government’s capacity to counter Blackwell’s constitutional arguments deprived us of the full benefits of the adversary process, but the inadequacy of the record obscures the factual contours of the problem and blurs perception of its legal ramifications. Indeed, a well-developed record is essential to decision of any question, especially one constitutional and novel in character, and the defective record we now have leaves open the possibility that factors relevant to resolution of the constitutional issue may escape judicial attention.”).

14. See DAVID J. GARROW, *LIBERTY AND SEXUALITY: THE RIGHT TO PRIVACY AND THE MAKING OF ROE V. WADE* 551-56 (1994) (indicating that certain Justices wanted to strike down abortion bans); see also JOHN C. JEFFRIES, JR., JUSTICE LEWIS F. POWELL, JR. 337 (1994) (“I will be God-damned! At lunch today, Potter expressed his outrage at the high handed way things are going, particularly the assumption that a single Justice if CJ can order things his own way, and that he can hold up for nine anything he chooses, even if the rest of us are ready to bring down 4-3s for example.”) (quoting Note from William Brennan, Assoc. Justice, U.S. Supreme Court, to William O. Douglas, Assoc. Justice, U.S. Supreme Court (June 1972) (on file with Library of Congress, William O. Douglas Papers, Madison Building, Box 1590, Folder 5))). This note from Justice Brennan is misquoted, in part, in GARROW, *supra*, at 556. Garrow misquotes the passage as “for nine months.” “Months” is not in the original version of the note in the Douglas Papers in the Library of Congress. The context indicates that “nine” most likely refers to the number of Justices since the rest of the sentence refers to “4-3s.”

15. See *Doe*, 410 U.S. at 201.

16. This was the position of the AMA in 1967, the year before Georgia passed its statute, and in 1970, the year the federal court challenge to the statute was filed. See *Medical News*, J. AM. MED. ASS’N, July 10, 1967, at 27, 38 (“[T]he [AMA] is opposed to induced abortion except when . . . [t]he procedure is performed in a hospital accredited by the Joint Commission on Accreditation of Hospitals”); *Committee on Human Reproduction*, 201 J. AM. MED. ASS’N 544 (1967) (indicating AMA’s opposition to induced abortions); *AMAGrams*, 213 J. AM. MED. ASS’N 359, 359 (1970) (resolving “[t]hat abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in an accredited hospital acting only after consultation with two other physicians”).

law or that of any other of the thirteen states that had legalized abortion between 1967 and 1970.

B. *The Medical Mantra That Drove the Result in Roe*

Since 1973, nearly every statement of history, law, and precedent in *Roe* and *Doe* has been subjected to criticism.¹⁷ Perhaps Harvard Law Professor Mark Tushnet, a clerk for Justice Thurgood Marshall during the deliberations in *Roe*, summed up the consensus best: “It seems to be generally agreed that, as a matter of simple craft, Justice Blackmun’s opinion for the Court was dreadful.”¹⁸

But one critical element that has been almost completely overlooked is the key medical premise that drove the result in the abortion decisions. Based on the briefs and arguments, the Court adopted a medical mantra—that “abortion is safer than childbirth”—which was never addressed by the district courts in either *Roe* or *Doe*. There was no record on this question. While it was asserted in the appellants’ briefs, it was disputed by the Assistant Attorneys General for Texas and Georgia, who pointed out that there was no basis for it in the record and that significant data contradicted the assertion.¹⁹ The adoption of the premise violated standards of judicial notice, because it was a statistical proposition that was sharply disputed.²⁰

17. See generally ABORTION AND THE CONSTITUTION: REVERSING *ROE V. WADE* THROUGH THE COURTS (Dennis Horan et al. eds., 1987); JOSEPH W. DELLAPENNA, DISPELLING THE MYTHS OF ABORTION HISTORY (2006); CHARLES FRIED, ORDER & LAW: ARGUING THE REAGAN REVOLUTION—A FIRSTHAND ACCOUNT (1991); MARY ANN GLENDON, ABORTION AND DIVORCE IN WESTERN LAW (1987); STEPHEN M. KRASON, ABORTION: POLITICS, MORALITY AND THE CONSTITUTION (1984); Robert M. Byrn, *An American Tragedy: The Supreme Court on Abortion*, 41 *FORDHAM L. REV.* 807 (1973); Joseph W. Dellapenna, *Nor Piety Nor Wit: The Supreme Court on Abortion*, 6 *COLUM. HUM. RTS. L. REV.* 379 (1974-1975); Clarke D. Forsythe & Stephen B. Presser, *Restoring Self-government on Abortion: A Federalism Amendment*, 10 *TEX. REV. L. & POL.* 301 (2006); Clarke D. Forsythe & Stephen B. Presser, *The Tragic Failure of Roe v. Wade: Why Abortion Should Be Returned to the States*, 10 *TEX. REV. L. & POL.* 85 (2005) (collecting sources showing criticism of *Roe*); Dennis J. Horan et al., *Two Ships Passing in the Night: An Interpretivist Review of the White-Stevens Colloquy on Roe v. Wade*, 6 *ST. LOUIS U. PUB. L. REV.* 229 (1987); Paul Benjamin Linton, *Planned Parenthood v. Casey: The Flight from Reason in the Supreme Court*, 13 *ST. LOUIS U. PUB. L. REV.* 15 (1993); Arnold H. Loewy, *Why Roe v. Wade Should Be Overruled*, 67 *N.C. L. REV.* 939 (1989); Michael Stokes Paulsen, *The Worst Constitutional Decision of All Time*, 78 *NOTRE DAME L. REV.* 995 (2003); William W. Van Alstyne, *Closing the Circle of Constitutional Review from Griswold v. Connecticut to Roe v. Wade: An Outline of a Decision Merely Overruling Roe*, 1989 *DUKE L.J.* 1677; Lynn D. Wardle, *Rethinking Roe v. Wade*, 1985 *BYU L. REV.* 231; Robert A. Destro, Comment, *Abortion and the Constitution: The Need for a Life-Protective Amendment*, 63 *CALIF. L. REV.* 1250 (1975).

18. Mark V. Tushnet, *Following the Rules Laid Down: A Critique of Interpretivism and Neutral Principles*, 96 *HARV. L. REV.* 781, 820 (1983).

19. See *Doe* Oral Argument, *supra* note 10, at 14; *Roe* Oral Argument, *supra* note 10, at 22.

20. See, e.g., *Castaneda v. Partida*, 430 U.S. 482, 499 (1977) (declining to take judicial notice when “[t]he problem is a complex one, about which widely differing views can be held, and, as such, it would be somewhat precipitate to take judicial notice of one view over another on the basis of a record as barren as this”); see also *Garner v. Louisiana*, 368 U.S. 157, 173

Justice Blackmun made two primary claims in his opinion regarding the safety of abortion. After contending (erroneously) that state abortion statutes were passed solely to protect the health of the woman (and not the unborn child),²¹ he stated in the *Roe* opinion that the situation had changed:

[A]bortion in early pregnancy, that is, prior to the end of the first trimester, although not without its risk, is now relatively safe. Mortality rates for women undergoing early abortions, where the procedure is legal, *appear to be* as low as or lower than the rates for normal childbirth. [Blackmun cited five medical sources in footnote 44 to support his assertion.] Consequently, any interest of the State in protecting the woman from an inherently hazardous procedure, except when it would be equally dangerous for her to forgo it, has largely disappeared.²²

Fourteen pages later, Justice Blackmun made a significant conclusion:

[T]he State's important and legitimate interest in the health of the mother [becomes] . . . compelling . . . in the light of present medical knowledge . . . at approximately the end of the first trimester. This is so because of the now-*established medical fact*, referred to above at [page 149], that until the end of the first trimester mortality in abortion may be less than mortality in normal childbirth. It follows that, from and after this point, a State may regulate the abortion procedure to the extent that the regulation reasonably relates to the preservation and protection of maternal health.²³

The “appear to be” on page 149 suddenly becomes an “established medical fact” on page 163.

Justice Blackmun immediately qualifies the “established medical fact” with

(1961) (“To extend the doctrine of judicial notice to the length pressed by the respondent would require us to allow the prosecution to do through argument to this Court what it is required by due process to do at the trial, and would be ‘to turn the doctrine into a pretext for dispensing with a trial.’” (quoting *Ohio Bell Tele. Co. v. Pub. Utils. Comm.*, 301 U.S. 292, 302 (1937))). Federal Rule of Evidence 201(b), adopted post-*Roe*, would not allow such a disputed statistical proposition: “The court may judicially notice a fact that is not subject to reasonable dispute because it: (1) is generally known within the trial court’s territorial jurisdiction; or (2) can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned.” FED. R. EVID. 201(b).

21. The literature demonstrating that state abortion laws were intended to protect the unborn child and the health of the mother is voluminous. See generally DELLAPENNA, *DISPELLING THE MYTHS OF ABORTION HISTORY*, *supra* note 17; JOHN KEOWN, *ABORTION, DOCTORS AND THE LAW: SOME ASPECTS OF THE LEGAL REGULATION OF ABORTION IN ENGLAND FROM 1803 TO 1982* (1988); Linton, *supra* note 17, app. A at 103-19 (asserting abortion laws were originally passed to protect unborn life); James S. Witherspoon, *Reexamining Roe: Nineteenth-Century Abortion Statutes and the Fourteenth Amendment*, 17 ST. MARY’S L.J. 29 (1985) (asserting nineteenth-century abortion statutes were passed with intent to protect unborn life).

22. *Roe v. Wade*, 410 U.S. 113, 149 (1973) (emphasis added) (footnote omitted).

23. *Id.* at 163 (emphasis added).

“may be less.”²⁴ Despite the contradiction in this paragraph (and the one on page 149), the Court adopted the medical mantra as fact.

The medical mantra was arguably the single most important premise that drove the results in the abortion decisions. It is difficult to exaggerate its importance. It formed the historical rationale for the right to abortion, the trimester framework, the state interest analysis, the prohibition on health and safety regulations in the first trimester, the limitations on health and safety regulations in the second trimester, the “health” exception after viability, and the extreme deference to the subjective discretion of the provider throughout.²⁵ What’s left?

Unfortunately, it was false: there was no reliable medical data to support the mantra in 1973, and none were cited in either opinion.

Between them, Justices Blackmun and Douglas (in his concurring opinion) cited seven medical articles, without analysis or discussion.²⁶ This begs the question, How reliable are the seven sources?

The first, an April 1961 article in the *Journal of the American Medical Association* by Christopher Tietze, is merely a self-styled “report” that comments on a so-called “International Conference on Abortion Problems and Abortion Control,” held in May 1960 in then-Communist East Germany.²⁷ It is not an analysis of data, much less a peer-reviewed study, but a report on conference papers addressing statistics from the 1940s and 1950s from Eastern European countries. Moreover, much of Tietze’s report is based on nothing more than personal communications with the conference speakers, rather than published data. No evidence is given that any of the asserted statistics are reliable.

The second Tietze paper, from 1969, titled *Mortality with Contraception and Induced Abortion*, claims to compare the risk of mortality from conception and abortion.²⁸ Tietze begins by imagining a “statistical model” and an express assumption of a mortality rate from childbirth of 20/100,000 as “a reasonable approximation.”²⁹ He then assumes an illegal abortion mortality rate of 100/100,000 pregnancies.³⁰ He calls this a “very rough estimate, and, almost certainly conservative,” but gives no basis for such a claim.³¹ This paper does not claim to compare mortality from childbirth and abortion, and there is no da-

24. *Id.*

25. See Nancy K. Rhoden, *Trimesters and Technology: Revamping Roe v. Wade*, 95 YALE L.J. 639, 640 (1986) (“[T]wo medically determined times—the time when the hazards of abortion surpassed those of childbirth, and the time of fetal viability—appeared to form the structural foundation of the *Roe* trimester framework.”).

26. See *Roe*, 410 U.S. at 149 n.44; *id.* at 216 n.5 (Douglas, J., concurring).

27. See generally Christopher Tietze & Hans Lehfeldt, *Legal Abortion in Eastern Europe*, 175 J. AM. MED. ASS’N 1149 (1961).

28. See Christopher Tietze, *Mortality with Contraception and Induced Abortion*, STUDS. FAM. PLANNING, Sept. 1969, at 6. This article is sometimes mis-cited as “*Mortality with Contraception and Induced Abortion*.”

