Health Matrix: The Journal of Law-Medicine

Volume 34 | Issue 1 Article 7

2024

A Health Justice Approach to Abortion

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ABSTRACT

The Supreme Court's watershed decision in Dobbs v. Jackson Women's Health Organization, *overturning fifty years of precedent protecting abortion rights, has led to chaos in both the legal and public health landscapes. With* Roe v. Wade *eliminated, reproductive rights and justice advocates urgently* need *new frameworks to help regain access to comprehensive reproductive health care in the long term. Recently, a number of legal scholars have argued in favor of medicalizing civil rights—adopting the framework of health justice to talk about civil rights issues. Scholars argue that the health justice framework could be used to advance civil rights in the realms of race discrimination in policing, fair housing, and poverty rights, by framing these concerns as public health issues. This Article is the first to extend the health justice framework to abortion. The health justice framework offers a new form of medicalization that could advance more equitable access to reproductive health care.*

Medicalization has a complicated history in the legal regulation of abortion. Although scholars do not all agree on a definition of the concept, "medicalization" is typically defined as the framing of a phenomenon as medical in nature and properly within the jurisdiction of medical experts in terms of decision-making authority. Feminist scholars have often viewed medicalization suspiciously, especially in the context of reproduction, since medicalization has tended to correspond with physician control over women's bodies. In the last few decades of intense debate over abortion, the focus has been on abortion as a constitutional right, but the notion of abortion as a medical concern has

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been lost since Roe, *in part due to feminist arguments against medicalizing abortion rights. In the decades since* Roe, *abortion has been siloed from healthcare in the law and segregated from mainstream medicine.*

*This Article pushes back against feminist legal scholars' critiques of the medicalization of abortion rights. It argues that, unlike the medicalization of the past, the health justice framework depends less on the sole professional authority of physicians and more on concerns about the social determinants of health and health equity at the population level. The health justice approach accommodates medicalized framings by focusing on public health outcomes of abortion restrictions, while also aiming for reducing health disparities through structural reforms and redistribution of resources rather than physician-controlled medical interventions. The health justice framework thus links together both medicalized (health-focused) and demedicalized (equality-focused) framings of abortion in a way that could advance reproductive health equity. Re-medicalizing abortion through a health justice lens provides strategic benefits in political and social climates hostile to abortion, especially in a post-*Dobbs *world.*

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INTRODUCTION

The Supreme Court's watershed decision in *Dobbs v. Jackson Women's Health Organization,* overturning fifty years of precedent protecting abortion rights, has led to chaos in both the legal and public health landscapes.[1] With *Roe v. Wade* eliminated,[2] reproductive rights and justice advocates urgently need new frameworks to help restore access to comprehensive reproductive health care in the long term. Abortion is not the only issue that has been losing ground as a civil right—racial justice is also on the chopping block as the Supreme Court takes aim at voting rights and affirmative action.[3] In many domains, scholars are talking about the need for new frameworks to advance civil rights, in new venues outside the federal courts.[4]

Recently, a number of legal scholars have argued in favor of medicalizing civil rights—adopting the framework of health justice to talk about civil rights issues. Health justice is a jurisprudential and social movement framework that focuses on the role of larger systems, including law, in supporting or eradicating health disparities at the population level.[5] The health justice framework relies heavily on public health research on the social determinants of health (SDOH).[6] SDOH research shows that social factors such as discrimination, poverty, and poor housing have a larger impact on health outcomes than access to healthcare alone.[7] Thus, the health justice framework supports advocacy for economic, racial, and gender equity through structural

1. Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2242, 2334 (2022); Jessica Winter, *The Dobbs Decision Has Unleashed Legal Chaos for Doctors and Patients*, NEW YORKER (July 2, 2022), https://www.newyorker.com/news/news-desk/the-dobbs-decision-has-unleashed-legal-chaos-for-doctors-and-patients [https://perma.cc/3EHL-LMH2].

2. *Dobbs*, 142 S. Ct. at 2242.

3. Leah Litman et al., *The Link Between Voting Rights and the Abortion Ruling,* WASH. POST (June 28, 2022, 12:13 PM), https://www.washingtonpost.com/outlook/2022/06/28/dobbs-voting-rights-minority-rule/ [https://perma.cc/VR4L-P59K].

