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REPRODUCTIVE RIGHTS AS HEALTH CARE RIGHTS

B. JESSIE HILL*

The idea that abortion rights are central to protecting women's health will hardly come as a surprise to most reproductive rights advocates. For example, much of the recent litigation challenging states' legal restrictions on abortion has centered around the requirement of a health exception—that is, around the question of whether legislation regulating abortion must contain an exception for cases where the regulated procedure is necessary to protect the woman's health.¹ Reproductive rights organizations also often espouse the language of “women's health.”²

* Associate Professor and Associate Director of the Center for Social Justice, Case Western Reserve University School of Law. I would like to thank the Columbia Journal of Gender and Law and the Center for Reproductive Rights for inviting me to participate in this symposium. I would also like to thank Jessica Berg, Sharona Hoffman, and Max Mehlman for their helpful comments and suggestions. Justine Konicki and Jack Blanton provided excellent research assistance. All errors are mine.

¹ See, e.g., *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 511–12, 517 (6th Cir. 2006) (upholding the district court's preliminary injunction against a state law regulating the abortion drug mifepristone, also known as RU-486, on the ground that the lack of a health exception may pose significant risks to some women's health but remanding to the district court for reconsideration of the scope of the injunction); *Planned Parenthood of Idaho, Inc. v. Wasden*, 376 F.3d 908, 930 (9th Cir. 2004) (striking down Idaho's parental consent law due to the insufficiency of its health exception); *Planned Parenthood of Rocky Mountains Servs. Corp. v. Owens*, 287 F.3d 910, 927 (10th Cir. 2002) (holding that Colorado's parental notice law “is unconstitutional because it fails to provide a health exception as required by the Constitution of the United States”). Litigation over the health exception is probably less likely in the future, due to the Supreme Court's holding in *Gonzales v. Carhart*, 550 U.S. 124, 147 (2007), that the federal Partial Birth Abortion Ban Act was facially constitutional despite its lack of a health exception.

² The Center for Reproductive Rights draws an explicit connection between the human right to health and reproductive rights. See, e.g., Letter from Melissa Upreti, Legal Advisor for Asia, Center for Reproductive Rights, to the Committee on the Elimination of Discrimination Against Women (CEDAW Committee), at 1, 3 (Jan. 15, 2007), http://reproductiverights.org/sites/crr.civicactions.net/files/documents/pub_sl_CEDAW_India2007.pdf. The American Civil Liberties Union's Reproductive Freedom Project decries the threat to women's health posed by the federal Partial Birth Abortion Ban Act, Press Release, American Civil Liberties Union, ACLU and National Abortion Federation Criticize Decision by U.S. Supreme Court Upholding Federal Abortion Ban (Apr. 18, 2007), <http://www.aclu.org/reproductiverights/abortion/29423prs20070418.html>, and by rules

Indeed, those organizations, along with numerous other NGOs and some scholars, advocate greater recognition of the fact that reproductive health care in *all* its manifestations—not just access to abortion and contraception, but also access to safe obstetric and gynecologic care, adequate prenatal nutrition and care, and sexually transmitted disease prevention—is an important part of women’s health care in general.³ At the same time, however, feminist legal scholars have largely shied away from discussing abortion as primarily a *medical* procedure, instead emphasizing the idea of abortion as an intensely personal decision and as a right that is essential to women’s equal citizenship. This framework underscores the concepts of decisional autonomy and equality underpinning the constitutional right to choose abortion. Although there are valid reasons for the emphasis taken by those reproductive rights scholars, this Article argues that it may be time to consider embracing an approach that emphasizes abortion as a form of health care.

If abortion is placed in the framework of health care, the right to access abortion may then be considered to be an aspect of the right to health. This right to health, moreover, should be conceived as a negative right, not as a positive right. Although the distinction between positive and negative rights is not always airtight,⁴ it may be roughly described as follows. A positive right is generally considered to be an *entitlement* to something—a right to call on the government to provide, at government expense, a particular public good, such as shelter, education, or medical care.⁵ Such rights are sometimes referred to as “socio-economic rights,” and they are recognized as constitutional rights in a number of foreign countries.⁶ International law and numerous national constitutions,

allowing individuals and entities to opt out of providing reproductive health care services, Press Release, American Civil Liberties Union, ACLU Calls Again for Withdrawal of Regulations Jeopardizing Women’s Health (Sept. 28, 2008), <http://www.aclu.org/reproductiverights/gen/36945prs20080926.html>.

³ See, e.g., Serra Sippel, *Achieving Global Sexual and Reproductive Health and Rights*, 35 HUM. RTS. 13, 13 (2008); Cynthia Soohoo & Suzanne Stolz, *Bringing Theories of Human Rights Change Home*, 77 FORDHAM L. REV. 459, 480–81 (2008).

⁴ Cass R. Sunstein, *Why Does the American Constitution Lack Social and Economic Guarantees?*, 56 SYRACUSE L. REV. 1, 6–7 (2005) (questioning the distinction between negative and positive rights as it is conventionally understood).

⁵ *Id.* at 5; Mark Tushnet, *Social Welfare Rights and the Forms of Judicial Review*, 82 TEX. L. REV. 1895, 1895 (2004).

⁶ See Sunstein, *supra* note 4, at 3–4 (citing examples of constitutions that recognize positive rights); Tushnet, *supra* note 5, at 1895 n.2.

moreover, specifically recognize a right to health, which is in most instances understood as a positive entitlement to health care.⁷ Negative rights, by contrast, are simply rights to be free of governmental interference with one's decision to do something; they are "negative checks on government, preserving a sphere of private immunity."⁸ The United States Constitution is usually understood to confer only negative rights; this understanding is largely based on a perception that negative rights fit best within the paradigm of classical liberalism, that they are more easily enforceable by courts than positive rights, and that their recognition does not generally have major budgetary implications. Consequently, the judicial enforcement of negative rights does not raise the separation of powers concerns that might be raised by court-ordered rearrangement of legislative priorities and substantial monetary outlays to provide certain goods to the public.⁹ A negative right to health could thus be understood as a right *against* government interference in health care access and medical decision-making, rather than a right *to* government-provided medical services.

As this Article demonstrates, the Supreme Court's abortion jurisprudence suggests the existence of a negative right to health, but this notion has not yet been fully explored by courts or by advocates. Thus, although the Supreme Court has not yet explicitly embraced the notion of a right to medical decision-making autonomy or a right to health, it is a concept whose time has come. Indeed, other countries have started to recognize and operationalize a negative right to health in ways that encompass the right to reproductive health care. These countries' jurisprudence may serve as model for thinking about how such a right could be understood and incorporated into U.S. law.

⁷ Universal Declaration of Human Rights, G.A. Res. 217A, at 76, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948); Int'l Covenant on Econ., Soc. & Cultural Rights, G.A. Res. 2200A (XXI), at 51, U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc A/6316 (Dec. 16, 1966); see generally Eleanor D. Kinney & Brian Alexander Clark, *Provisions for Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT'L L.J. 285 (2004) (compiling provisions relating to the right to health care, if any, in the constitution of every country in the world).

⁸ Sunstein, *supra* note 4, at 4 (internal citation omitted).

⁹ *Id.* at 4–5; Tushnet, *supra* note 5, at 1895–97; Mark Tushnet, *An Essay on Rights*, 62 TEX. L. REV. 1363, 1392–94 (1984). Cass Sunstein, for one, questions whether those rationales, or many of the others commonly given, adequately explain the absence of positive rights in the United States. Sunstein, *supra* note 4, at 8–19.

Thus, this Article draws on models from other countries in order to consider, in broad strokes, what a negative right to health might be understood to mean. Specifically, this Article discusses two cases in which the high courts of other countries have recognized and applied a constitutional right to health in ways that seem particularly applicable and translatable to American constitutional law. Both the Canadian Supreme Court and the Constitutional Court of South Africa have recently rendered decisions exploring and applying the constitutional right to health to cases outside the abortion context.¹⁰ This right to health, which is conceived by those courts, at least in part, as a negative right to noninterference with medical treatment decisions and the doctor–patient relationship, can and should be recognized in the United States as well, along with the rights to privacy, autonomy, and bodily integrity protected by the Fourteenth Amendment’s substantive due process guarantees.¹¹ In addition, the right to choose abortion can and should be understood to be protected in part (but not exclusively) by that right. The Canadian and South African decisions may therefore provide a model for shaping both legal and political discourse concerning reproductive rights around the notion of a negative right to health.

Embracing this discourse will have distinct legal and political advantages for reproductive rights advocates. First, it may provide a framework for challenging certain kinds of restrictions on abortion rights that can be extraordinarily burdensome yet are usually found to be constitutional under current reproductive rights jurisprudence. Further, it may help to create broader political appeal for the protection of reproductive rights by placing those rights in a gender–neutral context to which a large portion of the population can relate. Of course, a discourse foregrounding the right to choose abortion as an aspect of a negative right to health also has certain limitations. It will not improve access to abortion for women who cannot afford it, for example, and it may not be sufficient to protect the core of the right to abortion itself. This Article does not, therefore, advocate viewing abortion rights *only* as growing out of a negative right to access medical care without government interference. Rather, this Article argues that this is one way to frame abortion rights, which may be particularly useful for certain purposes, and that this

¹⁰ *Chaoulli v. Québec*, [2005] 1 S.C.R. 791 (Can.); *Minister of Health v. Treatment Action Campaign* 2002 (10) BCLR 1033 (CC) (S. Afr.).

¹¹ U.S. CONST. amend. XIV, §1 (“No state shall . . . deprive any person of life, liberty, or property, without due process of law.”).

framework should be deployed alongside existing arguments about privacy, autonomy, equality, and dignity.

Part I of this Article demonstrates that the conceptualization of reproductive rights as an aspect of a negative right to health was an early feature of Supreme Court jurisprudence, but that both the Court's more recent jurisprudence and legal scholars' analyses have moved away from this understanding. Instead, the Court's jurisprudence has been grounded in concepts of privacy, equality, and autonomy in making important life decisions. Part I also proposes some reasons why feminist scholars have tended to downplay the view of abortion rights as encompassed within the negative right to health and suggests that those reasons should not continue to hold sway.

Part II then briefly describes the recent decisions of the Canadian Supreme Court in *Chaoulli v. Québec*¹² and of the South African Constitutional Court in *Minister of Health v. Treatment Action Campaign*¹³ and draws on those opinions to consider how one might more fully conceive of a negative right to health—and of the abortion right as one aspect of that negative health care right—within U.S. constitutional law. The right to health in both cases is conceived as a right against government-mandated harm, whether in the form of denial of or delay in access to medical treatment. That harm, moreover, is broadly conceived to include physical, emotional, and psychological harm. While not limitless, the negative right to health is also a robust right against interference with the doctor-patient relationship and the decision-making that arises from that relationship.

Finally, Part III discusses why this is a particularly promising way of framing reproductive rights for the future. Specifically, Part III argues that the negative right to health, which already exists in incipient form in U.S. constitutional law, would be particularly useful for attacking certain kinds of legislation limiting reproductive rights, such as misleading informed consent laws, mandatory ultrasound requirements, prohibitions on particular methods of abortion, and onerous administrative regulations pertaining exclusively to abortion providers.¹⁴ Moreover, it may provide a means of garnering wider political support for abortion rights.

¹² [2005] 1 S.C.R. 791 (Can.).

¹³ 2002, (10) BCLR 1033 (CC) (S. Afr.).

¹⁴ See, e.g., *Planned Parenthood Minn. v. Rounds*, 530 F.3d 724, 726 (8th Cir. 2008) (en banc) (rejecting a constitutional challenge to an informed consent statute requiring women be told that in obtaining an abortion they are “terminat[ing] the life of a whole, separate, unique, living human being”); *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502, 517-18 (6th Cir. 2006) (affirming preliminary injunction against a state law

I. THE RISE AND FALL OF THE RIGHT TO HEALTH IN ABORTION JURISPRUDENCE

The right to choose abortion is a multifaceted one, comprising many different rights. Most famously, of course, the right to an abortion is described as a right to privacy, which usually means a right to make certain intensely personal, fundamental, and potentially life-changing decisions without interference from the government.¹⁵ It is also in part a right to equality—a right that is essential in order for women to be able to pursue their chosen life paths on the same terms as men, without fear of being forced into unplanned and unwanted childbearing.¹⁶ Finally, the right to choose abortion is a right to bodily integrity: a right against being forced to put one's womb in the service of the state's claimed interest in potential life.¹⁷

The right to abortion is also a health care right. It is a right to access a particular medical procedure and a right to use that medical procedure to protect one's health from significant harm, even if that procedure terminates a potential life. In fact, as explained in this Part, reproductive rights, including the right to contraception, have long been conceived in this way. The understanding of reproductive rights as health care rights, which has long been present in reproductive rights jurisprudence, has been downplayed by both courts and reproductive rights advocates in favor of a

regulating mifepristone (RU-486) but opining that the injunction may need modification); *Tucson Woman's Clinic v. Eden*, 379 F.3d 531, 537, 557 (9th Cir. 2004) (mostly rejecting a constitutional challenge to onerous statutory and administrative scheme governing abortion providers); *Greenville Women's Clinic v. Comm'r*, 317 F.3d 357, 371 (4th Cir. 2002) (rejecting a constitutional challenge to onerous administrative regulations governing abortion providers).

¹⁵ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 851 (1992) (plurality opinion) ("Our law affords constitutional protection to personal decisions relating to marriage, procreation, contraception, family relationships, child rearing and education At the heart of liberty is the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life. Beliefs about these matters could not define the attributes of personhood were they formed under the compulsion of the State.").

¹⁶ *Id.* at 856 ("The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.").

¹⁷ *Id.* at 857 (describing the abortion right as being, in part, a right of "bodily integrity, with doctrinal affinity to cases recognizing limits on governmental power to mandate medical treatment or to bar its rejection").

rhetoric centered on personal autonomy, equality, and dignity.¹⁸ This Part explores the reasons why this strand of reproductive rights jurisprudence has largely been lost or ignored and suggests that those reasons should not continue to hold sway.

A. The Right to Health and the Medical Model of Abortion in Early Abortion Jurisprudence

One strain that unquestionably runs through American abortion jurisprudence is the notion that abortion is a health care decision, to be made by the woman and her physician without government interference, and therefore that the abortion right is in part a negative health care right. This view of abortion may be labeled the “medical model” of abortion, according to which abortion is seen simply as one among many surgical procedures, whose appropriateness is to be determined in the same way that the appropriateness of other medical interventions is determined—using professional clinical judgment.¹⁹ In the medical model of abortion, the physician plays a central role, exercising at least as much power as the woman to decide whether the abortion should be performed. Indeed, according to the medical model, abortion restrictions may violate the physician’s right to practice medicine as much as the woman’s right to privacy and autonomy.²⁰ The medical model of abortion is thus the basis for understanding reproductive rights as negative health care rights.