29. See *id.* at 6.

30. See *id.*

31. *Id.*

ta in the paper that would enable one to make such a comparison.³² His methodology—which involves mixing and matching numbers from different countries and from different time periods—suffers from obvious problems.

The third Tietze paper on “therapeutic abortions” from 1970 is a very brief three-page report.³³ This report did not claim to be a study of maternal mortality from abortion compared to childbirth. Very little is said about maternal mortality; only bare numbers of deaths are reported. The category of therapeutic abortion is undefined, and there is no consistent measure in the paper that limits his analysis to “therapeutic” abortions. The data in this article were from the Professional Activities Survey (PAS) “conducted by the Commission on Professional and Hospital Activities,” which involved the *voluntary* participation of hospitals.³⁴ Tietze made four devastating concessions: that the hospitals in the PAS were “not a random sample,” that there was no reliable statistical information on therapeutic abortions in hospitals, that the data presented could only be used to arrive at “rough estimates of the numbers of therapeutic abortions,” and that the true number of such abortions “may well have been 10 per cent smaller or 20 per cent larger than the estimate shown.”³⁵

The fourth source, a 1970 paper by Malcolm Potts, contains no data and no supporting studies.³⁶ Virtually all assertions on data are undocumented and have no citations whatsoever.

The fifth source, a Vera Kolblova “article,” is really a *six-paragraph letter to the editor*.³⁷ Kolblova comments on Czech abortion law since 1957 with the purpose of showing that the law “has great advantages and ameliorates health problems.”³⁸ Kolblova describes the law, includes some statistics from 1957 to 1964 on complications and deaths, and asserts that the law accomplished its purpose “to limit the number of criminal abortions and reduce the number of consequent complications and deaths.”³⁹ The purpose of this letter to the editor is not to contend that abortion is safer than childbirth, and, in any case, there are no data to support that proposition.

The sixth source, authored by K.H. Mehland, a professor from East Germany, is from the May-June 1966 issue of the *World Medical Journal*.⁴⁰ No graph, figure, or table shows maternal mortality from abortion (legal or illegal)

32. Instead, Tietze simply cites another paper of his, “in print,” which purportedly gives an abortion mortality rate of 3/100,000 in Hungary, Czechoslovakia, and Slovenia for the 1957-1967 period. *Id.* at 6 n.1 (citing Christopher Tietze, *Abortion Laws and Abortion Practices in Europe*, in 5 *ADVANCES IN PLANNED PARENTHOOD* (Aquiles J. Sobrero ed., 1970)).

33. See Christopher Tietze, *United States: Therapeutic Abortions, 1963 to 1968*, *STUDS. FAM. PLANNING*, Nov. 1970, at 5, 7.

34. See *id.* at 5.

35. See *id.*

36. See D.M. Potts, *Post-contraceptive Control of Fertility*, 8 *INT’L J. GYNAECOLOGY & OBSTETRICS* 957, 967 (1970).

37. See generally Věra Kólblová, *Legal Abortion in Czechoslovakia*, 196 *J. AM. MED. ASS’N* 371 (1966).

38. See *id.*

39. *Id.*

40. See K.H. Mehland, *Combating Illegal Abortion in the Socialist Countries of Europe*, *WORLD MED. J.*, May-June 1966, at 84.

or childbirth. He merely claims that the abortion mortality rate “now stand[s] at 6 deaths per 100,000 operations performed in hospitals by specialists.” No mention is made of any possible long-term risks. Mehland cites no publications and has no bibliography.

The seventh source is probably the most important—a June 1971 report on data from New York City supposedly documenting the city’s experience since New York legalized abortion on July 1, 1970.⁴¹ The report encompassed no more than the first ten to eleven months of legalization in New York. Critics at the time pointed out that more than fifty percent of New York City abortion patients were non-residents and lost to follow-up. Their health status after abortion could not be verified.

The medical mantra in *Roe* was based entirely on these seven medical sources. Justice Blackmun cited the mantra twice in his opinion (and once in *Doe*⁴²), and Justice Douglas also cited the mantra.⁴³ None of the seven sources contained any data to support the mantra; none provided reliable data from which to confidently compare maternal mortality and childbirth mortality as of 1972. And there was no consideration whatsoever of long-term risks.

Instead of these seven sources, the Court should have looked at existing obstetrical textbooks, which commonly cull published articles for the best existing data. But no medical textbooks are cited in *Roe* to support the mantra because the mantra is never cited in any of the leading obstetrical textbooks published before 1972: Willson’s 4th edition (1971) never cites it,⁴⁴ nor *Williams Obstetrics* 14th edition (1971),⁴⁵ nor *Novak’s Textbook of Gynecology* 8th edition (1970),⁴⁶ nor J.P. Greenhill’s 13th edition (1965),⁴⁷ nor Reid and Ryan’s

41. *Abortion Mortality*, 20 MORBIDITY & MORTALITY WKLY. REP. 208, 209 (1971).

42. *See Doe v. Bolton*, 410 U.S. 179, 190 (1973) (“[A]dvances in medicine and medical techniques have made it safer for a woman to have a medically induced abortion than for her to bear a child.”).

43. *See Roe v. Wade*, 410 U.S. 113, 149 (1973) (“Mortality rates for women undergoing early abortions, where the procedure is legal, appear to be as low as or lower than the rates for normal childbirth.” (citing Potts, *supra* note 36, at 967); *Abortion Mortality*, *supra* note 41, at 209; Tietze & Lehfeldt, *supra* note 27, at 1152; Tietze, *supra* note 28, at 6; Tietze, *supra* note 33, at 7; *see also Roe*, 410 U.S. at 163 (“[U]ntil the end of the first trimester mortality in abortion may be less than mortality in normal childbirth.”)).

44. *See* J. ROBERT WILLSON ET AL., *OBSTETRICS AND GYNECOLOGY* 173-79 (4th ed. 1971).

45. *See* LOUIS M. HELLMAN & JACK A. PRITCHARD, *WILLIAMS OBSTETRICS* 520 (14th ed. 1971) (“It is a common fallacy, particularly in lay publications, to exaggerate the number of maternal deaths attributable to abortion each year. For example, Pilpel and Norwick state that ‘illegal (out-of-hospital) abortions account for as many as 8,000 maternal deaths each year.’ Although the exact number is unknown, in 1967 there was a total of only 50,683 deaths of women, aged 15 to 44, and only 987 maternal deaths. The often quoted high figure is therefore obviously impossible. The National Center for Health Statistics records 160 abortion deaths in 1967.”); David J. Garrow, *Roe v. Wade Revisited*, 9 GREEN BAG 71, 77 (2005) (reviewing *WHAT ROE V. WADE SHOULD HAVE SAID* (Jack M. Balkin et al. ed., 2005)) (noting that scholar “corrects a commonly-made abortion-rights error by rightly noting that in the years before *Roe* only a few hundred women per year died from illegal abortions, not the thousands upon thousands that some writers—[Cass] Sunstein in this volumes says ‘as many as 10,000’ annually—wrongly claim”).

46. *See* EDMUND R. NOVAK ET AL., *NOVAK’S TEXTBOOK OF GYNECOLOGY* 570-71

obstetrical text,⁴⁸ nor even Danforth's 3d edition, published four years after *Roe*.⁴⁹

The Court also disregarded contrary data. Justice Douglas's law clerk (RLJ), wrote a memo to Douglas on October 27, 1971, before the first oral argument, noting that a brief filed by "Certain Members of the American College of Obstetrics and Gynecologists" on October 15 "contains a fairly extensive survey of the medical hazards attendant to legally induced abortions."⁵⁰

The unreliability of the New York City data from 1970 to 1971 was brought directly to Justice Blackmun's attention by his law clerk. An undated, unsigned, one-page memo in Justice Blackmun's papers show that his law clerk pointed out the "devastating" criticism of the New York City data that had been made by one medical brief, showing that more than fifty percent of the women who underwent abortions in New York City were lost to subsequent follow-up, so their health outcome could not be determined.⁵¹ As Justice Blackmun was famously known to do,⁵² he edited the clerk's grammar, but ignored the problem by citing the New York data without comment, though it is possible that the "appear to be" qualification on page 149 and the "may be less" qualification on page 163 are due to this memo.

So, the mantra—the sole premise on which the Court relied to prohibit first-trimester regulations, limit second-trimester regulations, and extend the abortion right to viability and beyond—was based on no factual record and no reliable medical data. The Justices did not analyze, let alone refute, the contrary data; they simply ignored them.

(8th ed. 1970) ("Women should be discouraged from using abortion, which carries potential physical and psychological hazards, as a method of family planning.").

47. See Emanuel A. Friedman, *Therapeutic Abortion*, in *OBSTETRICS* 588, 588 (J.P. Greenhill ed., 13th ed. 1965) ("Despite this attitude of liberality, induced abortion even under the most ideal circumstances is not without danger and should not be approached lightly. The incidence of serious complications has been reported in the range of 3 to 19 per cent, depending on the technique used. Death rates range from 6 per 1000 to 6 per 100,000." (citations omitted)).

48. See DUNCAN E. REID ET AL., *PRINCIPLES AND MANAGEMENT OF HUMAN REPRODUCTION* 274 (1972) ("Regardless of indications or the methods and procedures, the physical and psychologic risks are real, even under the most careful scrutiny and medical supervision, and the long-term effects are not entirely clear.").

49. See *OBSTETRICS & GYNECOLOGY* 236-37 (David N. Danforth ed., 3d ed. 1977).

50. Memorandum from RLJ to Justice Douglas (Oct. 27, 1971) (on file with the Library of Congress, William O. Douglas Papers, Box 1590, Folder 5).

51. Memorandum from Law Clerk to Justice Blackmun (n.d.) (on file with the Library of Congress, Harry Blackmun Papers, Box 151, Folder 8).

52. See GREENHOUSE, *supra* note 12, at 107 ("And he himself reviewed his clerks' work, not only correcting their spelling and punctuation but also checking the accuracy of the citations in the opinions they drafted for him. No other justice engaged in this level of detailed review."); TINSLEY E. YARBROUGH, *HARRY A. BLACKMUN: THE OUTSIDER JUSTICE* 143, 152, 346 (2008) (demonstrating that Justice Blackmun was difficult to work for and "extraordinarily alert to errors of spelling and grammar").

C. *The Abrupt Expansion of the Abortion Right to Viability (and Beyond)*

The problems did not end with the medical mantra. Another factor that paved the way for the Gosnell scandal, especially the problem of live-birth abortions, was the Court's arbitrary expansion of the abortion right to viability, and beyond. As scholars have pointed out, the viability rule was complete dictum in *Roe*,⁵³ and in *Planned Parenthood of Southeastern Pennsylvania v. Casey*,⁵⁴ as well.⁵⁵ It was not relevant to the Texas or Georgia statutes. It was not addressed by the lower courts. There was no record on viability or its implications. It was not briefed or argued in the Supreme Court. The word was *not mentioned in four hours of oral argument in Roe and Doe* in December 1971 and October 1972.⁵⁶

Early drafts of the opinions in *Roe* and *Doe* designated the end of the first trimester as the "decisive moment" beyond which the states could prohibit abortion.⁵⁷ Only after the second oral argument in October 1972, when the Justices began negotiating about the abortion right they were creating, did some Justices suggest that the right be expanded to viability.⁵⁸ That was finally done in Justice Blackmun's third draft of December 21, 1972, four weeks before the opinions were released.⁵⁹

53. See, e.g., Randy Beck, *Self-conscious Dicta: The Origins of Roe v. Wade's Trimester Framework*, 51 AM. J. LEGAL HIST. 505, 507 (2011) (noting that "Justices who joined Justice Blackmun's opinion in *Roe* were self-consciously creating dicta"); see also John Hart Ely, *The Wages of Crying Wolf: A Comment on Roe v. Wade*, 82 YALE L.J. 920, 922 (1973) ("The opinion strikes the reader initially as a sort of guidebook, addressing questions not before the Court and drawing lines with an apparent precision one generally associates with a commissioner's regulations."); Mark Tushnet, *Two Notes on the Jurisprudence of Privacy*, 8 CONST. COMMENT. 75, 83 (1991) ("[U]sing the line of viability to distinguish the time when abortion is permitted from the time after viability when it is prohibited (as *Roe v. Wade* does), is entirely perverse.").