4. *See, e.g.*, B. Cameron Webb & Dayna Bowen Matthew, *Housing: A Case for the Medicalization of Poverty*, 46 J. L. MED. & ETHICS 588, 590, 592 (2018) (arguing for the need for new frameworks in the contexts of fair housing).

5. *See* Lindsay F. Wiley et al., *Introduction: What is Health Justice?*, 50 J. L. MED. & ETHICS 636 (2022).

6. *See id.*; *see also* Ruqaiijah Yearby, *The Social Determination of Health, Health Disparities, and Health Justice*, 50 J. L. MED. & ETHICS 641, 647 (2022).

7. *See* Yearby, *supra* note 6, at 644*; see also infra* Part III.

reforms and redistribution of resources as a means to address public health concerns about health disparities at the population level. Scholars argue that the health justice framework could be used to advance civil rights in the realms of race discrimination in policing, fair housing, and poverty rights, by reframing these concerns as public health issues. This Article is the first to extend the health justice framework to abortion. It contends that the health justice framework offers a new form of medicalization that could advance more equitable access to reproductive health care by bridging the gap between medicalized and demedicalized framings of abortion rights.

Medicalization has been the subject of much critique, particularly in the context of reproductive health care. The concept of medicalization has meant different things, depending on actors, times, and contexts.[8] Although scholars are not all in agreement on a definition of the concept, "medicalization" is typically defined as the framing of a phenomenon as medical in nature and properly within the jurisdiction of medical experts in terms of decision-making authority.[9] In abortion jurisprudence, medicalization has offered both hazards and opportunities for advancing reproductive rights.[10]

Some feminist social movement groups argued for abortion rights to be demedicalized in order to obtain greater sexual and reproductive autonomy for women, free from physician control.[11] Yet, while warranted in many instances, feminist critiques of the medicalization of reproductive rights did not lead to greater autonomy for women and pregnant people in the abortion context.[12] Instead, power over abortion decisions shifted professions from medical authority to legal authority.[13]

8. *See* Webb & Matthew, *supra* note 4, at 588–89 (briefly summarizing the history of scholarly debates on medicalization and arguing in favor of the medicalization of poverty in order to address the social determinants of health); *see also* Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165 (2020) (summarizing scholarship critical of medicalization).

9. *See infra* Part II.

10. *Id.*

11. *Id.*

12. This article at times uses the term "pregnant people" to recognize that trans and gender non-binary people also experience pregnancy and pregnancy-related health care needs, while also at times referring to impacts of policies on "women" to acknowledge the gendered impacts of regulation on women as traditionally defined. *See* Jessica A. Clarke, *They, Them, and Theirs*, 132 HARV. L. REV. 894, 951, 954–55 (2019) (discussing gender identity and pregnancy discrimination); LORETTA J. ROSS & RICKIE SOLINGER, REPRODUCTIVE JUSTICE: AN INTRODUCTION 6–8 (2017) (noting the struggle to both be inclusive of trans and gender non-binary people while also recognizing disproportionate impacts on women as that category has traditionally been defined).

13. *See infra* Part II.

Feminist advocates should ask: when an event is demedicalized, who gains control over it? Reproductive rights advocates likely did not expect demedicalization to correspond with shifting power over abortion back to social control by the law. Under conditions of intersecting subordination along lines of gender, race, and class, neither medicalized nor demedicalized rights framings robustly protected the reproductive autonomy of the most vulnerable populations.[14]

This Article reconsiders the feminist legal scholar critique of the medicalization of abortion rights and offers a more complex picture of the medicalization of abortion in the law.[15] In abortion jurisprudence, medicalization has been both good and bad. This Article argues that the benefits of medicalizing abortion may outweigh the risks for purposes of decreasing legal restrictions on abortion and increasing access to abortion care on the ground, particularly in a post-*Dobbs* world. In the last few decades of intense debate over abortion, the focus has been on abortion as a constitutional right, but the notion of abortion as a healthcare concern has been lost in the law since *Roe,* in part due to feminist push back against medicalizing abortion rights. Rather than choosing between a false binary of medicalization or demedicalization, the health justice framework offers a new approach that takes advantage of the benefits of both framings.