The predominance of the medical model of abortion is apparent in *Roe v. Wade*, with its heavy reliance on medico-legal history.²¹ The Court in *Roe*, summing up its holding, emphatically stated that its decision “vindicates the right of the physician to administer medical treatment

¹⁸ See *infra* Parts I.A and I.B.

¹⁹ Of course, at least since the approval of the abortifacient mifepristone by the FDA in 2000, abortion may be performed medically as well as surgically; even before the approval of mifepristone, the cancer drug methotrexate was used by medical professionals to induce abortions. See generally Malcolm Potts, *Non-Surgical Abortion: Who’s for Methotrexate?*, 346 LANCET 655 (1995).

²⁰ See, e.g., *Roe v. Wade*, 410 U.S. 113, 165-66 (1973) (discussing “the right of the physician to administer medical treatment according to his professional judgment”); *Doe v. Bolton*, 410 U.S. 179, 193 (1973) (discussing “the physician’s right to practice his profession”); Elizabeth Reilly, “*The Jurisprudence of Doubt*”: *How the Premises of the Supreme Court’s Abortion Jurisprudence Undermine Procreative Liberty*, 14 J.L. & POL. 757, 774-77 (1998).

²¹ *Roe v. Wade*, 410 U.S. at 130-47.

according to his professional judgment up to the points where important state interests provide compelling justifications for intervention.”²² Until the point of viability, when the state’s interest in the fetus becomes compelling, the Court explained, “the abortion decision in all its aspects is inherently, and primarily, a *medical* decision, and basic responsibility for it must rest with the *physician*.”²³ The Court was not alone in viewing the issue in *Roe* as, at least in part, an issue of medical decision-making autonomy. The lawyers for Jane Roe began the substantive portion of their Supreme Court brief with the heading, “The Right to Seek and Receive Medical Care for the Protection of Health and Well-Being Is a Fundamental Personal Liberty Recognized by Decisions of This Court.”²⁴ Thus, the plaintiffs asserted—in what they must have viewed to be their strongest argument, given its prominence in the brief—that “the personal right to care for one’s health is a fundamental right.”²⁵ Simply put, the abortion restrictions at issue in *Roe* were seen as “den[ying] Appellants . . . access to health care.”²⁶ Elsewhere, the plaintiffs described this right even more broadly, as the “right to care for and protect one’s health *in the manner one deems best*.”²⁷

Similarly, the Court in *Doe v. Bolton*,²⁸ the companion case to *Roe v. Wade*, repeatedly compared the abortion procedure to other surgical procedures, noting that the Georgia statute at issue in that case regulated abortion in ways that were unimaginable for other surgeries, and underlined the importance of the physician’s medical judgment in determining the appropriateness of abortion in an individual case.²⁹ That medical judgment

²² *Id.* at 165–66.

²³ *Id.* at 166 (emphasis added).

²⁴ See Brief for Appellants at 94–98, *Roe v. Wade*, 410 U.S. 113 (1971) (No. 70–18), 1971 WL 128054; see also Nan D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 171–72 (2006).

²⁵ Brief for Appellants, *supra* note 24, at 95.

²⁶ *Id.* at 98. The plaintiffs also noted that several medical organizations “draw no distinction between abortion and other medical procedures.” *Id.*

²⁷ *Id.* at 96 (emphasis added).

²⁸ 410 U.S. 179 (1973).

²⁹ See, e.g., *Bolton*, 410 U.S. at 197 (“We are not cited to any other surgical procedure made subject to committee approval as a matter of state criminal law.”); *id.* at 199 (“Again, no other voluntary medical or surgical procedure for which Georgia requires confirmation by two other physicians has been cited to us. If a physician is licensed by the State, he is recognized by the State as capable of exercising acceptable clinical judgment.”);

was broadly conceived, moreover, including the physician's ability to take into account emotional, psychological, and even "familial" factors. Such an inclusive understanding, the Court explained, "allows the physician the room he needs to make his best medical judgment"; this exercise of judgment "operates for the benefit, not the disadvantage, of the pregnant woman."³⁰ Therefore, as in *Roe*, the Court suggested that not only the woman's privacy rights but also "the physician's right to practice his profession" could be violated by certain kinds of abortion restrictions.³¹ But of course, the flip side of the physician's right to administer treatment was "[t]he woman's right to receive medical care in accordance with her licensed physician's best judgment."³²

Even before *Roe* and *Doe*, however, the right to contraception was viewed in part as a right to access medical treatment and protect one's health. Early state court cases involving challenges to contraceptive prohibitions centered in large part on the lack of a health exception and the right of women to protect themselves from pregnancies that could pose

cf. id. at 192 (noting that "where a particular operation is necessary for a patient's physical or mental health is a judgment that physicians are obviously called upon to make routinely whenever surgery is considered").

³⁰ *Id.* at 192.

³¹ *Id.* at 193 (striking down the portion of a Georgia abortion statute requiring that a hospital committee approve each individual abortion). The Court's apotheosis of physicians and their professional judgment in *Doe* is truly striking in some places. For example, although it held the committee-approval requirement for abortions unconstitutional, the Court nonetheless dismissed the possibility that the hospital committee would be guided in its decisions by anything other than pure medical judgment, such as their personal disapproval of extramarital sex:

The appellants' suggestion is somewhat degrading to the conscientious physician, particularly the obstetrician, whose professional activity is concerned with the physical and mental welfare, the woes, the emotions, and the concern of his female patients. He, perhaps more than anyone else, is knowledgeable in this area of patient care, and he is aware of human frailty, so-called 'error,' and needs. The good physician—despite the presence of rascals in the medical profession, as in all others, we trust that most physicians are 'good'—will have sympathy and understanding for the pregnant patient that probably are not exceeded by those who participate in other areas of professional counseling.

Id. at 196–97.

³² *Id.* at 197.

severe threats.³³ Even in *Griswold v. Connecticut*, traces of the medical view of reproductive rights are visible, for example, in the Court's objection to the way that the Connecticut contraceptives ban "operate[d] directly on an intimate relation of husband and wife *and their physician's role in one aspect of that relation.*"³⁴ Thus, while cases such as *Griswold*, *Roe*, and *Doe* were obviously the foundations for later reproductive rights jurisprudence that places the abortion right in the context of privacy, personal decision-making autonomy, and general bodily integrity, they contained another undeniable strand: a conception of reproductive rights as negative health care rights.³⁵

B. The Shift Away from the Medical Model of Abortion

Although the conception of reproductive rights as negative health care rights coexisted with many other rights-conceptions at the onset of the abortion rights debate, this strand has largely been lost or ignored by later courts and legal scholars. In part, the tendency to ignore the healthcare aspect of abortion rights might be attributable to the harsh criticism to which the medical view of abortion has been subjected. For example, many feminist scholars have criticized the medical model of abortion presented by decisions such as *Roe* and *Doe* for its tendency to place the abortion decision primarily in the physician's hands rather than the patient's, as well as for its emphasis on the centrality of professional medical judgment as opposed to the woman's individual personal and moral judgment. They argue that *Roe* was at best incomplete and at worst reinforcing of gender inequalities when it emphasized the medical aspects of abortion rather than its importance in securing equal citizenship for women.³⁶ And in vesting

³³ Connecticut was the site of one such battle. For a complete history, see Mary L. Dudziak, *Just Say No: Birth Control in the Connecticut Supreme Court Before Griswold v. Connecticut*, 75 IOWA L. REV. 915, 921–27, 932–35 (1990).

³⁴ 381 U.S. 479, 482 (1965) (emphasis added).

³⁵ See Part III.A, *infra*, for additional discussion.

³⁶ See, e.g., Reva Siegel, *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, 44 STAN. L. REV. 261, 273–79 (1992) [hereinafter Siegel, *Reasoning*]; Ruth Bader Ginsburg, *Speaking in a Judicial Voice*, 67 N.Y.U. L. REV. 1185, 1199–1200 (1992) ("The idea of the woman in control of her destiny and her place in society was less prominent in the *Roe* decision itself, which coupled with the rights of the pregnant woman the free exercise of her physician's medical judgment. The *Roe* decision might have been less of a storm center had it homed in more precisely on the women's equality dimension of the issue." (footnotes omitted)).

primary control over the abortion decision in the physician, rather than the woman, such critics contend, the medical model of abortion simply transfers authority over women's bodies and choices from the state to the physician while keeping the woman disempowered. Thus, some abortion rights advocates in the 1960's argued that even liberally reforming abortion laws—for example, to permit abortions only for health reasons, but with “health reasons” being generously defined—rather than repealing the criminal abortion laws altogether, “would simply mean that (primarily male) physicians would have wider latitude to make a decision that these women believed was the business only of the pregnant woman. The necessity of a doctor's approval, even under reformed abortion laws, reinforced the traditional role of the woman as dependent, without control over her future.”³⁷

Perhaps most influentially, Professor Reva Siegel has described the role of physicians in the early anti-abortion movement in America, and her scholarship gives ample reason to distrust medical and physiological rhetoric as it is used to justify restrictions on abortion. In her classic article *Reasoning from the Body: A Historical Perspective on Abortion Regulation and Questions of Equal Protection*, Professor Siegel explains that physicians who opposed abortion appropriated the language of women's health for their own ends, suggesting that interruption of pregnancy and, more fundamentally, of women's maternal destiny, was injurious to them both physiologically and psychologically.³⁸ Moreover, those physicians used physiological arguments to achieve the social end of maintaining existing societal arrangements with respect to gender.³⁹ Thus, “[m]en interested in establishing their professional authority over women's role in reproduction encouraged other men [i.e., legislators] to assert their political authority over women's role in reproduction by criminalizing the means of

³⁷ LAURENCE H. TRIBE, ABORTION: THE CLASH OF ABSOLUTES 45 (1990); see also KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 33 (1984) (noting that in the late nineteenth and early twentieth centuries, “physicians wanted to create a category of ‘justifiable’ abortion and to make themselves the custodians of it”); Siegel, *Reasoning*, *supra* note 36, at 296 (describing how physicians' rhetoric in the nineteenth century suggested that “[t]he physician was to serve as his [female] patient's ‘confessor’ and ‘physical guardian’”).

³⁸ Siegel, *Reasoning*, *supra* note 36, at 293–97.

³⁹ *Id.* at 299–314; cf. JAMES C. MOHR, ABORTION IN AMERICA: THE ORIGINS AND EVOLUTION OF NATIONAL POLICY 147–70 (1977) (documenting the physicians' movement against abortion in the nineteenth century and concluding that it was motivated in large part by a desire to professionalize medicine, raise its status, and eliminate competition from outsiders providing obstetric services, as well as by eugenic concerns and genuine moral opposition to the practice).

controlling birth, each acting to preserve life in the social order as they knew it.”⁴⁰

Professor Siegel also documents the role that such physiological arguments continue to play in both popular rhetoric and case law concerning pregnancy, abortion, and fetal protection.⁴¹ More recently, she has connected gender-based physiological arguments to the rise of “woman-protective” abortion legislation, such as the proposed 2006 South Dakota abortion ban, which was justified in terms of protecting women from the physical and mental health risks of abortion, while relying upon and perpetuating stereotypes about women’s capacity and women’s proper role in society.⁴²

Moreover, some recent scholarship suggests that physicians continue to exercise inappropriate and excessive control in the reproductive health context—for example, by valuing the fetus over the woman, whose life and labor are virtually erased from contemporary debates about fetal protection.⁴³ Professor Nancy Ehrenreich has persuasively demonstrated that the “medical model of reproduction,” which creates the illusion of pure objectivity in medicine, constructs a dichotomy whereby “medicine is seen as a scientific endeavor in which nature is controlled through culture—through active intervention by physicians. On the other hand, reproduction (and the women in whose bodies it occurs) is seen as a pathological, disease-like condition—the object that must be acted upon and controlled in order to eliminate danger.”⁴⁴ Women are not, therefore, vital agents in control of the process of reproduction but rather objects to be managed or controlled. That view of reproduction, combined with a high moral and

⁴⁰ Siegel, *Reasoning*, *supra* note 36, at 318.

⁴¹ *Id.* at 324-47.

⁴² Reva Siegel, *The New Politics of Abortion: An Equality Analysis of Woman-Protective Abortion Restrictions*, 2007 U. ILL. L. REV. 991 [hereinafter Siegel, *New Politics*] (discussing H.B. 1215, 2006 Leg., 81st Sess. (S.D. 2006) (repealed 2006)); *cf.* Reva Siegel, *Dignity and the Politics of Protection: Abortion Restrictions Under Casey/Carhart*, 117 YALE L.J. 1694, 1720-33 (2008) [hereinafter Siegel, *Dignity*] (discussing the recent strategy of some abortion opponents of focusing on women’s health). In November 2008, a second South Dakota initiative on abortion failed at the ballot box. *See* Tiffany Sharples, *Ballot Initiatives: No to Gay Marriage, Anti-Abortion Measures*, TIME, Nov. 5, 2008, <http://www.time.com/time/politics/article/0,8599,1856820,00.html>.

⁴³ Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 505 (1993); Siegel, *Reasoning*, *supra* note 36, at 330 n.285.

⁴⁴ Ehrenreich, *supra* note 43, at 538.

social value placed on the fetus and societal expectations that women will be self-sacrificing, is used to justify coercive measures, such as court-ordered cesarean sections, when women resist their passive role.⁴⁵ Similarly, Professor Michelle Oberman has argued that in so-called “maternal-fetal conflicts,” the doctor is presented as the wise and neutral mediator, whereas in reality “[i]t is the doctor who identifies the course of action deemed to be ‘in the fetus’s best interests,’” perhaps even viewing the fetus as a “second patient,” thereby becoming a party to the conflict and invariably “tip[ping] the balance . . . against the pregnant woman.”⁴⁶

Often, this understanding of medicine and its relation to reproduction visits disproportionate burdens on poor and minority women, against whom the state’s coercive power is most likely to be exercised in the reproductive health context—as, indeed, in many other contexts.⁴⁷ “[T]o the extent that judges entertain any of the prevailing stereotypes of outsider women [involved in maternal-fetal conflicts, for example,] their attitudes make it that much easier for them to minimize the health and autonomy interests of the women, while accepting the doctors’ assessments as accurate.”⁴⁸ Indeed, a substantial body of literature in the fields of medicine, ethics, and social science indicates the failure of the current structure of informed consent law and other aspects of the health care system in general to guarantee dignified, high-quality medical treatment to minority patients, due to a failure to take important cultural factors into account when communicating medical information.⁴⁹

Finally, it is perhaps relevant that, despite the medical language of *Roe* and *Doe*, the Supreme Court has generally treated contraception and abortion, in cases claiming a right to access that particular medical procedure, differently from most other claims of right to access medical treatment. The Supreme Court has acknowledged the important

⁴⁵ *Id.* at 564 (“Viewing the process as pathological, seeking to minimize risks to the fetus at all costs, and assuming that mothers are, and should be, self-sacrificing, [doctors] base their ‘scientific’ judgments on contested factual assumptions and value choices.”).

⁴⁶ Michelle Oberman, *Mothers and Doctors’ Orders: Unmasking the Doctor’s Fiduciary Role in Maternal-Fetal Conflicts*, 94 NW. U.L. REV. 451, 454–55, 471–78 (2000).