54. See *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992); see also Randy Beck, *The Essential Holding of Casey: Rethinking Viability*, 75 UMKC L. REV. 713, 715-19 (2007) [hereinafter Beck, *Essential Holding*] (arguing issue of viability is dicta); Randy Beck, *Gonzales, Casey, and the Viability Rule*, 103 NW. U. L. REV. 249, 250 n.9 (2009) [hereinafter Beck, *Viability Rule*] ("[T]he plurality's retention of the viability rule can be viewed as dicta.").

55. See Beck, *Essential Holding*, *supra* note 54, at 717.

56. See *Doe* Oral Argument, *supra* note 10; *Roe* Oral Argument, *supra* note 10.

57. See Beck, *Essential Holding*, *supra* note 54, at 722-23 (discussing early drafts setting first trimester as cutoff (citing GARROW, *supra* note 14, at 580-81; Garrow, *supra* note 45, at 79)).

58. See Beck, *supra* note 53, at 521-23 (quoting memorandum from Justice Powell to Justice Blackmun suggesting viability as possible line); GARROW, *supra* note 14, at 580 ("[T]he end of the first trimester is critical. This is arbitrary, but perhaps any other selected point, such as quickening or viability, is equally arbitrary." (quoting memorandum from Blackmun to other Justices)); GARROW, *supra* note 14, at 581 ("For the stage subsequent to the first trimester, the State may, if it chooses, determine a point beyond which it restricts legal abortions to stated reasonable therapeutic categories that are articulated with sufficient clarity so that a physician is able to predict what conditions fall within the stated classifications." (quoting second draft of November 22, 1972, in *Roe*)).

59. See GARROW, *supra* note 14, at 585-86; Beck, *supra* note 53, at 525 ("Justice Blackmun's third draft of the *Roe* opinion was the first to include the trimester framework.").

Beyond the dictum, the Court had no medical data suggesting that abortion was safe after twelve weeks. In fact, the primary assertion made at oral argument in the first and second *Doe* arguments by Margie Pitts Hames, the attorney for the Georgia plaintiffs, was that the risks increased considerably after twelve weeks.⁶⁰

D. *The “Health” Exception after Viability*

Next, the Court expanded the abortion right beyond viability. It announced that regulations or prohibitions after viability were not permitted if the woman’s “health” was at issue. *Roe* and *Doe* were to be “read together.”⁶¹ The Court defined “health” as “all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient.”⁶² It vested the provider with complete, subjective discretion to decide whether “emotional well-being” after viability was at issue.⁶³ If the provider decides that the woman’s emotional well-being would be affected by the requirements of the regulations after viability, the provider has the discretion to ignore the regulations.

The health exception means that any provider, with complete discretion, can ignore any regulation if the provider concludes that the patient’s emotional well-being is affected by the requirements of the regulation. The definition was reiterated in 1979 in *Colautti v. Franklin*,⁶⁴ and the Third Circuit’s broad interpretation was affirmed by the Supreme Court in 1986 in *Thornburgh v. American College of Obstetricians & Gynecologists*.⁶⁵ Though Justices Thomas, Rehnquist, and Scalia suggested in 1998 that the health exception was not a constitutional mandate,⁶⁶ that suggestion was in a dissent from a denial of cer-

60. See *Doe* Oral Argument, *supra* note 10, at 6; OBSTETRICS & GYNECOLOGY, *supra* note 49, at 237 (“Complication rates are three to four times higher for second-trimester abortions than for first-trimester abortions.”). In 2004, second-trimester abortions still carried greater risks than first-trimester abortions. See Linda A. Bartlett et al., *Risk Factors for Legal Induced Abortion-Related Mortality in the United States*, 103 OBSTETRICS & GYNECOLOGY 729, 731 (2004) (finding relative risk of abortion related mortality substantially higher in second trimester: 14.7/100,000 at thirteen to fifteen weeks, 29.5/100,000 at sixteen to twenty weeks, and 76.6/100,000 at or after twenty-one weeks).

61. *Roe v. Wade*, 410 U.S. 113, 165 (1973).

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

63. See *id.* (“[T]he medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient. All these factors may relate to health. This allows the attending physician the room he needs to make his best medical judgment.”); *Women’s Med. Prof’l Corp. v. Voinovich*, 130 F.3d 187, 208-09 (6th Cir. 1997) (“The Court suggested, however, that it favored providing broad discretion to physicians to make determinations as to ‘medical necessity’ in the abortion context . . .”).

64. 439 U.S. 379, 394 (1979) (“The contested provisions in [*United States v. Vuitch*, 402 U.S. 62 (1971), and *Doe v. Bolton*] had been interpreted to allow the physician to make his determination in the light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the patient. The present statute does not afford broad discretion to the physician.”).

65. 476 U.S. 747 (1986) (affirming Third Circuit’s definition of health exception), *overruled by Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833 (1992).

66. See *Voinovich v. Women’s Med. Prof’l Corp.*, 523 U.S. 1036, 1039 (1998) (Thom-

tiorari, and a number of federal courts have held otherwise.⁶⁷

As Harvard Law Professor Mary Ann Glendon has noted:

Doe's broad definition of "health" spelled the doom of statutes designed to prevent the abortion late in pregnancy of children capable of surviving outside the mother's body unless the mother's health was in danger. By defining health as "well-being," *Doe* established a regime of abortion-on-demand for the entire nine months of pregnancy, something that American public opinion has never approved in any state, let alone nationally.⁶⁸

Consequently, as a number of commentators have noticed, the post-viability prohibitions on the books in thirty-eight states have been unenforceable for many years.⁶⁹

On top of the health exception is the "medically necessary" standard in abortion law that gives subjective discretion to the abortion provider.⁷⁰ "Medi-

as, J., dissenting) ("Our conclusion that the statutory phrase at issue in *Doe* was not vague because it included emotional and psychological considerations in no way supports the proposition that, after viability, a mental health exception is required as a matter of federal constitutional law.").

67. See, e.g., *Voinovich*, 130 F.3d at 210; Am. Coll. of Obstetricians & Gynecologists v. Thornburgh, 737 F.2d 283, 299 (3d Cir. 1984) ("It is clear from the Supreme Court cases that 'health' is to be broadly defined. As the Court stated in *Doe v. Bolton*, the factors relating to health include those that are 'physical, emotional, psychological, familial, [as well as] the woman's age.'" (quoting *Doe*, 410 U.S. at 192)), *aff'd*, 476 U.S. 747 (1986); *Schulte v. Douglas*, 567 F. Supp. 522, 525-26 (D. Neb. 1981) (striking Nebraska post-viability abortion limitation because it did not allow for abortions under *Doe* health exception); *Margaret S. v. Edwards*, 488 F. Supp. 181, 196 (E.D. La. 1980) (striking Louisiana post-viability abortion limitation because it did not meet *Doe* health exception).

68. Mary Ann Glendon, *From Culture Wars to Building a Culture of Life*, in THE COST OF "CHOICE": WOMEN EVALUATE THE IMPACT OF ABORTION 3, 5 (Erika Bachiochi ed., 2004); see also DELLAPENNA, DISPELLING THE MYTHS OF ABORTION HISTORY, *supra* note 17, at 672 ("By 1971, those who sought to change abortion laws in the United States were seeking a total repeal of all abortion laws—'abortion on demand' as they then put it." (citation omitted)).

69. See *Voinovich*, 523 U.S. at 1039 (Thomas, J., dissenting) ("The vast majority of the 38 States that have enacted postviability abortion restrictions have not specified whether such abortions must be permitted on mental health grounds."); see also Michael J. Tierney, Note, *Post-viability Abortion Bans and the Limits of the Health Exception*, 80 NOTRE DAME L. REV. 465, 466-67 (2004) ("Three quarters of the states have legislation banning post-viability abortions. The majority of these states provide an exception to preserve the life or health of the mother, without defining what 'health' means, while other states expressly allow 'health' to include mental health." (footnotes omitted)); Brian D. Wassom, Comment, *The Exception That Swallowed the Rule?: Women's Professional Corporation v. Voinovich and the Mental Health Exception to Post-viability Abortion Bans*, 49 CASE W. RES. L. REV. 799, 810-11 (1999) (referring to Justice Thomas's dissent (citing *Voinovich*, 523 U.S. at 1036)).

70. See, e.g., *Nat'l Abortion Fed'n v. Gonzales*, 437 F.3d 278, 287 (2d Cir. 2006) ("[T]he procedure might sometimes be necessary to avoid risk to a woman's health."), *vacated*, 224 F. App'x 88 (2d Cir. 2007); see also *Planned Parenthood Fed'n of Am. v. Gonzales*, 435 F.3d 1163, 1172 (9th Cir. 2006) (noting that restrictions of abortion methods require exceptions when method is "'necessary, in appropriate medical judgment, for the preservation of the life or health of the mother'" (quoting *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000))), *rev'd*, *Gonzales v. Carhart*, 550 U.S. 124 (2007); *Carhart v. Gonzales*, 413 F.3d 791, 795 (8th

cally necessary” does not mean seriousness or emergency in abortion law. A medically necessary abortion is whatever an abortion provider, in the provider’s subjective judgment, determines it to be.⁷¹ At least as of 2006 in *Ayotte v. Planned Parenthood of Northern New England*⁷²—where the Court stated that “a State may not restrict access to abortions that are ‘necessary, in appropriate medical judgment, for the preservation of the life or health of the mother’”—this standard was alive and well.⁷³ When these two terms are combined—“medically necessary to preserve the health of the woman”—a medically necessary abortion means any abortion a provider agrees to perform for any reason.⁷⁴ The subjective elasticity of this standard is compounded by the courts’ loose references to “risk.” Risk is simply “exposure to the chance of injury or loss.”⁷⁵ Thus, “health risk” in abortion law means the potential for exposure to the chance of a loss of “well-being” under *Doe v. Bolton*.

These standards define the ease with which the federal courts can eliminate or enjoin abortion regulations and, in turn, the inhibitions and obstacles that state and local public health officials confront in attempting to regulate in this area. This public health vacuum—the prohibition on first-trimester regulations,

Cir. 2005) (same), *rev’d*, 550 U.S. 124; *Carhart v. Ashcroft*, 331 F. Supp. 2d 805, 1012 (D. Neb. 2004) (“[T]here are times when the banned procedure is medically necessary to preserve the health of a woman . . .”), *rev’d*, *Gonzales*, 550 U.S. 124.

71. See, e.g., *Doe*, 410 U.S. at 192 (“Whether . . . ‘an abortion is necessary’ is a professional judgment that the [] physician will be called upon to make routinely.”); *Voinovich*, 130 F.3d at 208-09 (noting “importance of giving the physician discretion to decide whether an abortion is necessary” and finding that health exception unconstitutionally limited “the physician’s discretion to determine whether an abortion is necessary to preserve the woman’s health”); *Roe v. Norton*, 522 F.2d 928, 934 (2d Cir. 1975); *Doe v. Beal*, 523 F.2d 611, 618, 622 n.23 (3d Cir. 1975) (emphasizing physician discretion), *rev’d on other grounds*, 432 U.S. 438 (1977); *Coe v. Hooker*, 406 F. Supp. 1072, 1082 (D.N.H. 1976); *Roe v. Norton*, 408 F. Supp. 660, 663-64 (D. Conn. 1975) (equating medically necessary and elective abortion), *rev’d*, *Maher v. Roe*, 432 U.S. 464 (1977); *Roe v. Ferguson*, 389 F. Supp. 387, 392 (S.D. Ohio 1974) (equating “necessary medical services” with “elective”), *rev’d*, 515 F.2d 279 (6th Cir. 1975); *Doe v. Wohlgenuth*, 376 F. Supp. 173, 191-92 (W.D. Pa. 1974) (same); *Klein v. Nassau Cnty. Med. Ctr.*, 347 F. Supp. 496, 500 (E.D.N.Y. 1972) (same), *vacated*, 412 U.S. 925 (1973).

72. 546 U.S. 320 (2006).

