Whole Women's Victory — or Not?

Facts about women's health won out over fiction in June, when the Supreme Court, even without examining the Texas legislature's motives, struck down its regulations aimed at closing abortion clinics. Now the question is whether facts about human development will be adequate on their own to overcome fiction in what will probably be the next front in the abortion wars: fetal pain.

Whole Woman's Health v. Hellerstedt is a turning point in Supreme Court jurisprudence, not just because it turned the tide in the face of 300-plus abortion restrictions passed by state legislatures in the past 5 years alone.1 It also signaled a refreshing willingness to test a law's justifications against its actual effects. In the context of women's reproductive rights, and abortion rights in particular, such willingness has potentially far-reaching effects for measures that interfere with physician judgment and the doctor–patient relationship, including waiting periods, prohibitions on the use of necessary techniques, and requirements for medically unnecessary procedures.

Claiming that they aimed to protect women's health, Texas abortion-rights opponents enacted rules requiring doctors to have admitting privileges at nearby hospitals and requiring clinics to meet the space and personnel standards of surgical services. The Court's decision includes a detailed critique of those restrictions' effects, in light of their claimed justification. The admitting-privileges requirement alone caused the shutdown of half the clinics in the state, reducing access while — according to the evidence cited — failing to improve in any way on the extraordinary safety record for abortions in Texas. Indeed, complication rates were so low that doctors did not admit enough women each year to qualify for admitting privileges. And implementing the surgical-center requirements (on top of the many facilities requirements the clinics already met) would have left only seven or eight clinics in operation for the entire state, without any appreciable change in the number or management of complications.

As Justice Ruth Bader Ginsburg noted in her concurring opinion, tonsillectomy, colonoscopy, in-office dental surgery, and childbirth are far more dangerous to patients yet are not subject to surgical-center or admitting-privileges requirements. That contrast invited the Court to examine the true motivations behind the restrictions, but its decision limited itself to assessing the factual claims and examining the balance between purported health benefits and effects on access.

There is lively debate about how much courts should defer to legislatures regarding factual information, given jurisprudential principles surrounding the separation of powers and concerns about expertise or partisanship in both institutions. In 2007, the Supreme Court seemed to signal an unquestioning acceptance of the legislative "facts" and "findings" that are often recited to justify a law, when, in *Gonzales v. Carhart*, it upheld a statute banning the use of dilation and extraction (D&X) on the basis of legislative "findings" (contrary to medical testimony) that the procedure is never necessary to protect a woman's health.2 The Court said that because the evidence was mixed, it should defer to the legislature. But the *Gonzales* opinion included language suggesting that entirely uncritical deference is inappropriate and noting that the "Court retains an independent constitutional duty to review factual findings where constitutional rights

are at stake." This 2007 language was put to use in *Whole Woman's Health* to justify the Court's independent assessment of relevant facts.

The *Whole Woman's Health* decision also made more explicit that whether a law constitutes an unconstitutional "undue burden" on abortion rights requires looking at whether its purported benefits are reasonable in light of the limitations it imposes. Recognizing the challenge this standard poses for disingenuous claims of promoting women's health, abortion-rights opponents will probably shift their strategy to claims related to the fetus — for example, that it can feel pain as early as 20 weeks after conception.3

Claims of fetal pain are not new. In 1984, abortion-rights opponents produced the film *The Silent Scream*, in which fetal movements are interpreted as reflecting distress and pain. Twenty years later, fetal movement in response to stimuli and release of hormones in response to stress were claimed to be proof of fetal pain. Since then there have been efforts to require fetal anesthesia, which would lead to the closing of many clinics that cannot meet the requirements for facilities offering such a service. Other bills would outlaw a commonly used second-trimester form of dilation and evacuation (D&E) as cruel to the fetus, and 14 states have already used claims about fetal pain to prohibit abortion entirely at 20 weeks after conception — a prohibition that directly challenges *Roe v. Wade*'s seminal holding of an expansive right to terminate a pregnancy while the fetus is not yet viable.3

It is here that the Court's degree of deference to legislative fact finding becomes crucial. Study after study has determined that perception of pain is not physically possible until nearly 30 weeks of gestation, when thalamocortical pathways are present and have begun to function.4 As Britain's Royal College of Obstetricians and Gynaecologists explains, "although the cortex can process sensory input from 24 weeks, it does not mean that the fetus is aware of pain . . . . The cortex is necessary for pain experience but this is not to say that it is sufficient. Similarly, the interpretation of ultrasound images is problematic. It is important that 'labelling' a set of movements, such as 'yawning,' with a functional or emotional purpose that is not possible does not imply such a purpose."5

But as with the late-term abortions that were in question in *Gonzales*, legislators can claim that medical opinion is mixed, even though the evidence for such pain has been dismissed as erroneous or misleading by authoritative medical societies. And judges may be as susceptible as anyone to the argument that since anesthesia is given to premature neonates, physicians must be convinced that pain is experienced even at these early stages of gestation. The response from the Royal Society and others — that the uterine environment induces a state akin to sleep or lack of consciousness that distinguishes the fetal experience from that of premature infants — may not be intuitive enough to be persuasive.

The difficulty of using factual assessments alone underlines the importance of examining legislative intent. Running throughout the majority and concurring opinions in *Whole Woman's Health* is a tone of disbelief that these restrictions could ever have been motivated by genuine concern for women's health, given how strategically written they were to single out abortion clinics for rules that don't apply to more dangerous procedures and how patently divorced they were from any actual increase in the quality of abortion services. But by failing to explicitly

acknowledge this disbelief, the Court missed an opportunity to free itself from a self-imposed straitjacket requiring it to defer to a claim of mixed medical opinion even when the motivations behind a law are clear.

By upholding a law that made no allowance for individual physician judgment about the safest procedure, the 2007 *Gonzales* decision prioritized concerns about the fetus over those about women's health. The question is whether this result would be tolerated again, despite the 2016 *Whole Woman's Health* decision. In *Gonzales*, the Court upheld the federal statute in part because "a fetus is a living organism within the womb, whether or not it is viable outside the womb" and "choosing not to prohibit [a brutal and inhumane procedure] will further coarsen society to the humanity of not only newborns, but all vulnerable and innocent human life, making it increasingly difficult to protect such life." One can easily imagine similar language in a decision that upholds prohibitions on second-trimester D&E procedures or 20-week bans by deferring to disputed legislative findings about fetal pain.

This scenario is not idle speculation. The Zika virus can have devastating effects on fetal development that cannot be detected until well into the second trimester. If courts fail to examine the real motivations behind the spate of new laws premised on fetal pain and therefore uphold 20-week bans, anesthesia requirements, or procedure limitations out of judicial deference to legislative findings, the *Whole Woman's Health* decision would no longer be a whole women's victory.

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