⁴⁷ Ehrenreich, *supra* note 43, at 519–30.

⁴⁸ *Id.* at 565. Professor Ehrenreich nonetheless documents the way in which privileged women, too, are subtly subordinated by medical discourse and medical authority. *Id.* at 530–32.

⁴⁹ Dayna Bowen Matthew, *Race, Religion, and Informed Consent—Lessons from Social Science*, 36 J.L. MED. & ETHICS 150, 156–60 (2008).

constitutional right at stake in the cases touching on contraception and abortion by applying heightened scrutiny and a non-deferential stance to the government's view of the medical facts, but most other cases dealing with plaintiffs' claims of a right to access a particular medical treatment are treated quite differently. When patients seek to access cannabis or unapproved experimental drugs, for example, their claims of a right to protect their health and access appropriate medical treatment are quickly dismissed, with courts applying little scrutiny and sweeping deference to the government's view.⁵⁰ Because reproductive rights-related autonomy claims receive more careful consideration from courts than claims of a right to access other medical interventions, it is not surprising that feminist scholars and other commentators have tended to view reproductive rights as distinct from, and unrelated to, other health-care issues in constitutional doctrine.

Thus, by the time of its 1992 decision in *Planned Parenthood v. Casey*,⁵¹ the Supreme Court had clearly moved away from the medical model of abortion and the associated primacy of the physician's judgment and role. Indeed, in *Casey*, the Court went so far as to assert that, not only was the doctor-patient relationship not entitled to any special solicitude in the abortion context, but "[w]hatever constitutional status the doctor-patient relation may have as a general matter, in the present context it is derivative of the woman's position."⁵² It continued, "[t]he doctor-patient relation does not underlie or override the two more general rights under which the abortion right is justified: the right to make family decisions and the right to physical autonomy."⁵³

C. Critiquing the Critiques of the Medical Model

The feminist critiques of the medical model of abortion are, no doubt, both valid and compelling. Without, therefore, intending to minimize them, this Article suggests that these critiques may be based in part on a historical view of medicine as male dominated and uninterested in women's autonomy that is no longer entirely accurate but that continues to exert a

⁵⁰ The argument made in this paragraph is set forth at greater length in B. Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277 (2007).

⁵¹ 505 U.S. 833 (1992).

⁵² *Id.* at 884.

⁵³ *Id.*

somewhat excessive influence on reproductive rights scholarship and legal practice. Indeed, it may be time to revive the latent strand of reproductive rights jurisprudence that envisions abortion as a medical procedure among others and vindicates a form of negative right to health.

One reason for rejecting, or at least sidelining, the criticisms of the medical model of abortion is that it is based in part on a state of affairs that no longer exists. Although it may have been reasonable to describe medicine as predominantly male⁵⁴ until fairly recently, or to assert that abortion politics were about “[m]en interested in establishing their professional authority over women’s role in reproduction encourag[ing] other men to assert their political authority over women’s role in reproduction,”⁵⁵ statistics now indicate that women have been entering the field of obstetrics and gynecology at a substantially higher rate than men for several years.⁵⁶

More importantly, critics’ concerns about women’s autonomy and empowerment within the physician–patient relationship may now be overstated, given the tremendous changes in professional beliefs, attitudes, and orientation toward patient autonomy that has been driven largely by the discipline of bioethics. Indeed, the era in which *Roe* was decided, the 1970s, was precisely the era in which patient autonomy became a primary focus of medical ethics.⁵⁷ This is not to suggest that concerns about women’s autonomy in the doctor–patient relationship have disappeared entirely; those concerns certainly persist, and they are particularly acute with respect to poor and minority women.⁵⁸ But it does seem fair to point out that there is now an entire field of study known as bioethics—influential in both legal

⁵⁴ Ehrenreich, *supra* note 43, at 538.

⁵⁵ Siegel, *supra* note 36, at 318.

⁵⁶ See, e.g., Susan E. Gerber & Anthony T. Lo Sasso, *The Evolving Gender Gap in General Obstetrics and Gynecology*, 195 AM. J. OBSTETRICS & GYNECOLOGY 1427, 1427 (2006) (noting that the proportion of women obstetrics and gynecology (ob-gyn) residents rose from forty-four percent in 1989 to seventy-four percent in 2002).

⁵⁷ See, e.g., Robert M. Veatch, *Autonomy’s Temporary Triumph*, 14 HASTINGS CTR. REP. 38, 38 (Oct. 1984).

⁵⁸ See, e.g., ALEXANDRA DUNDAS TODD, INTIMATE ADVERSARIES: CULTURAL CONFLICT BETWEEN DOCTORS AND WOMEN PATIENTS 77–97 (1989); **Khiara H. Bridges**, *Quasi-Colonial Bodies: An Analysis of the Reproductive Lives of Poor Black and Racially Subjugated Women*, 19 COLUM. J. GENDER & L. PAGE (2009); Ehrenreich, *supra* note 43; Oberman, *supra* note 46; cf. Veatch, *supra* note 57, at 39 (acknowledging the limitations of the concept of patient autonomy for addressing concerns about equality in health care).

and medical education and discourse—that is largely centered on increasing respect for patient autonomy and encouraging informed decision-making.⁵⁹ That field has largely grown as an academic discipline in the years since *Roe v. Wade* and *Doe v. Bolton*.⁶⁰ It is worth recalling as well that the American Medical Association (AMA), which had in the past been a prominent force in achieving the criminalization of abortion, now supports abortion rights.⁶¹ The AMA even filed an *amicus curiae* brief in the Supreme Court on behalf of Planned Parenthood in *Ayotte v. Planned Parenthood of Northern New England*,⁶² which involved a federal constitutional challenge to a state law requiring parental notification for minors seeking abortions.⁶³ In other words, the medical profession is not the same male-dominated, patriarchal, and paternalistic profession it was in the nineteenth century; bioethics, feminism, and the increased entry of women into the profession have changed and continue to change the way both patients and physicians approach the medical decision-making process. To the extent that challenges remain, there is no reason to believe that the same

⁵⁹ See, e.g., TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 57–112 (5th ed. 2001); Carl Schneider, *After Autonomy*, 41 WAKE FOREST L. REV. 411, 413 (2006) (describing the centrality of patient autonomy to bioethics and stating that “[b]ioethics was born a reform movement” with “medical imperialism” as its enemy).

⁶⁰ The Hastings Center, one of the most important and well-respected bioethics research centers in the United States, was founded in 1969, and the Kennedy Institute of Ethics at Georgetown University, which bills itself as “the world’s oldest and most comprehensive academic bioethics center” was founded in 1971. See The Kennedy Institute of Ethics, <http://kennedyinstitute.georgetown.edu/> (last visited Sept. 1, 2009); The Hastings Center, <http://www.thehastingscenter.org/> (last visited Sept. 1, 2009). Beauchamp and Childress’s seminal bioethics text was first published in 1979. See TOM L. BEAUCHAMP & JAMES F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (1st. Ed. 1979).

⁶¹ For a history of the American Medical Association’s opposition to abortion, see Siegel, *Reasoning*, *supra* note 36, at 285–86. For the AMA’s current position on abortion, see Brief for American College of Obstetricians and Gynecologists, et al. as Amici Curiae Supporting Respondents, *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320 (2006) (No. 04-1144), 2005 WL 2646471, at 2 (noting that the AMA does not “support or oppose abortion” but “believe[s] that this issue is a matter for physicians to decide individually, based on personal values and beliefs” and supports the “integrity and confidentiality of the patient/physician relationship and the ethical duty of physicians to respect and advocate for their patients’ personal autonomy”).

⁶² 546 U.S. 320 (2006).

⁶³ Brief for American College of Obstetricians and Gynecologists, et al. as Amici Curiae Supporting Respondents, *supra* note 61.

tools that have been used to transform the profession until now are no longer up to the task.

It may therefore be time to return to some of the premises from which reproductive rights jurisprudence began; in particular, it may be time to consider whether the right to choose abortion might, in part, be understood as an aspect of a constitutional right to make medical treatment decisions in consultation with a physician. Although such a right is not currently firmly or explicitly recognized in American constitutional doctrine, Part III of this Article argues that, reading between the lines, there is clear precedent for recognizing its existence as an aspect of substantive due process.⁶⁴ The cases discussed next, in Part II, may provide useful models for understanding how such a right might be understood.

II. REPRODUCTIVE RIGHTS AND THE RIGHT TO HEALTH: EXAMPLES FROM SOUTH AFRICA AND CANADA

This Part describes two decisions by the highest courts of South Africa and Canada and considers how the right to health is understood by each, as well as how such a right, which has largely been discussed outside the abortion context, can apply to abortion. These two cases provide particularly interesting and useful examples for thinking about the right to health for several reasons. First, they are noteworthy in that, although both decisions come from countries that grant substantially broader health care entitlements to their citizens than the U.S., these cases largely embrace the negative concept of a *right against* government interference with autonomous medical treatment decisions, rather than the positive concept of a *right to* subsidized medical services. They are thus more easily assimilated to U.S. constitutional jurisprudence than decisions establishing a positive right might be.⁶⁵ Moreover, both courts rely on a concept of the

⁶⁴ See *infra* Part III.A.; see also Hill, *supra* note 50, at 329–32 (discussing the wide variety of cases in which courts have held or assumed that individuals have a constitutional right to protect their health in the form of a “substantive-due-process right to make medical decisions without unwarranted government interference”).

⁶⁵ This Article emphasizes the negative quality of the health care rights recognized in the Canadian and South African cases because it is incontrovertible that courts in the United States are extremely unlikely to recognize a positive constitutional right to access health care services in the near future. U.S. constitutional law has never recognized constitutional rights as positive rights, and any move toward positive rights in the near future is virtually impossible to imagine. See, e.g., Tushnet, *An Essay on Rights*, *supra* note 9, at 1392–94. This Article does not argue that abortion rights should be understood as an aspect of the human right to health contained in instruments of international law, as others have argued. See *generally supra* note 2; Soohoo & Stolz, *supra* note 3, at 479–98 (arguing that

right to health that is related to, and includes, the right to access abortion. As such, they demonstrate how a negative right to health that includes a right to access abortion might be conceptualized. Finally, both cases are recent cases that garnered substantial attention both in their countries of origin and in the United States. As such, they may represent rising trends in judicial thinking about health care and the nature of health care rights.⁶⁶

Both South Africa and Canada have recognized in some form a “right to health” in ways that bear partly, though not exclusively, on the abortion right. South Africa has explicitly guaranteed a constitutional right to health that is understood, at least in part, as a positive entitlement to health care, including reproductive health services. Canada, on the other hand, has not gone so far as to recognize a positive constitutional right to health care.⁶⁷ In the recent case of *Chaoulli v. Québec*, however, various Justices read both the Charter of the province of Québec and the Canadian Charter of Rights and Freedoms to guarantee a negative right to noninterference with an individual’s access to health care services.⁶⁸ The right identified by the Court in the Québec Charter has a strong affiliation to the right of personal security in the Canadian Charter on which *Regina v. Morgentaler*,⁶⁹ the original Canadian decision recognizing a constitutional

advocates can use human rights, including the right to health, to support domestic change in the reproductive rights arena). Rather, this Article argues that courts can recognize, and to some extent already have recognized, a negative right to noninterference in medical treatment decisions. See *infra* Part III.A; Hill, *supra* note 50, at 329–32. This Article contends, moreover, that abortion rights may be placed usefully within that framework. Some commentators nonetheless maintain that a positive right to health care can and should be recognized in the United States. See, e.g., Jennifer Prah Ruger, *Governing Health*, 121 HARV. L. REV. F. 43, 44 (2008) (arguing that “a right to health care need not, indeed cannot, be framed in an absolute libertarian framework of wholly individualistic rights against the State” but rather must include a conception of obligation on the part of both state and non-state actors to help furnish the necessary public good of health care).

⁶⁶ See generally Melissa A. Waters, *Mediating Norms and Identity: The Role of Transnational Judicial Dialogue in Creating and Enforcing International Law*, 93 GEO. L.J. 487, 491–97 (2005) (discussing transnational dialogue among courts as a cooperative and synergistic enterprise).

⁶⁷ The Canada Health Act, which provides federal funding for comprehensive universal health care to be administered by the provinces, constitutes a positive statutory right to health care, however. Canada Health Act, R.S.C., c. C-6, s. 7 (1985). See generally Puneet K. Sandhu, Comment, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151, 1181–82 (2007).

⁶⁸ *Chaoulli v. Québec*, [2005] 1 S.C.R. 791 (Can.).

⁶⁹ [1988] 1 S.C.R. 30 (Can.).

right to choose abortion, was founded. The negative right to health recognized in South Africa and Canada is thus reminiscent of the medical model within American reproductive rights jurisprudence. It may therefore be fruitful to consider the South African and Canadian cases in greater depth in order to see how an incipient negative healthcare right in American constitutional law could be further developed and applied to abortion rights.

A. *Minister of Health v. Treatment Action Campaign*

Section 27 of the South African Bill of Rights explicitly guarantees a “right to have access to . . . health care services, including reproductive health care.”⁷⁰ A fair amount of recent scholarship has focused on South Africa’s enforcement of the right to health, among others, as positive rights, which impose affirmative duties on the government to take reasonable measures to achieve them for all citizens equally.⁷¹ As discussed below, however, this Article focuses on the right to health as it is elaborated on in one particular case decided by the South African Constitutional Court, *Minister of Health v. Treatment Action Campaign (TAC)*,⁷² in which the right to health shares many of the characteristics of a negative right to noninterference with medical treatment decisions.

The *TAC* decision dealt with access to an antiretroviral drug, Nevirapine, which had been approved in South Africa as safe and effective to prevent transmission of HIV from HIV-positive mothers to their babies during childbirth.⁷³ The South African government had made the drug available to women in the public health sector on a very limited basis, permitting only two test sites per province to administer it.⁷⁴ According to the government, the decision to limit the availability of Nevirapine was largely due to concerns about the complexity of providing the drug in the

⁷⁰ S. AFR. CONST. 1996 ch. 2, § 27.

⁷¹ See, e.g., Eric C. Christiansen, *Adjudicating Non-Justiciable Rights: Socio-Economic Rights and the South African Constitutional Court*, 38 COLUM. HUM. RTS. L. REV. 321 (2007); Alana Klein, *Judging as Nudging: New Governance Approaches for the Enforcement of Constitutional Social and Economic Rights*, 39 COLUM. HUM. RTS. L. REV. 351 (2008); Mitra Ebadolahi, Note, *Using Structural Interdicts and the South African Human Rights Commission to Achieve Judicial Enforcement of Economic and Social Rights in South Africa*, 83 N.Y.U. L. REV. 1565 (2008).

⁷² 2002 (10) BCLR 1033 (CC) (S. Afr.).

⁷³ *Id.* ¶ 10.