73. *Id.* at 327-28 (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992)) (internal quotation marks omitted). Whether the medically necessary discretionary standard survives *Gonzales v. Carhart* is uncertain, but obviously federal district courts can still cite numerous cases as authority in support of it.

74. See *Colausti v. Franklin*, 439 U.S. 379, 394 (1979) (“The contested provisions in those cases had been interpreted to allow the physician to make his determination in the light of all attendant circumstances—psychological and emotional as well as physical—that might be relevant to the well-being of the patient.”); *Women’s Med. Prof’l Corp. v. Taft*, 353 F.3d 436, 462 (6th Cir. 2003) (Tarnow, J., dissenting) (“To determine whether an abortion is medically ‘necessary,’ the Court in *Doe* stated that ‘medical judgment may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman’s age—relevant to the well-being of the patient. All these factors may relate to health.’ Decided on the same day and meant ‘to be read together,’ *Doe* and *Roe* indicate that a woman’s mental health, in addition to her physical health, must be considered in assessing whether an exception to an abortion regulation actually preserves the health of the pregnant woman.” (quoting *Doe*, 410 U.S. at 165, 191-92)).

75. RANDOM HOUSE WEBSTER’S UNABRIDGED DICTIONARY 1660 (2d ed. 1998).

the expansion to viability, and the health exception after viability—created the context for Kermit Gosnell's practices. Aside from the politics of the Gosnell scandal, who's to say other than Dr. Kermit Gosnell—given the scope of the *Doe* health exception—whether emotional well-being wasn't involved in each of the late-term abortions that Gosnell has done since he opened his clinic in 1973?

E. *The Mechanical Comparison of Abortion Mortality and Childbirth Mortality Rates*

The mantra that “abortion is safer than childbirth” is based on a mechanical comparison of the published abortion mortality rate and the maternal (childbirth) mortality rate. The two published rates are not comparable, however, and do not give an accurate picture about the risks of abortion.⁷⁶ The accuracy of the rate is completely dependent on an accurate number of deaths—the numerator. There are serious reasons to doubt the accuracy of published figures on abortion deaths in the United States; there is no uniform, mandatory tracking and reporting system of abortion deaths (mortality) or injuries (morbidity) at the state or federal level.⁷⁷

In addition, the two rates are inherently not comparable because their denominators are completely different. They might be comparable if both rates were composed of deaths (from abortion and childbirth) per 1,000 pregnancies, but that is not what is involved. Different elements go into the denominators.

The *maternal mortality rate* is defined by the Federal Centers for Disease Control & Prevention (CDC) as all maternal deaths per 100,000 live births, rather than pregnancies.

$$\text{Childbirth Mortality Rate} = \frac{\text{Maternal Deaths}}{100,000 \text{ Live Births}}$$

76. See David C. Reardon et al., *Deaths Associated with Abortion Compared to Childbirth—A Review of New and Old Data and the Medical and Legal Implications*, 20 J. CONTEMP. HEALTH L. & POL'Y 279, 318 (2004).

77. Only estimates are available. See generally David Grimes, *Estimation of Pregnancy-Related Mortality Risk by Pregnancy Outcome, United States, 1991 to 1999*, 194 AM. J. OBSTETRICS & GYNECOLOGY 92 (2006). Researchers from the Alan Guttmacher Institute (AGI) hinted at the problems with the CDC incidence data, though with understatement:

The estimates presented in this report are subject to some limitations and should be considered provisional. First, not all states are included; the estimates assume that changes in abortion incidence in the excluded states are similar to the overall trend seen in the reporting states. Second, the completeness of abortion reporting to state health departments can vary from year to year. We attempted to exclude all states that had inconsistent reporting, but if (for example) reporting improved in some states we included, it would mean that earlier state reports were too low and that the percentage decline we calculated was too small. In such cases, our new estimates of the number of abortions would be too high.

LAWRENCE B. FINER & STANLEY K. HENSHAW, GUTTMACHER INST., ESTIMATES OF U.S. ABORTION INCIDENCE, 2001-2003, at 3 (2006), available at http://www.guttmacher.org/pubs/2006/08/03/ab_incidence.pdf.

Using live births instead of pregnancies shrinks the denominator (since pregnancies are a larger group, and some end in miscarriage or stillbirth) and thereby inflates the maternal mortality rate. The use of live births as the denominator is dictated by the World Health Organization (WHO) for purposes of enhancing international comparability.⁷⁸ In addition, the CDC depends on voluntary reporting systems and estimates that maternal deaths are underreported by 30 to 150 percent.⁷⁹ The death certificate data may or may not tell if the death was maternal or abortion-related.⁸⁰

By contrast, the *abortion mortality rate* is defined by the CDC as “known legal induced abortion-related” deaths per 100,000 legal abortions.

$$\text{Abortion Mortality Rate} = \frac{\text{Known Legal Induced Abortion Related Deaths}}{100,000 \text{ Legal Abortions}}$$

The identification of a “legal” abortion—when one considers all the potential regulations at the local, state, or federal level that could theoretically apply, as well as the overlay of the Supreme Court’s thirty cases on abortion since 1973—is prone to being highly subjective and manipulated. In addition, both the numerator and denominator in this rate are also based on voluntary reporting.⁸¹

78. See Letter from Julie Louis Gerberding, Dir., Ctrs. for Disease Control and Prevention, to Walter M. Weber, Senior Litig. Counsel, Am. Ctr. for Law & Justice (Jul. 20, 2004), reprinted in Amicus Brief of the Am. Ctr. For Law & Justice in Support of Petitioner add. at *24, *Gonzales v. Carhart*, 550 U.S. 124 (2007) (No. 05-1382), 2006 U.S. S. Ct. Briefs LEXIS 613.

79. See Jeani Chang et al., *Pregnancy-Related Mortality Surveillance—United States, 1991-1999*, 52 MORBIDITY & MORTALITY WKLY. REP., NO. SS-2, 2003, at 7; Catherine Deneux-Tharaux et al., *Underreporting of Pregnancy-Related Mortality in the United States and Europe*, 106 OBSTETRICS & GYNECOLOGY 684 (2005).

80. See Letter from Julie Louis Gerberding to Walter M. Weber, *supra* note 78.

81. Cf. Reardon et al., *supra* note 76.

Why the Mortality Rates for Abortion and Childbirth Are Not Comparable

The Two Rates



How These Rates are Relatively Inaccurate and Measure Different Things

Why abortion deaths are undercounted:

- * No formal ascertainment;
- * Societal bias against self-reporting;
- * Intimate partner and family may be unaware; and
- * Only direct deaths included

{ N }

{ N }

Why maternal deaths are more complete:

- * Most states link birth and death certificates; and
- * Includes direct and indirect deaths, like homicides and suicides

Why this denominator is completely different:

- * Not formally certified;
- * Annual count by CDC & AGI differ by 15%; and
- * Time period limited to 24 hours

{ D }

{ D }

From this denominator:

- * All states have birth certificates;
- * Excludes all pregnancies that end by miscarriages, ectopic, and stillbirths; and
- * Time period covers pregnancy and one year after birth

© Clarke D. Forsythe 2012

Beyond the inherent difference in what these rates measure, there are additional problems. The maternal mortality figures do not take account of the stage of gestation. A genuine comparison would assess only the prospective risk of continuing the pregnancy from the time in gestation when the decision is made (e.g., the risk for this particular woman at eight weeks) rather than the mathematical risk throughout pregnancy. The maternal mortality rate for gestational age is not adjusted because it is not statistically feasible; those data are not available because death certificates do not provide data on gestational age.

In 2004, Dr. Julie Gerberding, then-director of the CDC, discouraged a mechanical comparison and warned that these rates cannot be compared because they are different measures. She emphasized that the two rates “are conceptually different and are used by CDC for different public health purposes.”⁸²

These elements—the lack of any factual record, the false medical mantra, the invalidation of a hospitalization requirement, the expansion of the abortion license to viability, the prohibition on health and safety regulations in the first trimester, the restrictions on health and safety violations in the second trimester, the disregard of existing data on the greatly increased risks to women after the first trimester, the health exception after viability which prevents the enforcement of prohibitions—created the public health vacuum that led to the Gosnell scandal, and others.⁸³

82. Letter from Julie Louis Gerberding to Walter M. Weber, *supra* note 78, at *25.

83. In January 2012, Steven Chase Brigham and Nicola Riley were indicted in Maryland for the homicide of viable unborn children after “police . . . said they found nearly three dozen late-term fetuses in a freezer.” Peter Hermann, *Doctor Arraigned in Maryland on Mur-*

III. HOW THE FEDERAL COURTS ENFORCED THE PUBLIC HEALTH VACUUM

The federal courts quickly enforced *Roe* and *Doe* to prevent any clinic regulations in the first trimester. The Sixth, Seventh, and Eighth Circuits,⁸⁴ along with a number of federal district courts in the First, Second, Fourth, Fifth, Sixth, Seventh, and Eleventh Circuits,⁸⁵ invalidated first-trimester clinic regulations.

The Supreme Court supported the action of the federal courts, denying review in 1975⁸⁶ and affirming invalidation of first-trimester clinic regulations in 1976.⁸⁷ The latter prompted a strong dissent by Justices White, Burger, and Rehnquist.⁸⁸

In Chicago, for example, the federal appeals court struck down Chicago's clinic regulations in 1974, and four years later, in November 1978, the *Chicago Sun-Times* published a twelve-part series on the terrible conditions found in abortion clinics based on an undercover investigation with the Better Government Association (BGA). As Dr. Edward F. King, the deputy director of the Chicago Medical Society told the *Chicago Tribune* in 1978, "The courts very effectively knocked the Department of Health out of the picture. We're not even entitled to cross the threshold of these clinics."⁸⁹ When Illinois tried to enact new regulations to deal with the findings of the *Sun-Times* and the BGA, an abortion provider again challenged those regulations and got the federal courts to strike them down in the 1980s.⁹⁰

der Charges in Abortion Case, BALTIMORE SUN, Jan. 6, 2012, www.baltimoresun.com/news/breaking/bs-md-abortion-doctor-arraigned-20120106,0,1944360.story.

84. See *Birth Control Ctrs., Inc. v. Reizen*, 743 F.2d 352, 365 (6th Cir. 1984); *Mahoning Women's Ctr. v. Hunter*, 610 F.2d 456, 460 (6th Cir. 1979), *vacated on other grounds*, 477 U.S. 918 (1980); *Wolfe v. Schroering*, 541 F.2d 523, 526-27 (6th Cir. 1976); *Friendship Med. Ctr., Ltd. v. Chi. Bd. of Health*, 505 F.2d 1141, 1149 (7th Cir. 1974); *Word v. Poelker*, 495 F.2d 1349, 1351-52 (8th Cir. 1974).

85. See, e.g., *Fla. Women's Med. Clinic, Inc. v. Smith*, 536 F. Supp. 1048 (S.D. Fla. 1982); *Fla. Women's Med. Clinic, Inc. v. Smith*, 478 F. Supp. 233 (S.D. Fla. 1979); *Westchester Women's Health Org. v. Whalen*, 475 F. Supp. 734 (S.D.N.Y. 1979); *Women's Med. Ctr. of Providence, Inc. v. Cannon*, 463 F. Supp. 531 (D.R.I. 1978); *Fox Valley Reprod. Health Care Ctr., Inc. v. Arft*, 446 F. Supp. 1072 (E.D. Wis. 1978); *Abortion Coal. of Mich., Inc. v. Mich. Dep't of Pub. Health*, 426 F. Supp. 471 (E.D. Mich. 1977); *Mobile Women's Med. Clinic, Inc. v. Bd. of Comm'rs of Mobile*, 426 F. Supp. 331 (S.D. Ala. 1977); *Arnold v. Sendak*, 416 F. Supp. 22 (S.D. Ind.), *aff'd*, 429 U.S. 968 (1976); *Hallmark Clinic v. N.C. Dep't of Human Res.*, 380 F. Supp. 1153 (E.D.N.C. 1974); *Hodgson v. Anderson*, 378 F. Supp. 1008 (D. Minn. 1974), *aff'd in part, rev'd in part*, *Hodgson v. Lawson*, 542 F.2d 1350 (8th Cir. 1976).