The reversal of *Roe* provides an opportunity to reframe abortion rights and creates an urgent need to find new strategies that will appeal to voters and policymakers who now determine the fate of abortion rights. Re-medicalizing abortion rights through a health justice lens offers potential strategic benefits if deployed in ways that aim to advance reproductive justice. Scholars have yet to directly place health justice into conversation with reproductive justice. Reproductive justice focuses on identifying power systems that prevent all people from equal enjoyment of reproductive autonomy in avoiding pregnancy, giving birth, or raising their children; it also emphasizes that redistribution of resources to ensure equal ability to exercise reproductive rights is as important as rights themselves.[16] This Article argues that the emerging framework of health justice offers a new approach to advocacy for

14. *Id.*

15. *See, e.g.*, Susan Frelich Appleton, *Doctors, Patients and the Constitution: A Theoretical Analysis of the Physician's Role in "Private" Reproductive Decisions*, 63 WASH. U. L. Q. 183, 197–200 (1985) (critiquing medical model of abortion as undermining women's agency and reinforcing gender inequality); 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 *Reasoning From the Body*]; *see also* Jack M. Balkin, Roe v. Wade*: An Engine of Controversy*, *in* WHAT *ROE V. WADE* SHOULD HAVE SAID: THE NATION'S TOP LEGAL EXPERTS REWRITE AMERICA'S MOST CONTROVERSIAL DECISION 3–42 (Jack M. Balkin ed., 2023).

16. *See infra* Part III.

abortion rights that builds on the reproductive justice framework, but in ways that emphasize a medicalized framing focusing on health disparities and health equity. This Article contends that both frameworks could work productively in tandem to shift public policy on abortion access.

By exploring the history of medicalization in abortion law and bringing this history into conversation with the health justice framework, this Article makes three significant contributions. First, it argues that the early history of abortion law illustrates medical and legal domains working together for mutual arrogation of power rather than operating in conflict with each other, contrary to theorizing about medicalization that suggests the two domains are mutually exclusive. Second, it demonstrates that medicalized framings in abortion jurisprudence correspond with greater access to abortion on the ground.[17] In Supreme Court opinions that frame abortion rights through deference to medical experts, women face fewer legal restrictions on access to abortion care.[18] This Part argues that, in *Roe* and its progeny, medicalization correlates with fewer legal restrictions in part because the Court rhetorically shifts decision-making power from legal control to medical control, rather than explicitly granting women themselves decision-making authority.[19] Thus, rhetorically sheltering abortion decisions within trusted medical authorities rather than women themselves helps justify less legal regulation of abortion. Third, this Article argues that a health justice approach to abortion leverages the benefits of both medicalized and demedicalized framings in ways that could persuade voters and policymakers to protect equitable access to abortion care.

Part I briefly recounts scholarly debates around the concept of medicalization, particularly regarding whether medicalization's harms outweigh its potential benefits. Part I also describes how the rise and fall of physicians as a dominant profession in the United States links to both medicalization as a phenomenon and to the early legal regulation

17. *See* LORI FREEDMAN, WILLING AND UNABLE: DOCTORS' CONSTRAINTS IN ABORTION CARE 9–13 (2010).

18. *See* Roe v. Wade, 410 U.S. 113, 130 (1973); Planned Parenthood v. Casey, 505 U.S. 833, 838, 882 (1992); Gonzales v. Carhart, 550 U.S. 124, 144 (2007); Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 608–09 (2016); June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2112–13 (2020).

19. This paper focuses on the legal opinions' construction of abortion as medical or not and the corresponding legal consequences of those framings, rather than looking upstream to explain how the Court came to medicalize or demedicalize abortion. Other legal scholars have analyzed the claims-making of different groups that occurred before, during, and after *Roe v. Wade* that helped to shape whether and how abortion is medicalized in the law. *See generally*, B. Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501 (2009) [hereinafter *Health Care Rights*].

of abortion, during which medicalization and criminalization of abortion arose together.