⁷⁴ *Id.*

context of a comprehensive treatment and prevention plan for HIV-positive mothers and their newborns. In particular, the government was concerned that the efficacy of the treatment could be undermined by multiple social, economic, and cultural factors, such as the necessity of counseling and follow-up care, the expense of providing infant formula to HIV-positive mothers, the difficulty of persuading women to substitute that formula for breastfeeding, and the absence of clean water in certain parts of the country, which would make formula feeding riskier.⁷⁵ The government also argued that it was concerned about the safety and efficacy of the drug as well as about the possibility of resistance to the drug developing in the HIV-positive mothers.⁷⁶ Unmentioned in the opinion, however, is the fact that the South African government's reluctance to provide access to Nevirapine was part of a larger program of heel-dragging in providing a nationwide treatment plan for HIV/AIDS, motivated by a well-known skepticism about the relationship between HIV and AIDS on the part of President Thabo Mbeki's administration.⁷⁷

The plaintiffs successfully brought suit against the Minister of Health and various other health officials to attain universal access to Nevirapine within the public health care system,⁷⁸ arguing that the South African Constitution required the government to make the drug available "where in the judgment of the attending medical practitioner this is medically indicated," and that the drug may be beneficial even when it is not administered in the context of a comprehensive plan.⁷⁹ They relied both

⁷⁵ *Id.* ¶¶ 14–16; *see also id.* ¶¶ 51–54. The government presented evidence suggesting that some infants who are HIV-negative at birth become HIV-positive afterwards, possibly as a result of breastfeeding by the HIV-positive mother. *Id.* ¶ 58.

⁷⁶ *Id.* ¶¶ 52–53.

⁷⁷ The depths of the government's intransigence, and its roots, are fascinatingly recounted in William E. Forbath, *Realizing a Constitutional Social Right—Cultural Transformation, Deep Institutional Reform, and the Roles of Advocacy and Adjudication*, in *STONES OF HOPE: AFRICAN LAWYERS USE HUMAN RIGHTS TO CHALLENGE GLOBAL POVERTY* (Jeremy Perelman and Lucie White eds., forthcoming 2010) (manuscript on file with author); *see also* Mark Heywood, *Shaping, Making, and Breaking the Law in the Campaign for a National HIV/AIDS Treatment Plan*, in *DEMOCRATISING DEVELOPMENT: THE POLITICS OF SOCIO-ECONOMIC RIGHTS IN SOUTH AFRICA* (Peris Jones & Kristian Stokke eds., 2005).

⁷⁸ *Minister of Health v. Treatment Action Campaign* 2002 (10) BCLR 1033 (CC) ¶¶ 18–19 (S. Afr.).

⁷⁹ *Id.* ¶ 18 (discussing Affidavit submitted by activists from the Treatment Action Campaign). Indeed, the Constitutional Court noted that "the wealth of scientific material produced by both sides makes plain that sero-conversion of HIV takes place in some, but not

on the right to health contained in Section 27 of the constitution and on Section 28, which guarantees children the right to certain basic goods, including basic health care.⁸⁰

Although the plaintiffs' claim for enforcement of the right to health was styled as a claim of positive right,⁸¹ it shared many characteristics of a negative right. First, the drug had been offered to the government free of charge for a period of five years. Thus, "the cost of the drug itself was not a factor" in the government's decision to deny access.⁸² Second, the Constitutional Court relied in part on the notion that the constitution imposes, "at the very least, a negative obligation placed upon the State and all other entities and persons to desist from preventing or impairing the right of access" to "health care services, including reproductive health care."⁸³ At issue in *TAC* was not so much the government's affirmative obligation to provide a drug to those dependent on the public health care system as much as its obligation not to interfere with patients' access to that drug.⁸⁴

The contours of a negative right to health, consisting of a right to be free from government-imposed harm and to maintain a broad range of discretion for medical decision making by physicians and their patients, thus emerge from the *TAC* decision. While accepting the government's

all, cases and that nevirapine thus remains to some extent efficacious in combating mother-to-child transmission even if the mother breastfeeds her baby." *Id.* ¶ 58.

⁸⁰ *Id.* ¶ 4 (citing S. AFR. CONST. ch. 2 §§ 27(1)(a), 28(1)(c)).

⁸¹ *Cf. id.* ¶ 39 (noting that the right to health in Section 27(1) of the South African Constitution is a right "to have 'access' to the services the state is obliged to provide," which is limited by the reasonableness standard explicitly set forth in Section 27(2)). Professor William Forbath notes that the case was designed to vindicate a positive constitutional right, although it the plaintiffs could achieve victory if the court only recognized a negative right, which is precisely what the lower court did. Forbath, *supra* note 77, manuscript at 12.

⁸² *Treatment Action Campaign*, (10) BCLR ¶ 48.

⁸³ *Id.* ¶ 46 (quoting *Government of the Republic of South Africa v. Grootboom*, 2001 (1) SA 46, ¶ 34 (CC) (S. Afr.); *cf. Sandhu*, *supra* note 67, at 1175 noting that the South African right to health is both a negative and a positive right); Tushnet, *supra* note 5, at 1902–08 (classifying the South African right to health as either a strong or a weak substantive right, depending on the case); *see also* Paul Nolette, *Lessons Learned from the South African Constitutional Court: Toward a Third Way of Judicial Enforcement of Socio-Economic Rights*, 12 MICH. ST. J. INT'L L. 91, 107, 118 (2003) (characterizing the socio-economic rights in the South African Constitution as "rights of access," as opposed to "rights on demand," and suggesting that they represent a "third way" between strong positive rights and a complete absence of positive rights).

⁸⁴ *See* Forbath, *supra* note 77, manuscript at 22.

view that parents were primarily responsible for affording health care to their children where possible, for instance, the Court emphasized that in this case, the government's own "rigid and inflexible" policy was responsible for harming the affected children and placing their rights "in peril."⁸⁵ In other words, the state, at the very minimum, has an obligation not to harm its citizens through its health care policies. The Court also declined to defer to the government's rather questionable view of the medical facts concerning the safety and efficacy of the drug in these particular circumstances, insisting that the medically appropriate course "must be left to health professionals to address during counseling."⁸⁶ Thus, in language suggestive of a right to noninterference with medical treatment decisions, the government was ordered to, *inter alia*, "[r]emove the restrictions that prevent [N]evirapine from being made available for the purpose of reducing the risk of mother-to-child transmission of HIV at public hospitals and clinics that are not research and training sites," as well as to both "permit" and "facilitate the use of [N]evirapine . . . when in the judgment of the attending medical practitioner . . . this is medically indicated."⁸⁷

B. *Chaoulli v. Québec*

1. *The Chaoulli Decision*

Though it arose in a very different context, the Canadian Supreme Court's decision in *Chaoulli v. Québec* bears many similarities to the *TAC* decision with respect to the right to health. In *Chaoulli v. Québec*,⁸⁸ the Court held that the province of Québec could not constitutionally prohibit private health insurance without running afoul of patients' rights to physical inviolability. The plaintiffs, a physician and a patient, had challenged the constitutionality of a Québec law that prohibited Québec residents from taking out insurance to pay for health services in the private sector if those same services were available through Québec's public health plan.⁸⁹

⁸⁵ *Treatment Action Campaign*, (10) BCLR ¶ 78.

⁸⁶ *Id.* ¶ 128. Similarly, the plaintiffs argued that "[w]hether or not to prescribe Nevirapine is a matter of professional medical judgment, which can only be exercised on a case-by-case basis. It is not a matter which is capable of rational or appropriate decision on a blanket basis." *Id.* ¶ 19.

⁸⁷ *Id.* ¶¶ 135(a), (b) (emphasis added).

⁸⁸ [2005] 1 S.C.R. 791 (Can.).

⁸⁹ *Id.* ¶¶ 1, 5.

Although the provincial government claimed that the prohibition was necessary in order to preserve the viability of the publicly financed universal health care system in Québec, the Court nonetheless held the law unconstitutional in a 4-3 opinion.⁹⁰

No single rationale commanded a majority of the Court. The lead opinion by Justice Deschamps relied upon Section 1 of the Québec Charter to find the prohibition unconstitutional and therefore did not reach the question whether the prohibition was unconstitutional under the Canadian Charter of Rights and Freedoms as well.⁹¹ Chief Justice MacLachlin, in a concurring opinion, agreed that the Québec law violated the Québec Charter but also relied upon Section 7 of the Canadian Charter, which protects Canadians' "right to life, liberty and security of the person."⁹²

The two opinions in the majority shared several commonalities, however. Although not explicitly presented in terms of a right to health, both opinions viewed the prohibition on private insurance as a form of state-mandated harm that impermissibly interferes with the individuals' rights to protect their health and life—broadly construed—through medical treatment. Justice Deschamps reasoned that the personal "inviolability" protected by Section 1 of the Québec Charter included "physical inviolability and mental or psychological inviolability,"⁹³ and that both of these were violated by the prohibition, because the long delays resulting from the lack of access to private sector health services led to injuries ranging from increased risk of morbidity or death, to severe pain, to a loss of quality of life.⁹⁴ Similarly, Chief Justice MacLachlin stated that the Québec prohibition "results in physical and psychological suffering"

⁹⁰ *Id.* ¶¶ 23–24, 100–104.

⁹¹ *Id.* ¶ 15; see also QUÉBEC CHARTER OF HUMAN RIGHTS & FREEDOMS, R.S.Q., ch. C-12 § 1 (1977) (Can.) ("Every human being has a right to life, and to personal security, inviolability and freedom.") [hereinafter QUÉBEC CHARTER].

⁹² Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11 § 7 (U.K.); *Chaoulli*, S.C.R. ¶¶ 102, 104.

⁹³ In the French version, the word for inviolability is "intégrité," which may also be translated as "integrity." Charte des droits et libertés de la personne, L.R.Q., ch. C-12 § 1 (1977) ("Tout être humain a droit à la vie, ainsi qu'à la sûreté, à l'intégrité et à la liberté de sa personne.").

⁹⁴ *Chaoulli*, S.C.R. ¶¶ 41–43. Justice Deschamps also concluded that the prohibition could not be justified by section 9.1 of the Québec Charter, which permits limits on individual rights and freedoms in the interest of "democratic values, public order and the general well-being of the citizens of Québec." QUÉBEC CHARTER, R.S.Q., ch. C-12 § 9.1.

through increased delays in accessing health care and increased health risks, thus violating the Section 7 right to “security of the person.”⁹⁵ He added that “[t]he state has effectively limited access to private health care except for the very rich, who can afford private sector care without need of insurance.”⁹⁶ Both opinions, then, relied upon a negative right against state-imposed harm to health through denial of, or delay in, access to medical services as a violation of the right to personal security or inviolability, and both understood the concept of harm to health broadly, to include non-trivial mental or psychological harm.⁹⁷

Justices Binnie and Lebel, writing in dissent, disagreed with the majority’s holding, but the disagreement was not so fundamental as it might at first appear.⁹⁸ Although the dissenting Justices felt that the Québec law, as a whole, did not violate principles of fundamental justice under the Canadian Charter, even they acknowledged two ways that the Section 7 right to personal security may be implicated: first, if “the public system fails to deliver life-saving care and an individual is simultaneously prevented from seeking insurance to cover the cost of that care in a private facility,” and second, if an individual’s medical condition will deteriorate due to a “lack of timely medical intervention” for which the state is responsible.⁹⁹ The dissent expressed discomfort with deciding the issue on the basis of a record that was somewhat sparse and abstract, however: for example, neither of the plaintiffs was an individual actually suffering from a medical problem that required immediate treatment, so the effects of the law could not be concretely evaluated.¹⁰⁰ In light of this fact, the dissent declined to “foreclose individual patients from seeking individual relief” as plaintiffs alleging a violation of their Section 7 rights by the Quebec law.¹⁰¹ But they

⁹⁵ *Chaoulli*, S.C.R. ¶ 123.

⁹⁶ *Id.* ¶ 106.

⁹⁷ Indeed, Justice Deschamps apparently would include “moral” harm as well. *Id.* at ¶ 41.

⁹⁸ *Chaoulli*, S.C.R. ¶ 203.

⁹⁹ *Id.* ¶¶ 203, 206.

¹⁰⁰ *Id.* ¶¶ 207, 224 (“One of the difficulties in assessing the effectiveness . . . [of the Québec system] is that neither [of the plaintiffs] is before the Court with an actual medical problem.”).

¹⁰¹ *Id.* ¶ 264 (“Judicial intervention at this level on a case-by-case basis is preferable to acceptance of the appellants’ global challenge to the entire single-tier health plan. It is important to emphasize that rejection of the appellants’ global challenge to

deemed a global challenge to the law—what might in U.S. law be termed a facial challenge—to be inappropriate in the current circumstances. Even the dissent in *Chaoulli*, then, assumed that some right to protect one's health both existed and might be violated by the private health insurance prohibition.¹⁰²

2. *Chaoulli and the Right to Access Abortion*

Both majority opinions in *Chaoulli* drew on the Canadian Supreme Court's decision in *Regina v. Morgentaler*¹⁰³—the case that first struck down a criminal prohibition on abortions under the Canadian Charter—in order to flesh out its reasoning regarding the unconstitutionality, under Section 7, of denying access to a medically indicated procedure in such a way as to cause serious physical or psychological harm. For example, in demonstrating that the Québec law did not comport with fundamental justice, Chief Justice MacLachlin noted that “rules that endanger health arbitrarily do not comply with the principles of fundamental justice,” citing *Morgentaler* as an example of a case in which “the rule against arbitrariness may be implicated in the particular context of access to health care.”¹⁰⁴ She also cited *Morgentaler* for the proposition that “delays in obtaining medical treatment which affect patients physically and psychologically trigger the protection of Section 7 of the Charter.”¹⁰⁵ Justice Deschamps's opinion

Québec's health plan would not foreclose individual patients from seeking individual relief tailored to their individual circumstances.”). Interestingly, the approach taken by the majority in *Gonzales v. Carhart*, 550 U.S. 124 (2007), is similar to that advocated by the dissent in *Chaoulli*. See *Gonzales*, 550 U.S. at 162–68 (holding that medical issues could not properly be resolved in the context of a facial challenge to the federal Partial Birth Abortion Ban Act but leaving the door open to an as-applied challenge).

¹⁰² The *Chaoulli* decision has been heavily criticized for its holding, and particularly for the likely harmful effects of that decision on the Canadian public health care system and Canadian health policy. See, e.g., Joan M. Gilmour, *Fallout from Chaoulli: Is It Time to Find Cover?*, 44 OSGOODE HALL L.J. 327 (2006); Martha Jackman, *The Last Line of Defence for [Which?] Citizens?: Accountability, Equality, and the Right to Health in Chaoulli*, 44 OSGOODE HALL L.J. 349, 363–72 (2006). This Article expresses no opinion as to the wisdom of that holding in the Canadian context or its broader implications. Rather, this Article seeks to mine the opinion for its perspective on the meaning of a negative right to health, which, despite its potentially undesirable effects in Canada, would fit comfortably within U.S. constitutional law and the already privatized U.S. health care system.