86. See *Chi. Bd. of Health v. Friendship Med. Ctr., Ltd.*, 420 U.S. 997 (1975) (denying certiorari).

87. See *Sendak*, 429 U.S. 968.

88. See *id.* at 968-69.

89. Bonita Brodt & Mike McCabe, *Abortion Investigation Set*, CHI. TRIB., Nov. 13, 1978, at 1.

90. See *Ragsdale v. Turnock*, 841 F.2d 1358 (7th Cir. 1988). Ragsdale was arrested on child pornography charges in September 1994. See Janan Hanna & Rick Pearson, *Abortion Doctor Faces Porn Charge*, CHI. TRIB., Sept. 24, 1994, at 5.

The Supreme Court compounded the problem by striking down a hospitalization requirement prior to sixteen weeks in 1983 in *City of Akron v. Akron Center for Reproductive Health, Inc.*⁹¹ This opinion extended the *Roe* framework by invalidating regulations in the *early second trimester* and effectively struck the requirement throughout the second trimester.

The Court also authorized abortion providers to challenge clinic regulations and to legally represent their patients, as though the interests of providers and those of women are identical.⁹² Such paternalism, which was receding in all other areas of medicine in 1973, exists in no other field of medicine—even obstetrics and gynecology—today.

In addition, the ability of state and local officials to defend legal challenges to clinic regulations was significantly curtailed. Federal courts applied the Civil Rights Attorney's Fees Awards Act of 1976 to abortion cases, requiring that state and local governments pay abortion-provider attorney's fees when a challenged clinic regulation is struck down or when an abortion provider only partially prevails.⁹³ Without a significantly shocking public health crisis, such as the death of a woman, public health officials are reticent to support regulations that will likely be struck down and cost state tax dollars. Even if a woman dies, however, it is possible for clinics to block regulations for more than a decade, as they did in Arizona after Louann Herron died in 1998.⁹⁴ The Arizona regulations were not allowed to go into effect until November 1, 2010.⁹⁵

With disincentives on state officials to create new clinic regulations, the Court is unable to do anything to fill the vacuum it created. As a passive institution, it must wait for a case to reach it—a case made lengthy and expensive by the conditions imposed by the federal courts. It was not until 2000 that federal courts even indicated state officials had the authority to enact or effectively enforce regulations. Lower courts in Arizona, South Carolina, Missouri, and Texas upheld meaningful clinic regulations. In addition, the Fourth,⁹⁶ Fifth,⁹⁷ and

91. 462 U.S. 416, 429 n.11, 431-39 (1983), *overruled by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992).

92. *See* Singleton v. Wulff, 428 U.S. 106, 113-18 (1976); *see also* Stephen J. Wallace, Note, *Why Third-Party Standing in Abortion Suits Deserves a Closer Look*, 84 NOTRE DAME L. REV. 1369 (2009).

93. *See* Civil Rights Attorney's Fees Award Act of 1976, 42 U.S.C. § 1988 (1976) (amended 1980, 1991, 1993, 1994, 1996, 2000); *see, e.g.,* Mahoning Women's Ctr. v. Hunter, 447 U.S. 918 (1980), *vacating and remanding* 610 F.2d 456 (6th Cir. 1979). The case was remanded "for further consideration in light of *New York Gaslight Club v. Carey* [regarding fees] and *Supreme Court of Virginia v. Consumers Union of the United States, Inc.*" *Mahoning Women's Ctr.*, 447 U.S. at 918 (citations omitted). Justices Stewart, White, Rehnquist, and Stevens dissented. *See id.*; *see also* *Aware Woman Clinic, Inc. v. City of Cocoa Beach, Fla.*, 629 F.2d 1146 (5th Cir. 1980) (*per curiam*) (determining whether to invalidate Florida city's attempt to pass clinic regulations). Thirty years later, in 2010, the plaintiff in *Aware Woman Clinic*, Randall Whitney, was under investigation in Florida.

94. *See* Tucson Woman's Clinic v. Eden, 379 F.3d 531, 536-37 (9th Cir. 2004).

95. *Cf. Arizona Abortion Clinic Regulations to Take Effect*, USA TODAY, Oct. 28, 2010, http://www.usatoday.com/news/nation/states/arizona/2010-10-28-177374953_x.htm; *see also* Will Humble, *Abortion Clinic Inspections*, AZ DEP'T OF HEALTH SERVS. DIR.'S BLOG, (Aug. 30, 2010), <http://directorsblog.health.azdhs.gov/?tag=abortion>.

96. *See* Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control,

Ninth Circuits⁹⁸ provided additional guidance by finding first-trimester regulations on clinic physical-space requirements, licensing requirements, and care and procedure requirements not to be facially unconstitutional.

But, thirty-nine years after *Roe*, the Supreme Court has yet to put its stamp of approval on any clinic regulations, denying certiorari to the Fourth Circuit case⁹⁹—the latest clinic regulations case to reach the Court. The lack of a definitive decision is the result of a standoff between state officials—who do not know how far to go without sparking long and costly test-case litigation—and the abortion providers—who fear getting a definitive Supreme Court decision from the Roberts Court which might uphold clinic regulations after the 2007 decision in *Gonzales v. Carhart*.¹⁰⁰ Where clinic regulations do exist, they may be enforced with some political and administrative discretion. But, as shown by the 2010 filing of *Bossier City Medical Suite, Inc. v. Greenstein*¹⁰¹ against the 2010 Louisiana law allowing closure of abortion clinics for violations, the federal courts ultimately hold all of the cards and decide whether regulations are enforceable.

If the history of the past thirty-nine years is replayed in Philadelphia, as it was in Chicago, the current furor over Gosnell will die down, some legislative body might pass new regulations, the ACLU or the Center for Reproductive Rights will file suit, the federal courts will strike down the regulations, the state will use tax dollars to pay attorney's fees to the clinics, the newspapers will turn a blind eye, and the case will never get to the Court. The Court's public health vacuum will continue to threaten the lives and health of women.

IV. THE LONG HISTORY OF CLINIC SCANDALS AND SQUALID CONDITIONS

Professor Calhoun has amply described the conditions in Gosnell's Philadelphia clinic. The clinic had not been inspected since 1993. When federal agents investigated the clinic in February 2010, they found "deplorable and unsanitary"¹⁰² conditions and numerous health and safety violations, including blood on the floor and parts of aborted fetuses in jars. Gosnell, who only worked evenings, was the only employee who had a medical license. Another employee, who was not a doctor, conducted gynecological examinations and administered painkillers. Authorities were alerted when a patient died after being given two separate doses of painkillers plus anesthesia before an abortion.¹⁰³ The Philadelphia District Attorney has charged Gosnell with murder

317 F.3d 357 (4th Cir. 2002).

97. See *Women's Med. Ctr. of Nw. Hous. v. Bell*, 248 F.3d 411 (5th Cir. 2001).

98. See *Tucson Woman's Clinic*, 379 F.3d 531.

99. See *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 538 U.S. 1008 (2003) (denying certiorari).

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

101. 781 F. Supp. 2d 313 (M.D. La. 2011).

102. Report of the Grand Jury at 20, *In re Cnty. Investigating Grand Jury XXIII, MISC. No. 0009901-2008* (Pa. Com. Pl. Jan. 14, 2011), available at <http://www.phila.gov/districtattorney/PDFs/GrandJuryWomensMedical.pdf>.

103. See *id.* at 19; Melinda Henneberger, *Kermit Gosnell's Pro-choice Enablers* (*Is*

for killing an abortion patient, and the grand jury report found, among other things, that there had been reports of substandard practices at the clinic for nearly twenty years without any action being taken.¹⁰⁴

But Kermit Gosnell is only the latest. Philadelphia's experience with Gosnell's clinic is mirrored in other cities and clinics year after year since 1973. The *Chicago Sun-Times*' 1978 series exposed the abortion clinic conditions that flourished after the Seventh Circuit struck down clinic regulations in *Friendship Medical Center, Ltd. v. Chicago Board of Health*.¹⁰⁵ In South Carolina in 1994, testimony before the General Assembly indicated that inspections found bloody, unwashed sheets and bloody cots in recovery rooms in the Charleston clinic of Dr. Jesse Johnce Floyd. Former clinic workers testified that fetal remains were not disposed of properly but instead rinsed down in sinks. A three-part series by Charleston's CBS affiliate (Channel 2) covered allegations, made by former clinic staffers, about conditions in Dr. Floyd's clinic. These investigations led to legislative amendment of state regulations in 1995, which resulted in eight years of litigation until the Supreme Court denied certiorari for a second time in April 2003.¹⁰⁶

In Phoenix in April 1998, a young mother visited the A-Z Women's Center seeking a late-term abortion. During the abortion, Dr. John Biskind, who had been investigated by the state board in January 1996 after the death of another abortion patient,¹⁰⁷ tore a two-inch laceration in the woman's uterus. Paramedics were eventually called, but the patient died. At Biskind's 2001 trial for manslaughter, a Phoenix fire captain, Brian Tobin, testified that upon arrival he "very quickly" recognized "that there wasn't a lot of competent medical care

This What an Industry That Self-regulates Looks Like?), POL. DAILY, Jan. 23, 2011, <http://www.politicsdaily.com/2011/01/23/kermit-gosnells-pro-choice-enablers-how-clinics-become-death-t/>.

104. The 63-page Presentment and 281 page grand jury report are available online. See Report of the Grand Jury, *supra* note 102; Presentment, *In re Cnty. Investigating Grand Jury XXIII*, Misc. NO. 0009901-2008, (Pa. Com. Pl. Jan. 19, 2011), available at <http://www.phila.gov/districtattorney/PDFs/PresentmentFinalWomensMedical.pdf>.

105. 505 F.2d. 1141 (7th Cir. 1974).

106. See generally *Greenville Women's Clinic v. Bryant*, 222 F.3d 157 (4th Cir. 2000); Peter Nyikos, *The Saga of the South Carolina Abortion Clinic Regulation Act*, 15 LIFE & LEARNING 363 (2005), available at <http://www.uffl.org/vol15/nyikos05.pdf>. The clinic director, Dr. Jesse Johnce Floyd, was involved in a notorious late-term abortion that sparked the Supreme Court case of *Anders v. Floyd*, 440 U.S. 445 (1979). The South Carolina regulations of 1995 did not go into effect until April 2003. A second suit was filed against the South Carolina regulations after the Supreme Court denied certiorari in 2001. See *Greenville Women's Clinic v. Bryant*, 531 U.S. 1191 (2001) (denying certiorari). The district court ruled for the plaintiffs again, and the Fourth Circuit again reversed in 2002. See *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, Nos. 01-2090 & 01-2235, 2002 U.S. App. Lexis 27311 (4th Cir. Nov. 15, 2002). The Supreme Court again denied certiorari on April 28, 2003. See *Greenville Women's Clinic v. Comm'r, S.C. Dep't of Health & Envtl. Control*, 538 U.S. 1008 (2003) (denying certiorari).

107. The Arizona Board of Medical Examiners had held a hearing on January 18, 1996, regarding Biskind's abortion of a prior patient on February 16-17, 1995, who died after the abortion from an eight-centimeter vertical laceration. The transcript of the 1995 hearing was published in the *Arizona Republic* after the death of Louann Herron in 1998.

going on.”¹⁰⁸ Biskind and his assistant were convicted of manslaughter, and Biskind was sentenced in May 2001 to five years in prison.¹⁰⁹ Litigation over the regulations passed in the aftermath of the patient’s death was not resolved until the fall of 2010.

In Kansas in 2005, inspections of the clinic of Dr. Krishna Rajanna revealed: fetal remains stored in the same refrigerator as food; a dead rodent in the clinic hallway; uncovered, overflowing disposal bins containing medical waste; improperly labeled and expired medicines; a carpeted floor in the surgical procedure room; and visible dirt and general disarray throughout the clinic. Rajanna’s license was first suspended and then revoked in June 2005.¹¹⁰ In Birmingham, Alabama in 2010, the Planned Parenthood clinic was placed on probation and entered into a consent order with the State Board of Health to correct violations of public health regulations, including verification of a patient’s age and the reporting of evidence of sexual abuse.¹¹¹

Newspapers and other media sources have exposed terrible conditions in abortion clinics across the country, including disregard of sexual abuse reporting, statutory rape, sex trafficking, and fraud.¹¹² The U.S. Department of Justice lists abortion clinics as a common location where sex trafficking can be found.¹¹³ Just in the past few years, there have been state medical investigations of the following clinics and practitioners: Ann Kristin Neuhaus in Kansas,¹¹⁴ Rapin Osathanondh in Massachusetts,¹¹⁵ Alberto Hodari in Michi-

108. Liz Townsend, *Biskind Convicted of Manslaughter for Botched Abortion*, NAT’L RIGHT TO LIFE NEWS, Mar. 2001, at 4, available at <http://www.nrlc.org/news/2001/NRL03/biskind.html> (internal quotation marks omitted).