¹⁰³ [1988] 1 S.C.R. 30 (Can.).

¹⁰⁴ *Chaoulli*, S.C.R. ¶ 133.

¹⁰⁵ *Id.* ¶ 118.

similarly relied on *Morgentaler* for the notion that state-caused delays in access to health care must be understood to implicate the right to personal inviolability, regardless of whether the resulting harm is mental or physical.¹⁰⁶

Indeed, in *Morgentaler* itself, the lead opinion described at length the problematic effects of the delays experienced by women seeking therapeutic abortions, including the greater risk of complications that accompany later abortions and the accompanying psychological and emotional distress. This possibility of physical and emotional distress imposed by the state's bureaucracy led Chief Justice Dickson and Justice Lamer to conclude that "in the case of abortion the implications of any delay . . . are potentially devastating."¹⁰⁷ The concurring opinion of Justice Beetz, while less focused specifically on delay, was even more explicit in drawing a connection between the right to access therapeutic abortion and the right to government noninterference in health care decisions:

Generally speaking, the constitutional right to security of the person must include some protection from state interference when a person's life or health is in danger If a rule of criminal law precludes a person from obtaining appropriate medical treatment when his or her life or health is in danger, then the state has intervened and this intervention constitutes a violation of that man's or that woman's security of the person. "Security of the person" must include a right of access to medical treatment for a condition representing a danger to life or health without fear of criminal sanction.¹⁰⁸

The connection between reproductive rights and a negative right to protect one's health is thus explicit in *Morgentaler*.¹⁰⁹ *Chaoulli* highlights this strand of the *Morgentaler* opinion and further suggests ways in which it may be applicable to reproductive rights.

¹⁰⁶ *Id.* ¶ 43; cf. *Rodriguez v. Attorney General*, [1993] 3 S.C.R. 519, ¶ 21 (Can.) ("[T]he judgments of this Court in *Morgentaler* can be seen to encompass a notion of personal autonomy involving, at the very least, control over one's bodily integrity free from state interference and freedom from state-imposed psychological and emotional stress.").

¹⁰⁷ *Morgentaler*, S.C.R. ¶ 58.

¹⁰⁸ *Id.* ¶ 90.

¹⁰⁹ Cf. Joanna N. Erdman, *In the Back Alleys of Health Care: Abortion, Equality, and Community in Canada*, 56 EMORY L.J. 1093, 1105–06 (2007) (noting that *Morgentaler*, in contrast to *Roe v. Wade*, relied not on a liberty interest but on the right to security of the person to hold the criminal abortion prohibitions unconstitutional).

B. Summary: Modeling a Right to Health

Both the South African Constitutional Court's decision in *TAC* and the Canadian Supreme Court's decision in *Chaoulli v. Québec* outline a right to health that may be described more precisely as a right to noninterference by the government with individuals' access to appropriate health care. These cases and their reasoning are described here in the hope that they may provide models for conceptualizing such a right within American substantive due process jurisprudence, which may include the right to access reproductive health services. To that end, this Section briefly summarizes the key aspects of the health care rights elaborated in *TAC* and *Chaoulli*.

First, and fundamentally, the health care rights in *TAC* and *Chaoulli* may be conceptualized as negative rights to freedom from government interference and not as potentially more problematic positive socioeconomic rights to access particular public goods. They are thus distinct from the sort of government entitlements that some scholars advocate and that some hope to enforce through international human rights mechanisms.¹¹⁰ As negative rights, they may fit within the general framework of U.S. constitutional law. They therefore escape the criticisms commonly leveled at positive rights. For example, negative rights do not require courts to interfere with legislatively determined budget priorities, nor do they raise difficult enforcement issues or the specter of inter-branch warfare.¹¹¹ Compared with robust positive rights, negative rights may be vindicated on the cheap.

In addition, *TAC* and *Chaoulli* both suggest, in broad strokes, how one might describe and operationalize such a negative healthcare right. In both cases, the right at issue is broadly conceived as a right to be free from state-imposed harm, including harm resulting from administrative and bureaucratic regulations that pose obstacles to obtaining medically appropriate care. The Canadian case, in particular, emphasizes the

¹¹⁰ See generally Tamara Friesen, *The Right to Health Care*, 9 HEALTH L.J. 205 (2001); Erika R. George, *Virginity Testing and South Africa's HIV/AIDS Crisis: Beyond Rights Universalism and Cultural Relativism Toward Health Capabilities*, 96 CAL. L. REV. 1447, 1500–13 (2008) (discussing possibilities for enforcement of both the international and South African positive right to health and its possible application to the problem of virginity testing); Klein, *supra* note 71, at 352 (arguing that some judicial enforcement of positive socio-economic rights is both possible and desirable); Ruger, *supra* note 65. .

¹¹¹ See generally Tushnet, *supra* note 5, at 1895–97 (briefly summarizing the principal objections to positive rights among American constitutional law scholars).

phenomenon of state–caused delay in obtaining health services as an injury in itself.¹¹²

Both cases also conceive of health care broadly. The Canadian case explicitly requires access to health care as a protection against significant state–imposed mental, emotional, and psychological harm, as well as physical harm.¹¹³ Because *TAC* involved a concrete case of physical suffering, it unsurprisingly focused on physical, rather than psychological, harm. Still, the South African case does suggest a large role for physician discretion, rather than “inflexible” state mandates, to determine precisely what sort of medical care is indicated.¹¹⁴ In both cases, the broad understanding of health and medical appropriateness was accompanied by a disinclination to defer to the government’s view of the medical facts. This left a bigger role for physicians and patients to determine the nature, scope, and necessity of the medical intervention.¹¹⁵

Finally, and perhaps most importantly, both cases recognize a connection between the negative right to health and reproductive rights. The South African case arose in the context of delivering reproductive health services, specifically, treatment to avoid HIV transmission from mother to infant during childbirth. Moreover, the Court relied upon a constitutional provision that explicitly includes reproductive health care within the scope of the right to health care.¹¹⁶ *Chaoulli*, by contrast, arose in a context that appears to be very much removed from reproductive rights, namely, a general provincial prohibition on private health insurance for most medical services. Yet, *Chaoulli* simultaneously drew on the Canadian Supreme

¹¹² *Chaoulli v. Quebec*, [2005] 1 S.C.R. 791 ¶¶ 43, 118 (Can.); cf. *Morgentaler*, S.C.R. ¶¶ 28–34; see also Erdman, *supra* note 109, at 1106–15.

¹¹³ *But see* Erdman, *supra* note 109, at 1141–48 (suggesting that some Canadian provinces have embraced too narrow a conception of medical necessity with respect to funding abortion).

¹¹⁴ *Minister of Health v. Treatment Action Campaign* 2002 (10) BCLR 1033 (CC) ¶ 128 (S. Afr.) (stating that the necessity of formula feeding in any particular case where Nevirapine is administered “must be left to health professionals to address during counseling”); *id.* ¶ 135(3)(b) (ordering the government to “make [Nevirapine] available . . . at hospitals and clinics when in the judgment of the attending medical practitioner acting in consultation with the medical superintendent of the facility concerned this is medically indicated”).

¹¹⁵ *Id.* ¶¶ 57–66; *Chaoulli*, ¶¶ 85–98; cf. Hill, *supra* note 50, at 332–41 (arguing that deference to legislatures is inappropriate where medical or scientific facts are concerned).

¹¹⁶ S. AFR. CONST. 1996 ch. 2, § 27(1).

Court's reasoning in *Regina v. Morgentaler* to describe the contours of the right at issue in that case.¹¹⁷ Thus, reproductive rights in many ways fit comfortably under the rubric of the negative health care right described herein. The right to access abortion is clearly one aspect of the negative right to health.¹¹⁸

Of course, a right to health care, even a negative one, cannot be unlimited, and it is not unlimited under the Canadian Charter or South African Constitution. Rather, both constitutions contain provisions that limit the extent of individual rights. The Section 7 right to security of the person may be limited in ways that accord with "the principles of fundamental justice."¹¹⁹ This provision has been understood as requiring balancing the interests of the individual and the state.¹²⁰ Similarly, the South African Constitutional Court has made it clear that health care rights are limited by reasonableness considerations.¹²¹ Nonetheless, both countries recognize a relatively robust constitutional right to access medical treatment, at least when such a right does not place significant claims on government financial resources. Such a constitutional right is broad enough in both countries to encompass a right to reproductive health care.

¹¹⁷ *Chaoulli*, ¶¶43, 118.

¹¹⁸ Cf. John A. Robertson, *Controversial Medical Treatment and the Right to Health Care*, 36 HASTINGS CTR. REP. 15, 15 (2006) (arguing that a negative right to health care "anchors a woman's use of abortion and contraception, and underlies the great deference ordinarily accorded doctors and patients to pursue medical care"). *But cf.* Erdman, *supra* note 109, at 1093 (2007) (asserting that under Canadian law, "[a]bortion can be a health service like any other, but it is not," because access and funding for abortion procedures are restricted in practice). Indeed, the project of bringing reproductive rights under the rubric of a negative health care right may well indirectly support the broader feminist project of assimilating reproductive health care, in all its manifestations, to the international right to health and basic health care.

¹¹⁹ Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982, ch. 11, §7 (U.K.) ("Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.").

¹²⁰ *Rodriguez v. Attorney General*, [1993] 3 S.C.R. 519, ¶¶ 31–35 (Can.).

¹²¹ *Minister of Health v. Treatment Action Campaign* 2002 (10) BCLR 1033 (CC) ¶¶ 67–68 (S. Afr.) (citing *Government of the Republic of South Africa v. Grootboom* 2001 (1) SA 46 (CC) ¶ 44 (S. Afr.)); *Soobramoney v. Minister of Health* 1997 (12) BCLR 1696 (CC) ¶ 42 (S. Afr.) (Madala, J., concurring) ("[T]he guarantees of the Constitution are not absolute but may be limited in one way or another."); *see also* Sunstein, *supra* note 4, at 4; Katharine G. Young, *The Minimum Core of Economic and Social Rights: A Concept in Search of Content*, 33 YALE J. INT'L L. 113, 169 (2008) (discussing balancing with respect to the right to health under the South African Constitution).

III. TOWARD A RIGHT TO HEALTH IN THE UNITED STATES

In describing several features of a negative right to health as it may be understood in South African and Canadian constitutional jurisprudence, this Article does not necessarily make the claim that the U.S. Supreme Court is likely to draw on foreign legal sources in developing a new right under the U.S. Constitution. Indeed, the Supreme Court is notoriously hesitant to expand the scope of substantive due process.¹²² Moreover, explicit borrowing from other countries' jurisprudence is both unlikely for the foreseeable future and possibly a perilous matter, given that the project of determining the suitability of adopting aspects of another nation's legal system is mired in practical and conceptual difficulty.¹²³

Rather, this Article makes two more modest claims. First, it argues that a negative right of noninterference with medical treatment decisions has already been recognized to some extent within our own constitutional jurisprudence.¹²⁴ As such, it may be possible and useful for reproductive rights advocates to foreground this doctrine in combination with the other legal arguments that are usually made in reproductive rights cases and scholarship. This notion of "the right to health" may also be deployed to frame new legal challenges to restrictions on abortion rights, particularly with respect to certain kinds of regulations that are generally upheld under current doctrine.¹²⁵ Because they are easily assimilated into the negative structure of American constitutional rights and closely related to the protection of reproductive rights in their respective countries, the *Chaoulli* and *TAC* cases suggest the contours of the health care right and the lines along which an argument relying upon that right might be made.

Second, this Article argues that advocates and scholars interested in achieving greater protection for reproductive rights in the United States should look to the negative right to health outlined in the Canadian and

¹²² See, e.g., Brian Hawkins, Note, *The Glucksberg Renaissance: Substantive Due Process Since Lawrence v. Texas*, 105 MICH. L. REV. 409, 428–29, 430 (2006) (noting courts' hesitance to recognize new constitutional substantive due process rights).

¹²³ See Mark Tushnet, *Returning with Interest: Observations on Some Putative Benefits of Studying Comparative Constitutional Law*, 1 U. PA. J. CONST. L. 325 (1998) (examining the problems associated with "constitutional borrowing or lending").

¹²⁴ See Hill, *supra* note 50, at 329–32. See generally Robertson, *supra* note 118 (discussing the negative right to health); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1824 (2007) (arguing that there is a constitutional "right to defend oneself using medical care").

¹²⁵ See *infra* Part III.B.

South African decisions as a potential additional rhetorical framework for talking about reproductive rights. The negative right to health will not necessarily expand access to reproductive health care for women who lack it, nor will it inevitably protect the core of *Roe v. Wade*. It should therefore be a supplement to, rather than a replacement for, the other ways in which courts and scholars currently view reproductive rights.

A. Locating the Negative Right to Health

The traces of a negative right to health—that is, a right to make medical treatment decisions without government interference—run through a long line of Supreme Court and lower court cases. Elsewhere, it has been argued at length that despite a significant degree of confusion in Supreme Court case law and a lack of explicit recognition, the existence of such a right can be inferred.¹²⁶ This Article will only summarize that argument here. In so doing, however, this Article acknowledges that the negative constitutional right to health is not one to which courts explicitly refer or which has formed the basis of major Supreme Court holdings. Instead, it is a strain that intersects and overlaps with other rights in a wide range of substantive due process cases. Its existence, while implicit, cannot simply be ignored or explained away, because some Supreme Court holdings—particularly in the abortion context, but elsewhere as well—are almost impossible to explain without it.¹²⁷

Thus, while it may initially sound novel, the right to protect one's health has long made appearances in our constitutional jurisprudence; indeed, some have argued that the right finds its roots in the common-law right of self-defense. Professor Eugene Volokh, for example, has recently argued that there is a right to “medical self-defense,” which may be defined as “a right to defend oneself using medical care.”¹²⁸ Arguably, there is no

¹²⁶ See Hill, *supra* note 50, at 329-32 (arguing that “the Supreme Court has already recognized a substantive-due-process right to make medical treatment choices,” although that the courts have not always embraced that right”).

¹²⁷ See *infra* text accompanying notes 128-148.