109. See *State v. Biskind*, No. CR99-00198 (Ariz. Sup. Ct. Feb. 13, 2001); *Abortion Doc Guilty in Woman’s Death*, CBS NEWS, Feb. 11, 2009, <http://www.cbsnews.com/stories/2001/02/20/national/main273313.shtml>; *Abortion Doctor Is Convicted of Manslaughter in Woman’s Death*, CHI. TRIB., Feb. 21, 2001, at 20, available at http://articles.chicagotribune.com/2001-02-21/news/0102210245_1_louanne-herron-carol-stuart-schadoff-dr-john-biskind.

110. See Consent Order, *In re Krishna Rajanna*, No. 50-H (Kan. Bd. of Healing Arts Feb. 14, 2005), <http://www.ksbha.org/boardactions/Documents/rajanna.pdf>; Final Order, *In re Krishna Rajanna*, No. 50-H-58 (Kan. Bd. of Healing Arts June 14, 2005), <http://www.ksbha.org/boardactions/Documents/rajanna3.pdf>; see also *2005 Board Actions*, KAN. ST. BD. OF HEALING ARTS, <http://www.ksbha.org/boardactions/Years/05bdact.html> (last visited Oct. 12, 2011).

111. See Consent Agreement, *Ala. Dep’t of Pub. Health v. Planned Parenthood of Ala., Inc.*, No. 09-0229 (Ala. Bd. of Health Jan. 15, 2010), available at http://www.cbs42.com/media/lib/124/0/8/d/08dd6ea6-7367-4fac-8332-973e5935eb17/PP_CON.AGREEMENT.pdf.

112. See, e.g., Bob LaMendola, *State Suspended Tamarac Doctor Who Didn’t Report Pregnant 12-Year-Old as Possible Abuse*, SUNSENTINEL.COM, Oct. 1, 2011, <http://www.sun-sentinel.com/health/fl-hk-pregnant-12yearold-20110930,0,6844621,print.story>.

113. See Graeme R. Newman, *The Exploitation of Trafficked Women*, in PROBLEM-ORIENTED GUIDES FOR POLICE (Office of Cmty. Oriented Policing Servs., U.S. Dep’t of Justice, Problem-Specific Guide Series no. 38, Feb. 9, 2006), available at <http://www.cops.usdoj.gov/pdf/pop/e02061007.pdf>.

114. See *Public Information*, KAN. ST. BD. OF HEALING ARTS, <http://www.ksbha.org/public.html> (last visited Oct. 12, 2011); *Trial Set in Kan. Late-Term Abortion Case*, WASH. POST, Mar. 15, 2009, at A10, available at <http://www.washingtonpost.com/wp-dyn/content/article/2009/03/14/AR2009031401607.html>.

gan,¹¹⁶ Feliciano Rios in California,¹¹⁷ Romeo A. Ferrer in Maryland,¹¹⁸ Nicola I. Riley in Maryland and Utah,¹¹⁹ Randall Whitney in Orlando, Florida,¹²⁰ Andrew Rutland in San Gabriel, California,¹²¹ James Pendergraft in Florida,¹²² Salomon Epstein in Jackson Heights, New York,¹²³ and the Northern Illinois Women's Center in Rockford, Illinois.¹²⁴ Steven Chase Brigham, who has been under investigation for years in several states, had his license suspended and was imprisoned after being investigated nearly twenty years earlier.¹²⁵

In the summer of 2011, the *Chicago Tribune* found six deaths and 4,000 injuries that had never been reported by the Illinois Department of Health.¹²⁶

115. See *Abortion Doctor Gets 6 Months in Woman's Death*, BOS. HERALD.COM, Sept. 15, 2010, <http://www.bostonherald.com/news/regional/view.bg?articleid=1281536>.

116. See *Abortion Clinics Investigated for Dumping Waste and Patient Records*, FOXNEWS.COM, Mar. 19, 2008 (on file with author).

117. See *North Carolina Mental Health Provider Sentenced to Prison*, MEDICAID FRAUD REP. (Nat'l Assoc. of Medicaid Fraud Control Units, Washington, D.C.), Sept./Oct. 2010, at 1, available at <http://www.namfcu.net/resources/medicaid-fraud-reports-newsletters/2010-publications/10SeptOct.pdf>.

118. See MD. BD. OF PHYSICIANS, SANCTIONS: SEPTEMBER 2010, at 1 (2010), available at <http://www.mbp.state.md.us/forms/sep10sanctions.pdf>.

119. *Two Maryland Abortion Doctors Face Murder Charges*, CNN, Dec. 30, 2011, http://articles.cnn.com/2011-12-30/justice/justice_maryland-abortion-doctors-murder_1_steven-brigham-abortion-clinic-fetuses?_s=PM:JUSTICE; see also Media Alert, Div. of Occupational and Prof'l Licensing, Utah Dep't of Commerce, Division of Occupational and Professional Licensing Enters Stipulation and Order with Nicola Irene Riley over Unlawful Conduct Regarding Her Utah Medical Licenses (Aug. 31, 2011), available at http://www.commerce.utah.gov/releases/11-08-31_opl-nicola-riley-stipulation.pdf.

120. Sheryl Young, *Florida Abortion Doctor in Trouble Is One of Several This Month*, EXAMINER.COM (Sept. 29, 2010), <http://www.examiner.com/faith-politics-in-tampabay/florida-abortion-doctor-trouble-is-one-of-several-this-month>.

121. Courtney Perkes, *Abortion Doctor Gives Up License Again over Death*, ORANGE CNTY. REG., Jan. 25, 2011, <http://www.ocregister.com/articles/rutland-285561-death-license.html>.

122. Kelli Cook, *Doctor's License Suspended for Fourth Time*, CFNEWS13.COM, Aug. 11, 2010 (on file with author).

123. See Steven Ertelt, *Health Department Probes NY Abortionist Who Killed Woman in Failed Abortion*, LIFENEWS.COM, Feb. 23, 2010, <http://www.lifenews.com/2010/02/23/state-4839/>; Michael J. Feeney et al., *Queens Clinic AI Medicine Probed After Alexandra Nunez Is Fatally Injured While Undergoing Abortion*, NYDAILYNEWS.COM, Jan. 27, 2010, <http://www.nydailynews.com/news/queens-clinic-a1-medicine-probed-alexandra-nunez-fatally-injured-undergoing-abortion-article-1.460728>.

124. See Corina Curry, *Rockford Abortion Clinic's License Suspended Indefinitely*, ROCKFORD REG. STAR, Sept. 30, 2011, available at http://www.rrstar.com/top_stories/x824871591/Rockford-abortion-clinic-s-license-suspended-indefinitely.

125. See Susan K. Livio, *N.J. Physician Disciplinary Board Suspends License of Controversial Abortion Doctor*, NJ.COM, Oct. 13, 2010, http://www.nj.com/news/index.ssf/2010/10/nj_asks_physician_disciplinary.html; Hermann, *supra* note 83.

126. See Megan Twohey, *State Abortion Records Full of Recording Gaps*, CHI. TRIB., June 16, 2011, at C1, available at http://articles.chicagotribune.com/2011-06-16/news/ct-met-abortion-reporting-20110615_1-abortion-providers-fewer-abortions-national-abortion-federation.

The need for clinic regulations is clear from the investigations of these and other clinics across the country.

Beyond the publicized incidents, accurately assessing the risks is significantly complicated by the fact that abortion injuries and deaths are laundered out of the United States public health system through a series of filters. The first is haphazard data. There are two national organizations that collect data: the Alan Guttmacher Institute and the CDC. There is no federal reporting law—reporting to both is voluntary.¹²⁷ State laws are haphazardly enforced.¹²⁸ In *Thornburgh v. American College of Obstetricians & Gynecologists*,¹²⁹ the Supreme Court invalidated reporting requirements, and other federal courts have invalidated some states' reporting requirements, which are necessary for public health monitoring and oversight.¹³⁰ California, for example, accounts for twenty-five percent of all abortions in the United States, but has not reported its data to the CDC for years, so California abortions can only be estimated.¹³¹

The second filter is in the clinics. Clinics typically tell a patient who suffers complications to go to the nearest emergency room (ER). By urging women to go to the nearest ER, clinics do not see the injuries they cause. Furthermore, only twenty-six states require reporting of complications, but if they do, neither the clinic nor the ER is inclined to keep records and neither do so.¹³²

The third filter is in the ER. The ER doctor may have no reason to suspect abortion or may simply report the presenting symptoms rather than the underlying cause. The coding procedures (addressed below) give the ER doctor a financial incentive to report the woman's condition as caused by something else, like embolism, sepsis, or cardiomyopathy. ER doctors are paid (reimbursed) more if they submit the billing as "treatment for septic shock" rather than "abortion."

127. The CDC's data is collected by two different agencies that use different definitions: the National Vital Statistics System (NVSS) and the Pregnancy Mortality Surveillance System (PMSS). Between 1995 and 1997, only fifty-four percent of the deaths identified were reported in both systems. See generally Andrea P. MacKay et al., *An Assessment of Pregnancy-Related Mortality in the United States*, 19 PEDIATRIC & PERINATAL EPIDEMIOLOGY 206 (2005).

128. See Rachel K. Jones et al., *Abortion in the United States: Incidence and Access to Services, 2005*, 40 PERSP. ON SEXUAL AND REPROD. HEALTH 6, 7 n.3 (2008) ("Many state health departments are able to obtain only incomplete data from abortion providers, and in some states, only 40-50% of abortions are reported.").

129. 476 U.S. 747, 764-68 (1986), *overruled in part by* Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992). In *Casey*, the Court held that certain reporting requirements that do not place an undue burden on a woman's right to choose are valid. See *Casey*, 505 U.S. at 883.

130. See, e.g., *Mahoning Women's Ctr. v. Hunter*, 610 F.2d 456 (6th Cir. 1979), *vacated on other grounds*, 447 U.S. 918 (1980).

131. See Jones et al., *supra* note 128, at 7 (citing data on state abortion clinics that report).

132. See Rebekah Saul, *Abortion Reporting in the United States: An Examination of the Federal-State Partnership*, 30 FAM. PLAN. PERSP. 244, 247 (1998); *Abortion Reporting Requirements*, STATE POLICIES IN BRIEF (Guttmacher Inst., New York, N.Y.), Mar. 1, 2012, available at http://www.guttmacher.org/statecenter/spibs/spib_ARR.pdf (examining which states have reporting requirements).

Payment mechanisms are the fourth filter. Because most abortions in the United States are paid for with cash, there is no submission of the procedure to a third-party payer and no financial record of the transaction.

Coding requirements are the fifth filter. Those abortions that are billed to insurance companies are billed according to coding requirements (current procedural technology (CPT) codes) and must be linked with an International Classification of Disease (ICD) code. The ICD-9 codes (the current version used in the United States) lump four different types of pregnancies together: spontaneous abortion, elective abortion, ectopic pregnancy, and molar pregnancy. The ICD-9 codes make it impossible to specifically link a complication to elective abortion. Abortion is treated differently than other gynecological procedures, and the different treatment hides complications and deaths.

The sixth filter is unreliable death certificates. Unreliable death certificates prevent accurate statistics on maternal deaths.¹³³ For these reasons, any estimate of complications, injuries, and deaths in the United States is unreliable.¹³⁴ In this climate of haphazard data collection and uncertain legal authority, the Supreme Court's abortion doctrine has dictated deference to providers and against public health officials.