¹²⁸ Volokh, *supra* note 124, at 1824. Given the long pedigree and fundamental quality of this assumed right to protect one's life and health, some have argued that even if *Roe v. Wade* were overruled, some constitutional limitations would likely apply to states' ability to outlaw abortions needed to prevent serious damage to one's health. Richard H. Fallon, *If Roe Were Overruled: Abortion and the Constitution in a Post-Roe World*, 51 ST. LOUIS U. L.J. 611, 626 (2007). Professor Fallon argues that these questions would arise under even mere rationality review of abortion legislation. He does not, however, argue that there is a specific constitutional right to access medical treatment. *Id.*; see also Michael C. Dorf, *The Supreme Court's Surprisingly Unanimous Abortion Decision: A Parting Gift for*

way to understand the requirement that abortion regulations must contain an exception to protect against harm to a woman's health other than as a statement of the negative right to health.¹²⁹ This concept was first announced in *Roe v. Wade*, but the Court has consistently adhered to it through *Stenberg v. Carhart* and still assumed its validity in *Ayotte v. Planned Parenthood* and *Gonzales v. Carhart*.¹³⁰ Indeed, this right to a health exception—or the right to noninterference by government in a woman's decision to protect her health through an abortion—applies even post-viability, after the government interest in the fetus has become sufficiently compelling to override the woman's interest in personal autonomy and reproductive choice.¹³¹ The health exception requirement therefore does not emerge solely from the right to procreative choice, nor is it even clearly related to that right. The right to seek a life or health-preserving medical procedure appears to be an independent constitutional command, having little to do with the right to make autonomous decisions about childbirth and other intensely personal matters.¹³²

Thus, in *Thornburgh v. American College of Obstetricians and Gynecologists*,¹³³ which held unconstitutional a state law requiring physicians to use the abortion method most likely to preserve the life and health of a viable fetus if that method was not significantly riskier for the woman, the Supreme Court explained in no uncertain terms that the state

Justice O'Connor?, FINDLAW'S WRIT, Jan. 30, 2006, <http://writ.findlaw.com/dorf/20060130.html> (arguing that a minor woman "has a constitutional right to be free of state regulation that effectively subjects her to a serious risk of losing a limb," and that even if *Roe v. Wade* were overruled, it would remain a genuine constitutional question whether an abortion ban that lacks a health exception would be constitutional).

¹²⁹ Volokh, *supra* note 124, at 1824–26; *see also* Hill, *supra* note 50, at 329–32.

¹³⁰ *Gonzales v. Carhart*, 550 U.S. 124, 161 (2007); *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 327 (2006); *Stenberg v. Carhart*, 530 U.S. 914, 930 (2000); *Roe v. Wade*, 410 U.S. 113, 164–65 (1973).

¹³¹ Volokh, *supra* note 124, at 1824–26. Professor John Robertson has advocated for the existence of a negative right to health care services and has also, like Volokh, explicitly linked that right to "a legal tradition of lawful self-defense and Supreme Court precedents about the importance of protecting life over claims to end it." Robertson, *supra* note 118, at 16; *see also* John A. Robertson, *Embryo Culture and the "Culture of Life": Constitutional Issues in the Embryonic Stem Cell Debate*, 2006 U. CHI. LEGAL F. 1, 7–15.

¹³² *See infra* text accompanying notes 133–140.

¹³³ 476 U.S. 747 (1986).

cannot “require the mother to bear an increased medical risk in order to save her viable fetus.”¹³⁴ The Tenth Circuit echoed the *Thornburgh* Court by holding a similar statute unconstitutional, concluding, even after the Supreme Court’s modification of abortion law in *Planned Parenthood v. Casey*, that “the woman’s health must be the physician’s ‘paramount consideration.’”¹³⁵

Stenberg v. Carhart (the first “partial-birth” abortion case) represents the most robust recognition of the negative right to health.¹³⁶ In *Stenberg*, the Court struck down a Nebraska law banning the abortion procedure referred to as “D&X” in part because it lacked a health exception.¹³⁷ The Court recognized that the purpose of the law was not fetal preservation; rather, the law was simply aimed at preventing the use of one abortion method that the state found repugnant but that medical experts deemed safest for some women.¹³⁸ The effect of the ban on D&X would not be to prevent particular women from obtaining abortions, but rather to require them to obtain abortions by a riskier method. As such, *Stenberg* did not revolve around the right to choose abortion per se, but rather focused on the right to protect one’s health by choosing the method by which the abortion would be performed. In striking down the Nebraska ban, the Supreme Court acknowledged that alternative procedures were available but nonetheless held that the Constitution forbids imposing the “significant health risks” on women that were mandated by this particular ban.¹³⁹ By vindicating a woman’s right to choose the safest abortion procedure for her, *Stenberg* may be understood as upholding a right against government interference in medical treatment decisions.¹⁴⁰

¹³⁴ *Id.* at 769; see also *Northland Family Planning Clinic v. Cox*, 487 F.3d 323, 339-40 (6th Cir. 2007).

¹³⁵ *Jane L. v. Bangerter*, 61 F.3d 1493, 1504 (10th Cir. 1995), *rev’d on other grounds sub nom. Leavitt v. Jane L.*, 518 U.S. 137 (1996) (per curiam).

¹³⁶ *Stenberg v. Carhart*, 530 U.S. 914 (2000).

¹³⁷ *Stenberg*, 530 U.S. at 929–31.

¹³⁸ *Stenberg*, 530 U.S. at 934–36 (discussing the health-related findings of the District Court); *cf. id.* at 951 (Ginsburg, J., concurring) (noting that “this law does not save any fetus from destruction”).

¹³⁹ *Id.* at 931.

¹⁴⁰ *Id.* at 936–38; see also Hill, *supra* note 50, at 291–92.

The Court's more recent decision in *Gonzales v. Carhart*¹⁴¹ significantly cut back on the scope of *Stenberg*'s holding. Without overruling *Stenberg*, the Court in *Gonzales* nonetheless upheld a federal ban on the D&X procedure, even though that ban, like the Nebraska law at issue in *Stenberg*, lacked a health exception and therefore imposed risks on women who needed the procedure to protect their health.¹⁴² The Court rejected the plaintiffs' claims because it felt that a facial challenge was inappropriate in this particular set of circumstances: the statute had not yet been applied, there were disputes as to the relevant medical facts, and no plaintiff was presenting an actual medical need for the procedure.¹⁴³

It would nonetheless be inaccurate to say that the Court did away with *Stenberg*'s holding altogether and the negative right to health. The Court continued to recognize that abortion restrictions that impose significant health risks on women are unconstitutional; indeed, it clearly stated that "[t]he prohibition in the Act would be unconstitutional, under precedents we here assume to be controlling, if it 'subject[ed] [women] to significant health risks.'"¹⁴⁴ If one takes the Court's language at face value, it seems the Court rejected the challenge because of its procedural posture. It appeared to leave intact the underlying substantive doctrine forbidding the government from imposing significant health risks on women through abortion restrictions. Thus, *Gonzales* does not undermine the notion that the negative right to health—the right to protect one's health through seeking medical care without government interference—has been consistently recognized in abortion case law.

Outside the abortion context, the recognition of the right has been less consistent, although several cases suggest the existence of some sort of right to protect one's health, often accompanied by a willingness to leave to the patient and his or her physician the question of how best to do so. For example, in *Jacobson v. Massachusetts*,¹⁴⁵ which upheld a compulsory

¹⁴¹ 550 U.S. 124 (2007).

¹⁴² *Gonzales*, 550 U.S. at 155–56.

¹⁴³ *Id.* at 166–68.

¹⁴⁴ *Id.* at 161 (quoting *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 320 (2006)); cf. David J. Garrow, *Significant Risks: Gonzales v. Carhart and the Future of Abortion Law*, 2007 SUP. CT. REV. 1, 2 (arguing that *Gonzales* "has had and likely will continue to have far more modest consequences than many critics and commentators initially proclaimed").

¹⁴⁵ *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

vaccination law and is often seen as emblematic of courts' willingness to allow public health needs to override individual rights, the Court nonetheless suggested that individuals have a right to protect their health against state-imposed harm from required vaccines.¹⁴⁶ Additionally, in *Whalen v. Roe*,¹⁴⁷ the Court spoke in dicta of the "right to decide independently, with the advice of [a] physician, to acquire and use needed medication."¹⁴⁸

Lower courts have recognized the right on occasion as well. In *Andrews v. Ballard*, the district court, in striking down a law prohibiting non-physicians from practicing acupuncture, stated that the "decision to obtain or reject medical treatment" was a fundamental right that could be analogized to the privacy right recognized in *Roe*.¹⁴⁹ Similarly, the Fifth Circuit announced in the pre-*Griswold* case of *England v. Louisiana Board of Medical Examiners* that the plaintiffs could challenge a law prohibiting the practice of chiropractic medicine on due process grounds, asserting that "the State cannot deny to any individual the right to exercise a reasonable choice in the method of treatment of his ills."¹⁵⁰ More recently in 2006, the D.C. Circuit held that individuals had a substantive due process right to access an experimental cancer drug that had passed only the initial stage of FDA review.¹⁵¹ Although that ruling was subsequently vacated by the en banc court, even that court left open the possibility that government

¹⁴⁶ *Id.* at 39 (asserting that a mandatory vaccination statute would have to provide exceptions in cases where the vaccination would likely result in death or serious harm to health); see also *State v. Hay*, 35 S.E. 459, 461 (N.C. 1900) (noting that a health exception to a mandatory vaccination law was required).

¹⁴⁷ *Whalen v. Roe*, 429 U.S. 589 (1977).

¹⁴⁸ *Id.* at 603 (upholding a New York statute requiring disclosure of the names of patients receiving prescriptions for certain drugs to the state health department against constitutional challenge). Other cases cut precisely in the opposite direction, suggesting that no right to medical autonomy exists. See *Hill*, *supra* note 50, at 284–86. This Article argues that courts' unwillingness to recognize such a right in some contexts has been largely (and wrongly) created by their tendency to defer in reflexive fashion to government claims of protecting public health. *Id.* at 286.

¹⁴⁹ *Andrews v. Ballard*, 498 F. Supp. 1038, 1048 (S.D. Tex. 1980).

¹⁵⁰ *Eng. v. La. Bd. of Med. Exam'rs*, 259 F.2d 626, 627 (5th Cir. 1958).

¹⁵¹ *Abigail Alliance for Better Access to Dev. Drugs v. Von Eschenbach*, 445 F.3d 470, 472 (D.C. Cir. 2006), *rev'd en banc*, 495 F.3d 695 (D.C. Cir. 2007).

interference with individuals' access to medical treatment might implicate a fundamental right.¹⁵²

At the same time, a number of cases can be found that hold or suggest that no negative right to health exists. These cases range from the lower court cases denying access to laetrile and medical marijuana,¹⁵³ to another case denying access to an experimental cancer drug.¹⁵⁴ It cannot therefore be asserted without hesitation that the negative right to health is on firm footing in U.S. constitutional jurisprudence. It is nonetheless undeniable that cases both within and outside the abortion context rely on such a right. Although it is not often explicitly articulated as such, the notion of a right to seek medical treatment without government interference explains and renders coherent much of the substantive due process jurisprudence just discussed.

Of course, as with any constitutional right, the right to noninterference in health care decision making is not unlimited. Case law suggests that the right may be limited by the need to protect the public from an imminent threat or by other important government interests.¹⁵⁵ Thus, while the Supreme Court's recognition of a right to health in the abortion cases has been particularly robust, it has declined to recognize a right to assisted suicide.¹⁵⁶ Although a right to choose assisted suicide would not exactly be a right to *protect* one's health, a right to seek medical intervention to end one's life would be encompassed within a broad understanding of the negative right to health. Yet, *Glucksberg* does not entirely undermine the notion that such a right exists. First, Justice O'Connor's concurring opinion in *Glucksberg*, which provided the necessary fifth vote, declined to hold that there was *no* right to seek medical intervention to end physical suffering.¹⁵⁷ Instead, it insisted that even if there were such a right, the state's interest in preserving life was sufficiently

¹⁵² *Id.* at 701–03.

¹⁵³ *See, e.g.,* Rutherford v. United States, 616 F.2d 455, 457 (10th Cir. 1980) (laetrile); United States v. Cannabis Cultivators Club, 5 F. Supp. 2d 1086, 1102–03 (N.D. Cal. 1998) (medical marijuana).

¹⁵⁴ *See, e.g.,* Smith v. Shalala, 954 F. Supp. 1, 2 (D.D.C. 1996) (cancer drug).

¹⁵⁵ *See, e.g.,* Washington v. Glucksberg, 521 U.S. 702 (1997); Jacobson v. Massachusetts, 197 U.S. 11, 25–26 (1905).

¹⁵⁶ *Glucksberg*, 521 U.S. at 723.

¹⁵⁷ *Id.* at 736–38. (O'Connor, J., concurring).

strong to overcome it.¹⁵⁸ Moreover, a majority of the Justices in *Glucksberg* suggested that there may be a constitutional substantive due process right to receive palliative medication, even in a quantity that might hasten death.¹⁵⁹ As *Glucksberg* establishes, although the negative right to health may be limited by valid governmental interests, that right runs through a long line of Supreme Court case law. Indeed, some aspects of that case law, such as the post-viability health exception requirement in abortion cases and much of the *Glucksberg* Court's discussion, would be unexplainable without it.¹⁶⁰

B. Reframing the Abortion Right as a Negative Health Care Right: Legal Implications

This Article has elucidated the contours of a possible negative right to health and argued that it already exists, at least in incipient form, in U.S. constitutional law. Yet given the developed case law and scholarship surrounding abortion, in particular the persistent calls to think of the abortion right in terms of concepts such as equality and dignity,¹⁶¹ and in light of the criticisms of the “medical model” of abortion outlined above, why turn to this comparatively narrow and somewhat controversial right to frame reproductive rights? This Article argues that there are several advantages—political, rhetorical, and legal—to be gained from thinking of

¹⁵⁸ *Id.* at 736–37 (O'Connor, J., concurring).

¹⁵⁹ *Id.* at 736–38 (O'Connor, J., concurring); *id.* at 745 (Stevens, J., concurring); *id.* at 779–82 (Souter, J., concurring); *id.* at 791–92 (Breyer, J., concurring). *But see* Norman L. Cantor, *On Kamisar, Killing, and the Future of Physician-Assisted Death*, 102 MICH. L. REV. 1793, 1835 (2004) (“The legal status of terminal sedation is still unclear.” (citing Norman L. Cantor & George C. Thomas III, *The Legal Bounds of Physician Conduct Hastening Death*, 48 BUFF. L. REV. 83, 142–50 (2000))).

¹⁶⁰ *See, e.g.*, *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 879 (1992); *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747, 768–69 (1986); *Colautti v. Franklin*, 439 U.S. 379, 400 (1979); *Planned Parenthood of Central Mo. v. Danforth*, 428 U.S. 52, 76–79 (1976); *Doe v. Bolton*, 410 U.S. 179, 197 (1973). In *Stenberg*, the Court described this jurisprudence as establishing that “the State may promote but not endanger a woman's health when it regulates the methods of abortion.” *Stenberg v. Carhart*, 530 U.S. 914, 931 (2000).