V. THE GROWING INTERNATIONAL DATA ON THE LONG-TERM MEDICAL RISKS

The Court legalized abortion in 1973 without a factual record and without critically examining the then-existing medical literature. Consequently, the haphazard federal and state data collection system that has resulted from *Roe* has created a vacuum when it comes to reliably assessing the long-term risks of abortion. But much has changed in the past thirty-nine years. The risks of abortion have been studied internationally in medical journals for decades, and the studies have been increasing in number and sophistication in the last decade, especially. Not only do numerous countries have data to draw on, but many

133. See CARLA ABOUZAHRA & TESSA WARDLAW, MATERNAL MORTALITY IN 2000: ESTIMATES DEVELOPED BY WHO, UNICEF, AND UNFPA 4 (2004) [hereinafter WHO REPORT ON 2000], available at <http://whqlibdoc.who.int/publications/2004/9241562706.pdf>; LALE SAY ET AL., MATERNAL MORTALITY IN 2005: ESTIMATES DEVELOPED BY WHO, UNICEF, UNFPA AND THE WORLD BANK (2007) [hereinafter WHO REPORT ON 2005], available at http://whqlibdoc.who.int/publications/2007/9789241596213_eng.pdf; Deneux-Tharoux et al., *supra* note 79, at 684-85; Isabelle L. Horon, *Underreporting of Maternal Deaths on Death Certificates and the Magnitude of the Problem of Maternal Mortality*, 95 AM. J. PUB. HEALTH 478 (2005); Reardon et al., *supra* note 76, at 280-81.

134. See WHO REPORT ON 2000, *supra* note 133, at 4 (“[A]ll existing estimates of maternal mortality are subject to greater or lesser degrees of uncertainty.”); WHO REPORT ON 2005, *supra* note 133 (showing that WHO has used seven different methods to estimate maternal mortality); Chang et al., *supra* note 79; Laurie D. Elam-Evans et al., *Abortion Surveillance—United States, 2000*, 52 MORBIDITY & MORTALITY WKLY. REP., no. SS-12, 2003; Horon, *supra* note 133, at 478; Donna J. Harrison, *Removing the Roadblocks from Achieving MDG 5 by Improving the Data on Maternal Mortality: How Faulty Definitions of “Abortion,” “Safe Abortion,” and “Unsafe Abortion” in Reproductive Health Indicators for Global Monitoring Lead to Miscalculating the Causes of Maternal Mortality* 1-8 (Int’l Orgs. Research Grp. Briefing Paper No. 5), available at http://www.c-fam.org/docLib/20090514_Removing_the_Roadblocksfinal.pdf.

have better data than the United States because they have centralized medical systems that track and report every abortion (which the nation's medical system pays for).

The data need to be handled with care, however. Women are ultimately interested in whether abortion *causes* any particular medical or psychological outcome. The answer to this causality question depends not on any one study but on a number of studies, each conducted according to reliable methods. Association should not be confused with causation, and the data should be accurately described and not exaggerated. One study cannot settle a medical issue, and more are needed, but dozens currently exist on the long-term risks of abortion. The world-wide body of data on abortion risks should not be dismissed by citing a conclusory statement by some established medical organization or by noting that some published studies have found no increased risk.¹³⁵

A. A 2003 "Benchmark"

A landmark article in the January 2003 issue of the *Obstetrical and Gynecological Survey* (OGS)—one of the three leading obstetrical journals in the United States—examined medical studies of abortion going back to the 1960s to assess the long-term physical and psychological health consequences for women from induced abortion.¹³⁶ The authors noted that “[t]he high prevalence of a history of induced abortion means that even small positive or negative effects on long-term health could influence the lives of many women and their families,” and that until “a large epidemiologic, cohort study” is completed, “women are making important health decisions with incomplete information.”¹³⁷

The OGS authors emphasized three important conclusions:

- [W]omen contemplating their first induced abortion early in their reproductive life should be informed of two major long-term health consequences. First, their risk of subsequent long-term birth, particularly of a very low-birth weight infant, will be elevated above their baseline risk in the current pregnancy. Second, they will lose the protective effect of a full-term delivery on their lifetime risk of breast carcinoma. This loss of protection will be in proportion to the length of time that elapses before they experience their first delivery.¹³⁸
- Increased rates of placenta previa and the disputed independ-

135. See generally BRENDA MAJOR ET AL., REPORT OF THE APA TASK FORCE ON MENTAL HEALTH AND ABORTION (2008), available at <http://www.apa.org/pi/women/programs/abortion/mental-health.pdf>; Vignetta E. Charles et al., *Abortion and Long-Term Mental Health Outcomes: A Systematic Review of the Evidence*, 78 CONTRACEPTION 436 (2008).

136. See generally John M. Thorp, Jr. et al., *Long-Term Physical and Psychological Health Consequences of Induced Abortion: Review of the Evidence*, 58 OBSTETRICAL & GYNECOLOGICAL SURV. 67 (2003) (assessing long-term consequences).

137. See *id.* at 68, 77.

138. *Id.* at 77.

ent risk of induced abortion on breast cancer risk warrant mention as well.¹³⁹

- [P]reterm delivery and depression are important conditions in women's health and avoidance of induced abortion has potential as a strategy to reduce their prevalence.¹⁴⁰

Together with the OGS study, the international medical literature is growing and numerous studies have begun to provide significant evidence suggesting six long-term physical and psychological risks from abortion that need to be seriously considered:

- Increased risk of pre-term birth (or premature delivery) in future pregnancies;¹⁴¹
- Increased risk of placenta previa in future pregnancies;¹⁴²
- Increased incidence of drug and alcohol abuse;¹⁴³
- Increased incidence of suicide and psychiatric admission after abortion;¹⁴⁴
- Loss of the protective effect against breast cancer of a first full-term pregnancy;¹⁴⁵ and
- Increased incidence of violence and assault after abortion.¹⁴⁶

What is impressive about the recent data on the long-term risks of abortion to women is the growth of the number of studies, over several decades, from numerous countries. These studies need to be carefully read and considered, especially by doctors. But—as the OGS authors recommend—women also need to have a dialogue with their doctors about the data, not only for their immediate decision about abortion, but also for their long-term health monitoring.

B. *Pre-term Birth*

Pre-term birth means birth before thirty-seven weeks gestation. “Preterm birth is . . . the leading cause of infant morbidity and mortality.”¹⁴⁷ Very pre-term birth means birth at less than twenty-eight weeks gestation. Very pre-term birth is associated with cerebral palsy. The March 2003 issue of *ACOG Today* reported that “premature birth has increased 27 percent since 1981.”

139. *Id.*

140. *Id.* at 67.

141. *See supra* notes 137-40; *infra* notes 147-49.

142. *See infra* notes 155-56.

143. *See infra* notes 157-60.

144. *See infra* notes 162-68.

145. *See infra* notes 174-78.

146. *See* Mika Gissler et al., *Injury Deaths, Suicides and Homicides Associated with Pregnancy, Finland 1987-2000*, 15 *EURO. J. PUB. HEALTH* 459 (2005); Mika Gissler & Elina Hemminki, *Pregnancy-Related Violent Deaths*, 27 *SCAND. J. PUB. HEALTH* 54 (1999); Elizabeth M. Shadigian & Samuel T. Bauer, *Pregnancy-Associated Death: A Qualitative Systematic Review of Homicide and Suicide*, 60 *OBSTETRICAL & GYNECOLOGICAL SURV.* 183 (2005).

147. Thorp, Jr. et al., *supra* note 136, at 75.

The OGS researchers observed that “[d]espite substantial investigative effort, primary preventive measures to lower the rate of preterm births have proven futile and rates have been steady or increased over the past two decades.”¹⁴⁸ Over 114 studies have been published finding a statistically significant increase in pre-term birth or low-birth weight after an induced abortion, 30 of these since 2000.¹⁴⁹

- A 2006 report by the Institute of Medicine acknowledged that induced abortion is a risk factor for pre-term birth.¹⁵⁰
- A 2007 study in the *Journal of Reproductive Medicine* concluded that complications of pre-term birth after induced abortion for mother and child cost an estimated \$1.2 billion in annual health care costs.¹⁵¹
- In 2009, three systematic evidence reviews were published that found an increased risk of pre-term birth after abortion.¹⁵² One of these, by P.S. Shah and J. Zao, concluded that a single elective abortion was associated with a subsequent pre-term birth odds ratio (OR) of 1.36 (a 36% increased risk) and more than one abortion was associated with an OR of 1.93 (a 93% increased risk).
- A 2010 study in *Human Reproduction* by Emmanuel A. Anum et al. concluded that “prior pregnancy termination is a major risk factor for cervical insufficiency,” and black women have an increased risk of cervical insufficiency.¹⁵³ The more prior abortions, the greater the increased risk.

148. *Id.*

149. See Letter from Donna J. Harrison, President, Am. Ass’n of Pro-life Obstetricians & Gynecologists, to Cecilia Moeller, Comm’r, Office of the United Nations High Comm’r on Human Rights (Nov. 27, 2009), available at <http://www.aaplog.org/international-issues/aaplog-objection-to-inclusion-of-universal-access-to-reproductive-healthcare-as-a-part-of-mdg-5-letter-to-un-high-commissioner-on-human-rights/>.

150. See Greg R. Alexander, *Prematurity at Birth: Determinants, Consequences, and Geographic Variation*, in *PRETERM BIRTH: CAUSES, CONSEQUENCES, AND PREVENTION* app. B at 604, 625, tbl.B-5 (Richard E. Behrman & Adrienne S. Butler eds., 2007).

151. See generally Byron C. Calhoun et al., *Cost Consequences of Induced Abortion as an Attributable Risk for Preterm Birth and Impact on Informed Consent*, 52 J. REPROD. MED. 929 (2007) (listing fifty-nine other studies on risk of pre-term birth going back to 1960s).

152. See Rosanne Freak-Poli et al., *Previous Abortion and Risk of Pre-term Birth: A Population Study*, 22 J. MATERNAL-FETAL & NEONATAL MED. 1 (2009); P.S. Shah & J. Zao, *Induced Termination of Pregnancy and Low Birthweight and Preterm Birth: A Systematic Review and Meta-analysis*, 116 BRIT. J. OBSTETRICS & GYNECOLOGY 1425 (2009); Hanes M. Swingle et al., *Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses*, 54 J. REPROD. MED. 95 (2009); see also Pierre-Yves Ancel et al., *History of Induced Abortion as a Risk Factor for Preterm Birth in European Countries: Results of the EUROPOP Survey*, 19 HUMAN REPROD. 734 (2004); Caroline Moreau et al., *Previous Induced Abortion and the Risk of Very Preterm Delivery: Results of the EPIPAGE Study*, 112 BRIT. J. OBSTETRICS & GYNECOLOGY 430 (2005); Brent Rooney & Byron C. Calhoun, *Induced Abortion and Risk of Later Premature Births*, 8 J. AM. PHYSICIANS & SURGEONS 46 (2003).

153. See Emmanuel A. Anum et al., *Health Disparities in Risk for Cervical Insuffici-*

- A comprehensive study of pre-term birth by Jay D. Iams and Vincenzo Berghella in August 2010 referenced the increased risk of pre-term birth after abortion.¹⁵⁴

C. *Placenta Previa*

A number of studies have found an increased risk of placenta previa after induced abortion. Placenta previa occurs when the placenta covers all or part of the cervix during pregnancy. While the placenta normally attaches at the top of the uterus, scarring from the curette scraping from a prior-induced abortion can prevent proper implantation or increase the risk of abnormal implantation of the placenta in future pregnancies. The formation of the placenta over the cervical opening—if it persists until the onset of labor—carries substantial risk to the mother (including life-threatening hemorrhage, increased risk of postpartum hemorrhage, and increased incidence of cesarean delivery) and to the unborn child (including pre-term birth, low birth weight, and perinatal death). In labor, it creates a medical emergency, making a cesarean section medically necessary to deliver the child, with obvious risks to mother and child. The OGS study authors noted that “[p]lacenta previa . . . is the leading cause of uterine bleeding in the third trimester and of medically indicated preterm birth. Pregnancies complicated by placenta previa result in high rates of preterm birth, low birth weight, and perinatal death.”¹⁵⁵

The OGS study found that induced abortion increased the risk of placenta previa in subsequent pregnancies—one study found a thirty-percent increased risk. Three studies before 2003 showed an increased risk of fifty percent after abortion.¹⁵⁶ And when a woman has had two prior induced abortions, there is more than twice the risk of placenta previa—what researchers call a “dose effect”: the stronger the dose (or exposure), the stronger the effect that can be seen.