¹⁶¹ *See, e.g.*, Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to Roe v. Wade*, 63 N.C. L. REV. 375, 382–83 (1985); Siegel, *Reasoning*, *supra* note 36, at 351 (urging reconsideration of the abortion right in terms of equality rather than “physiological reasoning”); Siegel, *Dignity*, *supra* note 42, at 1703 (framing the abortion debate in terms of competing conceptions about dignity); Siegel, *New Politics*, *supra* note 42, at 994 (advocating an equal protection approach to “woman protective” abortion legislation”).

reproductive rights as health care rights for those who wish to gain lasting protection for those rights.¹⁶²

One of the most important advantages to be gained from advocating and foregrounding the negative constitutional right to health is that it may provide a framework for challenging various sorts of legal restrictions that are usually upheld under current abortion doctrine. Before explaining in greater detail what the right to health might do, however, it is important to emphasize what it will not do. First, it most likely will not improve access to reproductive health services for women who cannot afford them or otherwise cannot obtain them due to practical obstacles, such as living in areas where there are few providers of such services. Second, it will not necessarily be sufficiently robust to ensure that the core of *Roe* is preserved. Although the negative right to health has numerous implications in the abortion context, the notion that individuals have a right to make medical treatment decisions without interference from the government is probably not enough, alone, to ground the right to choose nontherapeutic abortion. Even if courts do recognize that a right to make medical treatment decisions without government interference must operate in the abortion context, they will still be compelled to weigh that right against the state's interest in the fetus.¹⁶³ It is certainly conceivable that that state interest would be judged to win out over the woman's right to medical decision-making autonomy. In other words, abortion, even early abortion, will likely never be viewed in the United States as just another medical procedure. The political stakes are too high and the morally fraught nature of the procedure is too inescapable. Nonetheless, many contemporary legal controversies concern abortion restrictions that are not directly justified by a state interest in protecting fetal life. Couching the right involved in such cases in terms of a right to medical decision-making autonomy might provide a superior framework for vindicating women's rights.

The aim of this Section is not to set out a detailed legal framework for analyzing various abortion regulations in terms of a right to health, nor is it to develop a comprehensive right-to-health jurisprudence. Instead, this

¹⁶² Cf. Robertson, *supra* note 118, at 19 (suggesting that even if *Roe* were overturned, the government may not be able to ban abortions needed to protect health or life, due to the negative right to medical treatment).

¹⁶³ In general, the Court's substantive due process jurisprudence applies heightened scrutiny to government-imposed burdens on rights recognized as fundamental but still requires some form of weighing of the importance of those rights against the state interests served by the restrictions. See, e.g., *Glucksberg*, 521 U.S. at 721-22; *Casey*, 505 U.S. at 869 (holding that the woman's procreative liberty must be weighed against the state's interest in potential life).

Section suggests several instances in which reconceptualizing abortion rights as an aspect of the negative right to health might provide stronger and a more coherent standard for challenging certain kinds of abortion restrictions, particularly those that are not directly motivated by the state's interest in the fetus.

1. *Informed consent.* The often onerous informed consent requirements applied in many states exclusively to the abortion procedure are classic examples of abortion regulations that are not, generally speaking, primarily concerned with fetal protection, but rather with controlling the conditions under which women can obtain legal abortions.¹⁶⁴ Examples of such informed consent requirements include “fetal pain” laws, in which women must be told that a fetus over a particular gestational age may feel pain (sometimes accompanied by a requirement that she be offered anesthesia for the fetus),¹⁶⁵ and the South Dakota informed consent law, recently upheld by the en banc Eighth Circuit in *Planned Parenthood v. Rounds*, that requires women seeking abortions to be told that an abortion “terminate[s] the life of a whole, separate, unique, living human being.”¹⁶⁶

¹⁶⁴ Harper Jean Tobin, *Confronting Misinformation on Abortion: Informed Consent, Deference, and Fetal Pain Laws*, 17 COLUM. J. GENDER & L. 111, 125, 146 & nn.206–07 (2008) (noting that informed consent statutes may be designed to discourage women from choosing abortion but also that they may be aimed at increasing women's anxiety about abortion, encouraging women to choose anesthesia for the procedure, and indirectly increasing the cost of abortions); cf. Linda C. Fentiman, *Pursuing the Perfect Mother: Why America's Criminalization of Maternal Substance Abuse Is Not the Answer—A Comparative Legal Analysis*, 15 MICH. J. GENDER & L. 389, 417–18 (2009) (noting that abortion informed consent statutes are unusual in that they mandate the substance of the physician's communication, whereas “most American informed consent law focuses on the process of ensuring full communication between patients and their healthcare providers rather than the content of the physician-patient dialogue, relying on the healthcare professional to determine what information to convey to a particular patient based on her own individual needs” (footnotes omitted)).

¹⁶⁵ Nine states in all require that women seeking abortions be given information about fetal pain. GUTTMACHER INST., STATE POLICIES IN BRIEF: COUNSELING AND WAITING PERIODS FOR ABORTION (SEPT. 1, 2009), available at http://www.guttmacher.org/statecenter/spibs/spib_MWPA.pdf. For some examples, see ARK. CODE ANN. § 20-16-1105 (requiring that certain women seeking abortions be given information about fetal pain); GA. CODE ANN. § 31-9A-4 (same); LA. REV. STAT. ANN. § 40:1299.35.6 (2001) (same); MINN. STAT. § 145.4243(a)(3) (same); OKLA. STAT. ANN. tit. 63, § 1-738.10 (same); UTAH CODE ANN. § 76-7-305-2(a)(iv)(A).

¹⁶⁶ *Planned Parenthood Minn. v. Rounds*, 530 F.3d 724, 726 (8th Cir. 2008) (en banc). The South Dakota statute further defines “human being” as “individual living member of the species of *Homo sapiens*, including the unborn human being during the entire embryonic and fetal ages from fertilization to full gestation.” S.D. CODIFIED LAWS § 34-23A-1(4) (2009).

One might also include within this class the requirement in some states that a woman seeking an abortion view an ultrasound of the fetus before going ahead with the procedure.¹⁶⁷ They are measures whose primary effect—and perhaps whose primary aim—is to make abortions riskier, more expensive, and/or more traumatic.

Of course, some of those laws may well have been motivated in part by some legislators' sincere view that such information is necessary to decide whether to have an abortion.¹⁶⁸ Many supporters of such laws no doubt believe that women would choose not to have abortions if they had access to this information. However, the laws are unlikely to have such an effect. Indeed, at least one commentator has argued that “even where mandated disclosures are . . . calculated to dissuade, it is far from clear that a significant number of women will actually forego abortions as a result.”¹⁶⁹ Thus, “[t]he harm of such requirements most likely lies less in scaring women into not getting abortions, but in elevating the fear and anxiety women experience when they do have abortions.”¹⁷⁰

¹⁶⁷ Carol Sanger, *Seeing and Believing: Mandatory Ultrasound and the Path to a Protected Choice*, 56 UCLA L. REV. 351, 377 (2008). Currently, five states—Alabama, Arizona, Florida, Louisiana, Mississippi, and Oklahoma—require physicians to perform ultrasounds and to offer the ultrasound for viewing by the patient before terminating a pregnancy in at least some cases. ALA. CODE § 26-23A-4(b)(4) (2002); ARIZ. REV. STAT. ANN. § 36-2301.02; FLA. STAT. ANN. § 390.012(d)(4); LA. REV. STAT. ANN. § 40:1299.35.2(C) (1999); MISS. CODE ANN. § 41-41-34(1) (2007). Eleven other states have laws either requiring women to be offered a view of the ultrasound only if the physician decides to perform one or allowing women to request a view of the ultrasound. GUTTMACHER INST., STATE POLICIES IN BRIEF: REQUIREMENTS FOR ULTRASOUND (SEPT. 1, 2009), available at http://www.guttmacher.org/statecenter/spibs/spib_RFU.pdf. Oklahoma's statute was recently struck down in a legal challenge captioned *Nova Health Systems v. Henry*. OKLA. STAT. ANN. tit. 63 § 1-738.3b (West 2008); see Steven Ertelt, *Oklahoma Judge Tosses Abortion-Ultrasound law on Procedural Technicality*, LIFE NEWS, Aug. 18, 2009, available at <http://www.lifenews.com/state4356.html>.

¹⁶⁸ Sanger, *supra* note 167, at 376–77. Fetal pain laws are somewhat different from mandatory ultrasound laws in that the fetal pain laws often require false, or at least misleading, information to be given to women about fetal pain. See generally Tobin, *supra* note 164, at 143–48; Robert M. Godzeno, Note, *The Role of Ultrasound Imaging in Informed Consent Legislation Post-Gonzales v. Carhart*, 27 QUINNIPIAC L. REV. 285, 311 (2009).

¹⁶⁹ Tobin, *supra* note 164, at 125. For example, women were willing to undergo high levels of risk to obtain abortions in the pre-*Roe* era. *Id.* at 125 n.79 (citing LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE AND LAW IN THE UNITED STATES 1867–1973, 193–215 (1997)).

¹⁷⁰ *Id.*

Such laws might be effectively challenged within a framework that defined state-imposed stress and other such psychological harm as a result of such regulations affecting access to medical services as a violation of the right to health, as in the Canadian cases. Because such informed consent requirements often impose stress and anguish without any real medical benefit, they can be viewed as unacceptable intrusions into the medical decision-making process, which should instead be left largely to the patient and her physician.¹⁷¹ Framing the abortion right as a right to autonomy in access to medical treatment and in making decisions about medical treatment may thus provide a viable route for challenging ultrasound requirements and fetal pain laws.

Of course, any such interference or state-mandated harm would have to be balanced against any legitimate government interests served by the legislation. Nonetheless, viewing the right to seek medical care and to make medical decisions without government interference as fundamental would presumably result in more exacting review of such informed consent laws than the existing regime derived from *Planned Parenthood v. Casey*, which explicitly approves informed consent requirements so long as they are “truthful and nonmisleading,” regardless of how burdensome or coercive they may be.¹⁷² Indeed, it is doubtful that any of the current ultrasound laws could be considered an undue burden under *Casey*, since they likely do not present a substantial obstacle to obtaining an abortion.¹⁷³ Even to the extent that they may raise the cost of abortions, such increased cost is likely insufficient to constitute an undue burden on the abortion right, as the *Casey* Court itself made clear.¹⁷⁴

Additionally, the Canadian and South African cases explicitly recognize that delay caused by administrative and bureaucratic structures affecting access to health care may itself be a form of state-imposed harm.

¹⁷¹ See generally Sanger, *supra* note 164, at 397–401 (discussing how mandatory ultrasound statutes are designed to, and do, interfere with the woman’s autonomous decision-making process).

¹⁷² *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 882 (1992); see also *Planned Parenthood Minn. v. Rounds*, 530 F.3d 724, 733–34 (8th Cir. 2008) (en banc) (identifying *Casey*’s standard as the applicable one in a challenge to South Dakota’s onerous informed consent law); *id.* at 737 (noting that the plaintiffs had failed to meet their burden of showing that the law was “untruthful or misleading”).

¹⁷³ See, e.g., Godzeno, *supra* note 168, at 313–14 (suggesting that mandatory ultrasound laws most likely do not constitute an undue burden under *Casey*).

¹⁷⁴ *Casey*, 505 U.S. at 877.

A focus on delay in accessing services and the harm that can flow from that delay may provide an effective device for challenging in-person informed consent laws that are combined with a waiting period. These laws often result in substantial delay in obtaining the abortion, along with all of the health risks associated with that delay. Courts in the United States have repeatedly recognized that delay in access to abortion is a form of interference with “medically appropriate treatment.”¹⁷⁵ At the same time, courts almost universally uphold such waiting periods because they do not, under *Casey*, appear to constitute a substantial obstacle to accessing the procedure itself.¹⁷⁶

Viewing abortion rights as an aspect of the negative right to health, moreover, would constitute a partial return to the medical model of abortion, in which abortion is treated in most respects like any other medical procedure. This approach mirrors somewhat the approach of the Canadian and South African constitutions, which make strong and explicit connections between the right to choose abortion and the right to make medical treatment decisions in other areas. Such an approach—viewing abortion as just another medical procedure, at least with respect to laws such as informed consent requirements where fetal protection is not actually the goal—might be more protective of women’s autonomy than the current approach. As Professor Maya Manian has demonstrated, the law of informed consent in the abortion context has increasingly diverged from the general law of informed consent since the early post-*Roe* cases, in which the Supreme Court struck down intrusive informed consent and counseling requirements.¹⁷⁷ The height of this divergence may well be *Gonzales v.*

¹⁷⁵ Cf. *Planned Parenthood v. Owens*, 287 F.3d 910, 920 (10th Cir. 2002) (agreeing with the lower court that a “forty-eight-hour delay required by the [parental notice law] would interfere with the medically appropriate treatment—an abortion—for these women”); *A Woman’s Choice—East Side Women’s Clinic v. Newman*, 132 F. Supp. 2d 1150, 1173 (S.D. Ind. 2001) (noting harmful delay caused by in-person informed consent law, combined with a waiting period), *rev’d*, 305 F.3d 684 (7th Cir. 2002).

¹⁷⁶ See, e.g., *Cincinnati Women’s Services, Inc. v. Taft*, 468 F.3d 361, 372–74 (6th Cir. 2006); *A Woman’s Choice—East Side Women’s Clinic v. Newman*, 305 F.3d 684, 693 (7th Cir. 2002) (upholding Indiana waiting period law and noting that “[n]o court anywhere in the country (other than [the court below]) has held any similar law invalid in the years since *Casey*”); *Fargo Women’s Health Org. v. Schafer*, 18 F.3d 526, 531–32 (8th Cir. 1994); *Utah Women’s Clinic, Inc. v. Leavitt*, 844 F. Supp. 1482, 1487–91 (D. Utah 1994), *rev’d in part*, 75 F.3d 564 (10th Cir. 1995).

¹⁷⁷ Maya Manian, *The Irrational Woman: Informed Consent and Abortion Decision-Making*, DUKE J. GENDER L. & POL’Y 225, 244–47 (2009) (discussing *City of Akron v. Akron Ctr. for Reproductive Health*, 462 U.S. 416 (1983), and *Thornburgh v. Am. Coll. of Obstetricians & Gynecologists*, 476 U.S. 747 (1986)).

Carhart, in which the Court accepted paternalistic “woman-protective” reasoning for both allegedly protecting women from psychological harm by banning an abortion procedure altogether and subjecting some women to serious physical risks. And according to Manian, “*Carhart*’s ‘woman-protective’ rationale has already had significant impact in the courts and in the public arena, as exhibited particularly by legislatures enacting even more biased ‘informed consent’ laws, such as the legislation recently upheld in South Dakota.”¹⁷⁸ It is thus reasonable to think that keeping abortion rights and reproductive health care within the general legal framework regulating health care might have led courts in a notably different direction.¹⁷⁹

2. *Bans on particular methods of abortion.* A medical autonomy framework also better explains precisely what is so problematic about both the so-called “partial-birth abortion” bans and other regulations of abortion methods, such as recent attempts to regulate the abortion drug mifepristone.¹⁸⁰ “Partial-birth” abortion bans do not prevent women from obtaining abortions but simply require them to have abortions by riskier methods. As explained above with respect to *Stenberg v. Carhart* and *Gonzales v. Carhart*, such bans are thus not aimed directly at the right to choose abortion in the way that the criminal prohibition at issue in *Roe v. Wade* was; nor are they technically about relegating women to a particular status in society through forced childbearing. Rather, they are aimed at intruding on the doctor-patient relationship in a way that forces women to undergo risks to their health that they and their doctors feel are unnecessary and excessive. As such, robust recognition of a right to avoid state-mandated physical harm and to seek medical care autonomously and without interference from the state could well provide more protection to women for whom such banned procedures are deemed more medically appropriate.¹⁸¹

¹⁷⁸ *Id.* at 289 (discussing *Planned Parenthood of Minn. v. Rounds*, 530 F.3d 724 (8th Cir. 2008)).

¹⁷⁹ Cf. Rebecca Dresser, *Protecting Women from Their Abortion Choices*, 37 HASTINGS CTR. REP. 13, 14 (2007) (“It is difficult to see why the worry about patients’ sensibilities merits denying them access to only one of many possibly disturbing medical interventions.”).

¹⁸⁰ OHIO REV. CODE ANN. § 2919.123 (West 2004); OKLA. ST. ANN. tit. 63, § 1-729 (West 2008).

¹⁸¹ Indeed, such a right would look very much like the standard articulated in *Stenberg v. Carhart*, 530 U.S. 914 (2000), according to which a statute lacking a health exception is unconstitutional if it imposes significant health risks on some women, *id.* at

Similarly, litigation is currently pending in Ohio over a law that purports to require physicians to prescribe the abortifacient mifepristone at an unnecessarily high dosage and only through seven weeks of pregnancy, although it can be used safely and effectively at a lower dosage until at least eight or nine weeks.¹⁸² What is so troubling about a law that might prescribe dosages and unnecessary time limitations on the abortion drug is that it interferes in the doctor–patient relationship in ways that are medically unnecessary and inappropriate. It interferes with women’s medical autonomy and may impose physical or psychological injury by forcing some women, such as those who are beyond the statute’s time limit, to choose surgical abortion procedures when they would prefer equally safe and effective medical abortions.¹⁸³ It attempts to micromanage the physician–patient relationship and may impose additional and unnecessary financial and emotional costs on patients.

The “undue burden” framework set forth in *Planned Parenthood v. Casey* fails to capture those troubling aspects of such laws. Under *Casey*, abortion restrictions are unconstitutional only if they place a substantial obstacle in the path of a woman seeking an abortion, and delay and increased cost alone cannot constitute undue burdens.¹⁸⁴ The notion that an

937–38. But the litigation over this issue has centered on the health exception requirement, derived from *Roe* but never explicitly justified in terms of a negative right to health. The lack of explicit justification for the health exception requirement may partly explain the Court’s decision to depart from *Stenberg* in *Gonzales v. Carhart*, 550 U.S. 124 (2007). Again, making the negative right to health explicit and grounding the unconstitutionality of the D&X ban in that right might have better protected a woman’s right to choose the most medically appropriate abortion procedure for her; it would have arguably justified facial, rather than as-applied, invalidation of the federal Partial Birth Abortion Ban Act at issue in *Gonzales v. Carhart* as an unwarranted intrusion in the doctor–patient relationship, in addition to an imposition of physical harm by the state.

¹⁸² *Planned Parenthood Cincinnati Region v. Strickland*, 531 F.3d 406 (6th Cir. 2008); *Planned Parenthood Cincinnati Region v. Taft*, 444 F.3d 502 (6th Cir. 2006). Although it is unclear whether the law does ban these uses of the drug; the state has taken the position that it does so. In the interest of full disclosure, this Author is lead counsel for one of the plaintiffs in this litigation.

¹⁸³ See, e.g., Joanna N. Erdman, Amy Grenon & Leigh Harrison-Wilson, *Medication Abortion in Canada: A Right-to-Health Perspective*, 98 AM. J. PUB. HEALTH 1764, 1766 (2008) (noting that the advantages of medication abortion that may lead some women to prefer it over surgical methods).

¹⁸⁴ *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 877 (1992) (defining “undue burden”). The Court noted that a twenty-four-hour waiting period requiring two trips to the clinic will increase costs and delay abortions, but found that the measure did not constitute an undue burden, and held that the fact that the measure limits a physician’s discretion does not require its invalidation. *Id.* at 885-86.

abortion restriction violates the Constitution only if it actually impedes a woman's access to abortion by placing a substantial obstacle in her path misses the various ways in which many abortion restrictions violate women's dignity and autonomy within the physician–patient relationship. Such laws can, however, effectively—and perhaps most effectively—be framed primarily as a violation of the negative right to health.¹⁸⁵ Indeed, at least one commentator has suggested that denial of access to a preferred abortion method constitutes a violation of the Canadian and international right to health.¹⁸⁶

3. *Targeted Regulations of Abortion Providers (TRAP Laws)*. The term “TRAP laws” refers to “laws that single out physicians’ offices and outpatient clinics where abortions are performed, and subject them to wide-ranging medical, administrative, and facility requirements that are not imposed on comparable medical facilities.”¹⁸⁷ TRAP laws often have the effect, and perhaps the purpose, of increasing the cost of abortion services both to patients and to clinics. Indeed, some have suggested that TRAP laws are responsible for running some abortion providers out of business, making abortions less accessible in any given geographic area.¹⁸⁸

¹⁸⁵ One might argue that because of the deep political divisions surrounding abortion rights, the strategy of relating abortion to other forms of health care risks backfiring by encouraging greater regulation of all health care providers and procedures in order to be able to regulate abortion. As an empirical matter, it is hard to know how great this danger is.

¹⁸⁶ Erdman, et al., *supra* note 183, at 1766; *cf. id.* at 1768 (arguing that under the right to health “[g]overnment may not obstruct the approval of safe and effective medicines, nor may it remain passive when financial and political barriers impede the introduction of essential reproductive health medicines”).

¹⁸⁷ Amalia W. Jorns, Note, *Challenging Warrantless Inspections of Abortion Providers: A New Constitutional Strategy*, 105 COLUM. L. REV. 1563, 1568 (2005). Such requirements may include “training and qualification specifications for staff members; mandatory testing of patients for sexually transmitted diseases, even if unnecessary for their treatment; requiring employees to submit to physical examinations; and requirements regarding the physical design and function of the clinic itself”—to the point of “micromanaging everything from elevator safety to countertop varnish to the locations of janitors’ closets”—as well as “authoriz[ing] state health departments to inspect the offices and medical records of abortion providers who are subject to these licensing schemes without a warrant or probable cause to search.” *Id.* at 1569 (quoting *Greenville Women’s Clinic v. Comm’r*, 317 F.3d 357, 371 (4th Cir. 2002) (King, J., dissenting)) (footnotes omitted).

¹⁸⁸ *Id.* at 1567.

However, constitutional challenges to such onerous and unnecessary abortion-specific regulations have largely failed.¹⁸⁹ While TRAP laws increase the cost of abortions and ultimately render them inaccessible in some places, they are rarely considered sufficiently onerous to constitute an “undue burden” on the abortion right under *Casey*, and they do not invoke any heightened scrutiny under an equal protection analysis.¹⁹⁰ In fact, as Professor Gillian Metzger has argued, TRAP laws often appear to courts “as a species of ordinary regulation with the effect that courts assess their constitutionality against the background of the government’s broad power to regulate in the name of health as well as doctrines of deference to administrative expertise.”¹⁹¹ As the Fourth Circuit explained in turning away a challenge to a North Carolina TRAP law in *Greenville Women’s Clinic v. Bryant*, such laws are:

little more than a codification of national medical—and abortion—association recommendations designed to ensure the health and appropriate care of women seeking abortions; . . . [they do] not “strike at the [abortion] right itself”; . . . the increased costs of abortions caused by implementation of [such laws], while speculative, are even yet modest and have not been shown to burden the ability of a woman to make the decision to have an abortion; and abortion clinics may rationally be regulated as a class while other clinics or medical practices are not.¹⁹²

A doctrine that viewed bureaucratically-imposed obstacles to obtaining medical care as interfering with a fundamental right, by contrast, would invoke heightened scrutiny for TRAP laws. The delays in obtaining abortions and the increased health risks that such delays entail are not unlike the problems created by the Québec law struck down in *Chaoulli* as interfering with the right to security of the person.¹⁹³ A right-to-health framework for analyzing TRAP laws would thus likely protect access to abortion more fully than *Casey*’s undue burden standard currently does.

¹⁸⁹ Gillian E. Metzger, *Abortion, Equality, and Administrative Regulation*, 56 EMORY L.J. 865, 873–75, 873 n.29 (2007).

¹⁹⁰ *Id.*

¹⁹¹ *Id.* at 868.

¹⁹² 222 F.3d 157, 159 (4th Cir. 2000) (quoting *Planned Parenthood of Se. Pa. v. Casey*, 505 U.S. 833, 874 (1992)).

¹⁹³ *Chaoulli v. Quebec*, [2005] 1 S.C.R. 791 ¶¶ 41–43, 123 (Can.).

Of course, some bureaucratic regulation would still be permissible and even necessary under this new framework. The fundamental right to noninterference in one's decision to seek medical treatment would have to be weighed against certain legitimate government interests, such as safety and public health. However, at least in the right-to-health framework, administrative regulations in the form of TRAP laws would receive a higher level of scrutiny than they currently do, and they would likely be held unconstitutional more often.

C. Reframing the Abortion Right as a Negative Health Care Right: Other Implications

In addition to providing new ways of framing various legal issues pertaining to abortion rights, placing reproductive rights within the broader framework of health care rights may have several political and rhetorical advantages. First, putting reproductive rights in the context of health care rights in general may garner a wider base of political support for government noninterference with women's access to reproductive health care than framing the issue in terms of reproductive choice, privacy, or even equality has done. The right to health, as a right to medical decision-making autonomy, is an inclusive concept that touches on areas that are of concern or likely to one day be of concern to most people. As people age, they begin to worry more about their future interactions with the medical establishment in the context of end-of-life decision making, access to appropriate palliative care, and possibly to experimental drugs; in particular, they may reasonably fear that intrusive government regulators will attempt to control those interactions.¹⁹⁴ There may be substantial political support for the idea that the government should not dictate health care decisions, whether they are decisions about experimental treatments for cancer or reproductive health care.¹⁹⁵ Indeed, the notion of a right to health

¹⁹⁴ Consider, for example, the controversy over the death of Terri Schiavo, the woman in a persistent vegetative state whose husband faced a long political and legal battle when he attempted to have her feeding tube removed. Ultimately, the political frenzy over the right-to-die issue—which included lawmakers discussing in detail the minutiae of Ms. Schiavo's medical condition—backfired on conservative lawmakers who had attempted to prolong Ms. Schiavo's life. See generally Ruth A. Miller, *On Freedom and Feeding Tubes: Reviving Terri Schiavo and Trying Saddam Hussein*, 19 CARDOZO STUD. L. & LIT. 161, 180–81 (2007) (describing the “fascination with the minutiae of [Schiavo's] bodily function”); Charles Babington, *Post-Schiavo Questions Await Congress's GOP Leaders*, WASH. POST, Apr. 5, 2005, at A4 (describing the backlash).

¹⁹⁵ Cf. *Abigail Alliance for Better Access to Dev. Drugs v. Von Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007) (en banc) (reversing the appellate panel's decision that plaintiffs

is not gender-specific, and therefore may carry a broader political appeal than the notion of a right to gender equality or reproductive decision-making autonomy.

Focusing on the medical aspects of abortion may have other rhetorical advantages as well. Putting the abortion right into this broader context—the context of medical decision-making—would highlight the fact that the abortion decision is at least in part a decision about medical treatment, not merely an economic transaction in which one vulnerable party stands to be exploited. The view of women as perpetually vulnerable to the efforts of profit-seeking abortion providers who force them into procedures they do not want arguably pervades portions of Justice Kennedy's opinion in *Gonzales v. Carhart*, for example.¹⁹⁶ In an area that is so heavily driven by political rhetoric, influencing the language used to describe abortion and abortion providers could tip the scales of public and perhaps even judicial opinion in favor of pro-choice advocates in some instances.¹⁹⁷

Moreover, emphasizing the medical side of abortion rights may engage non-obstetrician physicians more in reproductive rights issues. After all, many of the legal restrictions that apply to abortion providers would probably strike other physicians as outrageous if applied to them. Indeed, the *Doe v. Bolton* court's embrace of the medical model of abortion, which compared abortion to "other surgical procedures" and found the uniquely onerous regulation of abortion to be constitutionally problematic, is an approach that has largely disappeared from reproductive rights case

had a constitutional right to access experimental cancer drugs that had passed only Phase I review by the FDA).

¹⁹⁶ *Gonzales v. Carhart*, 550 U.S. 124, 159 (2007) ("In a decision so fraught with emotional consequence some doctors may prefer not to disclose precise details of the means that will be used, confining themselves to the required statement of risks the procedure entails."); *id.* at 183–84 (Ginsburg, J., dissenting) (criticizing the majority's view, which relies in part on "women's fragile state" to deny them reproductive autonomy).

¹⁹⁷ Similarly, putting abortion into a broader context of medical treatment may minimize the tendency on the part of some to forget that the doctors who provide abortions are "physicians" and not, as Justice Kennedy and Justice Scalia referred to them in *Stenberg v. Carhart*, "abortionists." *Stenberg v. Carhart*, 530 U.S. 914, 954 (2000) (Scalia, J., dissenting); *id.* at 957–79 (Kennedy, J., dissenting). The word "abortionist" is generally understood to have negative connotations. In addition, it is often used to refer to non-physicians who performed abortions when it was illegal, and often did so unsafely. *See, e.g.*, *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 557 (1989) (Blackmun, J., concurring in part and dissenting in part) (referring to "back-alley abortionists"). Notably, Justice Kennedy switched to the term "doctor" in *Gonzales*, 550 U.S. 124.

law but that might provide a framework for criticizing many abortion regulations, especially TRAP laws.¹⁹⁸

IV. CONCLUSION

Although reproductive rights activists often recognize in their rhetoric and their arguments that the abortion right is at least partly about the right to make medical treatment decisions autonomously, many feminist scholars and advocates tend to downplay this argument. It may be time to re-think that strategy, however, and to embrace this aspect of abortion rights more fully. This Article recognizes that such an approach will not be a panacea; it will not necessarily increase access to reproductive health care for those who cannot afford it, for example. Moreover, such a right would be subject to balancing against recognized government interests, such as the state's interest in potential life and in regulating the practice of medicine in the interest of safety. Finally, the right—which I contend is already established, if only implicitly, within substantive due process doctrine—will no doubt strike some as novel and unlikely to garner the support of courts in the near future. Nonetheless, it is still a path worth pursuing, given the relative lack of scrutiny applied to most types of abortion restrictions in the wake of *Planned Parenthood v. Casey*¹⁹⁹ and the confused but unpromising state of abortion jurisprudence in the wake of *Gonzales v. Carhart*.²⁰⁰ In particular, this model possesses potential for reframing—both rhetorically and legally—some current legal controversies for which *Casey*'s “undue burden” standard and even the language of equality and dignity provide little basis for challenge.

¹⁹⁸ *Doe v. Bolton*, 410 U.S. 179, 192, 197, 199 (1973).

¹⁹⁹ 505 U.S. 833 (1992).

²⁰⁰ 550 U.S. 124 (2007).