D. *Increased Incidence of Drug and Alcohol Abuse*

A number of studies since the 1970s have found an increased use of drug and alcohol after abortion. “[T]here is considerable evidence that having an abortion is a significant predictor of later drug and alcohol abuse and dependence.”¹⁵⁷

- A 2000 study in the *American Journal of Drug and Alcohol Abuse* found a “five-fold increased incidence of abuse of al-

cy, 25 HUMAN REPROD. 2894, 2899 (2010) (concluding that “prior pregnancy termination is . . . a major risk factor for cervical insufficiency”).

154. See generally Jay D. Iams & Vincenzo Berghella, *Care for Women with Prior Preterm Birth*, 203 AM. J. OBSTETRICS & GYNECOLOGY 89 (2010).

155. Thorp, Jr. et al., *supra* note 136, at 75.

156. See *id.* at 70.

157. DELLAPENNA, DISPELLING THE MYTHS OF ABORTION HISTORY, *supra* note 17, at 784 (citing studies in 1970s and 1980s).

- cohol and drugs in those who had aborted compared with those who carried to term.”¹⁵⁸
- A 2004 study in the same journal looked at data from the National Longitudinal Study of Youth and found that women who had abortions had a higher rate of subsequent substance abuse than women who had never been pregnant or women who gave birth after unexpected pregnancies.¹⁵⁹
 - A 2009 study found abortion associated with depression, anxiety, and substance abuse.¹⁶⁰

E. *Increased Risk of Suicide and Psychiatric Admission*

This risk is one of the most controversial and disputed medical aspects of abortion. While there are published articles concluding that there is no adverse mental health impact from abortion,¹⁶¹ there have also been more than 102 peer-reviewed studies published in international medical journals that suggest an association between abortion and adverse mental health outcomes.¹⁶²

Studies support both sides of the debate: some find an increased risk of mental health trauma, while others do not. Certainly there is a need for additional, extensive research in the years ahead. Nevertheless, many recent, well-done, peer-reviewed studies show a negative mental health impact from abortion.¹⁶³ A number of rigorous studies have been published that suggest a link between abortion and emotional distress, depression, substance abuse, suicide

158. See generally David C. Reardon & Philip G. Ney, *Abortion and Subsequent Substance Abuse*, 26 AM. J. DRUG & ALCOHOL ABUSE 61 (2000).

159. See generally David C. Reardon et al., *Substance Use Associated with Unintended Pregnancy Outcomes in the National Longitudinal Survey of Youth*, 30 AM. J. DRUG & ALCOHOL ABUSE 369 (2004).

160. See generally Priscilla K. Coleman et al., *Induced Abortion and Anxiety, Mood, and Substance Abuse Disorders: Isolating the Effects of Abortion in the National Comorbidity Survey*, 43 J. PSYCHIATRIC RES. 770 (2009).

161. See, e.g., Charles et al., *supra* note 135, at 436; Brenda Major et al., *Abortion and Mental Health: Evaluating the Evidence*, 64 AM. PSYCHOLOGIST 863 (2009); Trine Munk-Olsen et al., *Induced First-Trimester Abortion and Risk of Mental Disorder*, 364 NEW ENG. J. MED. 332 (2011).

162. See Letter from Donna J. Harrison to Cecilia Moeller, *supra* note 149; see also Zoë Bradshaw & Pauline Slade, *The Effects of Induced Abortion on Emotional Experiences and Relationships: A Critical Review of the Literature*, 23 CLINICAL PSYCHOLOGY REV. 929 (2003); Anne N. Broen et al., *Reasons for Induced Abortion and Their Relation to Women's Emotional Distress: A Prospective, Two-Year Follow-Up Study*, 27 GEN. HOSP. PSYCHIATRY 36 (2005); Jesse R. Cogle et al., *Generalized Anxiety Following Unintended Pregnancies Resolved Through Childbirth and Abortion: A Cohort Study of the 1995 National Survey of Family Growth*, 19 J. ANXIETY DISORDERS 137 (2005); Mika Gissler et al., *supra* note 146; David C. Reardon et al., *Psychiatric Admissions of Low-Income Women Following Abortion and Childbirth*, 168 CAN. MED. ASS'N J. 1253, 1253 (2003).

163. See generally Priscilla K. Coleman, *Abortion and Mental Health: Quantitative Synthesis and Analysis of Research Published 1995-2009*, 199 BRIT. J. PSYCHIATRY 180 (2011); Gissler et al., *supra* note 146; Christopher L. Morgan et al., Letter, *Suicides After Pregnancy: Mental Health May Deteriorate as a Direct Effect of Induced Abortion*, 314 BRIT. MED. J. 902 (1997).

and suicidal ideation, attempts at self-harm, anxiety, violence and assault, frayed relationships, and coercion. And many or most of these have done a good job at controlling for pre-existing conditions.

A number of studies have found an increased risk of suicide and psychiatric admission after abortion.¹⁶⁴

- The 2003 OGS study identified a number of studies which found that “induced abortion increased the risks for . . . of mood disorders substantial enough to provoke attempts of self-harm.”¹⁶⁵
- A study by Mika Gissler from Finland in 1996 found a more than three-fold increase in risk of suicide after induced abortion.¹⁶⁶
- A 2010 study in the *Canadian Journal of Psychiatry* found that “abortion was associated with an increased likelihood of several mental disorders—mood disorders . . . , substance abuse disorders . . . , as well as suicidal ideation and suicide attempts.”¹⁶⁷
- A September 2011 study in the *British Journal of Psychiatry* found an 81% increased risk of mental trauma after abortion.¹⁶⁸

Recently, the U.S. Court of Appeals for the Eighth Circuit, in *Planned Parenthood Minnesota v. Rounds*,¹⁶⁹ upheld certain requirements of the South Dakota informed consent law (H.B. 1166) enacted in 2005.¹⁷⁰ Specifically, the three-judge panel upheld three “advisories,” but split over a “suicide advisory,” which the majority struck down.¹⁷¹ Judge Gruender, in a thorough and well-reasoned dissent, would have upheld the suicide advisory, citing “numerous

164. See generally David M. Fergusson et al., *Abortion in Young Women and Subsequent Mental Health*, 47 J. CHILD PSYCHOLOGY & PSYCHIATRY 16 (2006); David M. Fergusson et al., *Reactions to Abortion and Subsequent Mental Health*, 195 BRIT. J. PSYCHIATRY 420 (2009); Natalie P. Mota et al., *Associations Between Abortion, Mental Disorders, and Suicidal Behavior in a Nationally Representative Sample*, 55 CAN. J. PSYCHIATRY 239 (2010).

165. See Thorp, Jr. et al., *supra* note 136, at 67.

166. See generally Mika Gissler et al., *Suicides After Pregnancy in Finland, 1987-94: Register Linkage Study*, 313 BRIT. MED. J. 1431 (1996).

167. See Mota et al., *supra* note 164, at 239.

168. See generally Coleman, *supra* note 163, at 180. In response to critical letters to the editor, Professor Coleman’s study was given a thorough defense by David Fergusson, who conducted follow-up meta-analyses to answer these critical letters. See David Fergusson, *A Further Meta-Analysis*, BRIT. J. PSYCHIATRY (Oct. 5 2011), http://bjp.rcpsych.org/content/199/3/180.abstract/reply#bjrcpsych_el_33839 (reviewing Coleman, *supra* note 163).

169. 653 F.3d 662 (8th Cir.), *vacated in part en banc* 662 F.3d 1072 (8th Cir. 2011).

170. See *id.* at 673.

171. See *id.* at 665-67 (discussing advisories required by South Dakota abortion law); see also S.D. CODIFIED LAWS § 34-23A-10.1(1)(e)(ii) (2011), *held unconstitutional by Rounds*, 653 F.3d 662.

studies” in the record “published in peer-reviewed medical journals that demonstrate a statistically significant correlation between abortion and suicide.”¹⁷² Furthermore, Judge Gruender noted that “even the evidence relied upon by Planned Parenthood acknowledges a significant, known statistical correlation between abortion and suicide. This well-documented statistical correlation is sufficient to support the required disclosure that abortion presents an ‘increased risk’ of suicide, as that term is used in the relevant medical literature.”¹⁷³

F. *Increased Risk of Breast Cancer*

Along with the claimed increased risk of suicide and suicidal ideation, the increased risk of breast cancer is obviously a controversial and disputed issue. However, at least since 1957, medical journal studies have found an increased risk of breast cancer after abortion.¹⁷⁴ Holly Howe’s 1989 study was one of the earliest in the United States.¹⁷⁵ National Cancer Institute researcher Janet Daling’s study in 1994 also found an increased risk of breast cancer after abortion.¹⁷⁶

Based on the existing data, the OGS study authors concluded that “clinicians are obliged to inform pregnant women that a decision to abort her first pregnancy may almost double her lifetime risk of breast cancer through loss of the protective effect of a completed first full-term pregnancy earlier in life.”¹⁷⁷ This “‘loss of protection’ effect is most pronounced in women under 20 years of age who elect to undergo abortion rather than continue their pregnancy.”¹⁷⁸ The OGS authors, utilizing the Gail Model, a familiar scale for assessing breast cancer risk from an exposure, concluded that if an eighteen-year-old finds herself pregnant for the first time, her decision to abort almost doubles her lifetime risk of breast cancer.

The studies and the data need to be more widely known, and doctors need to discuss them with their patients. If doctors will not, women need to initiate a dialogue with their doctors. Women who have had abortions need to discuss the pros and cons of heightened screening for the long-term risks. The public needs to carefully examine the studies themselves, instead of examining the public statements that interest groups have released about the data.

172. See *Rounds*, 653 F.3d at 675-77 (Gruender, J., concurring in part and dissenting in part) (citing numerous “peer-reviewed medical literature” that suggest connection between abortion and suicide).

173. *Id.* at 673-74.

174. Segi M et al., *An Epidemiological Study on Cancer in Japan*, 48 GAN TO KAGAKU RYOHO [JAPANESE J. CANCER & CHEMOTHERAPY] supp. 1 (1957).

175. See generally Holly L. Howe et al., *Early Abortion and Breast Cancer Risk Among Women Under Age 40*, 18 INT’L J. EPIDEMIOLOGY 300 (1989).

176. See generally Janet R. Daling et al., *Risk of Breast Cancer Among Young Women: Relationship to Induced Abortion*, 86 J. NAT’L CANCER INST. 1584 (1994).

177. Thorp, Jr. et al., *supra* note 136, at 76.

178. *Id.*

VI. CONCLUSION

Accurate knowledge about clinic conditions and the short-term and long-term risks is essential before any productive discussion of clinic regulations policy can be attempted. To make sense, effective clinic regulations need to be reasonably connected to the medical risks in clinics.¹⁷⁹

In 1973 the Supreme Court created the public health vacuum that allowed Kermit Gosnell and many other substandard practitioners across the country to flourish and prevented anyone else from filling that vacuum. The biggest obstacle to effective health and safety regulations is not creating majority support for clinic regulations; it is the obstruction of the federal courts applying the Court's abortion doctrine. If clinic regulations are genuinely intended to protect women's health, they should effectively do that, whether or not they otherwise "limit" abortions. But if, as a growing body of international medical data shows, there are long-term risks that are inherent in abortion, like the increased risk of pre-term birth, then clinic regulations can only do so much. They can never really protect women's health. And the Court, as the national abortion control board, cannot do anything to fix the situation, except to overturn *Roe* and *Doe* and leave the issue to the people, through their elected representatives, and the public health system.

179. See Chang et al., *supra* note 79, at 5 (noting that three main causes of abortion-related death are infection (33.9%), hemorrhage (21.8%), and embolism (13.9%)); Maarit Niinimäki et al., *Immediate Complications After Medical Compared with Surgical Termination of Pregnancy*, 114 *OBSTETRICS & GYNECOLOGY* 795 (2009) (conducting study based on registry data of all women in Finland undergoing induced abortion from 2000 to 2006 with gestational duration of sixty-three days or less, and finding "medical termination is associated with a higher incidence of adverse events" than surgical abortion).