Part II provides an overview of the doctrinal shifts in the Supreme Court's abortion jurisprudence from *Roe v. Wade* to *Dobbs v. Jackson Women's Health Organization,* as well as shifts in medicalized and demedicalized framings of abortion in the Court's opinions. Part II does not argue that abortion should be medicalized on the grounds that medical experts rightly have epistemic authority over abortion care. Rather, it focuses on descriptively mapping out the trajectory of medicalization and demedicalization in the Supreme Court's abortion jurisprudence to understand what happens to access to and agency over abortion decisions when framed as "medical" in the law. Ultimately, throughout its abortion jurisprudence, the Court has never openly granted women complete decision-making authority over abortion; instead, authority shifts between medicine and law. Yet, since *Roe*, Part II shows how demedicalizing abortion in the law has correlated with hindered access to abortion care on the ground, especially for low-income people and people of color. Thus, if the goal is to increase women's agency over abortion decisions in the real world, the advantages of medicalized framings of abortion may outweigh the risks.[20] Even though anti-abortion advocates can deploy medicalization against abortion rights as well, sheltering women's decision-making within the legitimacy of health professional expertise shields women from increased legal curtailment of abortion access Although women never fully escape the disciplinary authority of either law or medicine, Part II argues that situating abortion within a health care frame is the lesser of two evils, particularly in a world where the Supreme Court has retracted civil rights protections.

Finally, Part III summarizes recent legal scholarship arguing in favor of medicalizing civil rights issues such as fair housing, race discrimination, and poverty rights more broadly, through a health justice framework—and extends this scholarship to the abortion context. This Part aims to thread together literatures on medicalization, reproductive justice, and the burgeoning legal scholarship on health justice to argue in favor of bringing together medicalized and demedicalized framings of abortion rights. A number of legal scholars have argued for reconnecting abortion with women's health and framing abortion care as an aspect of health care.[21] This

20. *See* Konnoth, *supra* note 8, at 1202 (arguing that medical frames can offer strategic benefits in an era of reduced civil rights and that the benefits of medicalization may outweigh the costs in the contexts of disability, trans rights, and other areas but not analyzing abortion law).

21. *See, e.g.*, Maya Manian, *Lessons From Personhood's Defeat: Abortion Restrictions and Side Effects on Women's Health*, 74 OHIO ST. L. J. 75, 76, 78 (2013) [hereinafter *Lessons From Personhood*] (urging a resurrection of the healthcare framing of abortion rights and citing other scholars arguing for reconnection between abortion and medical

Part builds on that line of scholarship through the health justice framework. The health justice approach to abortion does not aim to resurrect the doctor-patient focus of *Roe.* Rather, it offers a new form of medicalization given its critical differences from historically physician-focused forms of medicalization. The health justice framework depends not on the professional authority of physicians, but rather on public health expertise about the social determinants of health and health disparities. The health justice approach's emphasis on the social determinants of health and race and class health equity in access to reproductive health care could be particularly resonant in a post-COVID and post-*Dobbs* world.[22]

In sum, the health justice approach offers a new framework for abortion rights that links together both medicalized (health-focused) and demedicalized (equality-focused) framings of abortion in a way that addresses some of the downsides of past modes of medicalizing abortion rights. Re-medicalizing abortion through a health justice lens provides strategic benefits in political and social climates hostile to abortion, especially in a post-*Dobbs* world.

I. A BRIEF HISTORY OF THE CONCEPT OF MEDICALIZATION

This Part briefly summarizes the main threads in the rich literature debating the pros and cons of medicalization and highlights aspects of the debate relevant to analyzing abortion law.[23] This Part also touches on the related issue of the rise and fall of physicians' professional dominance in the United States, describing how that trajectory relates to medicalization and the early history of abortion regulation. It argues that, while feminist skepticism towards the medicalization of reproductive healthcare is understandable, reproductive rights and justice advocates need to reconsider medicalization's possibilities in a post-*Dobbs* world.

A. Medicalization as Both Promise and Peril

Despite over four decades of scholarship on the phenomenon, "medicalization" does not have a firm definition. Historically, scholars understood medicalization as the adoption of a medical framing around issues not previously thought to be medical in order to bring those

care); *Health Care Rights*, *supra* note 19, at 502, 505 (summarizing feminist critiques of *Roe*'s medical model of abortion and arguing for reframing abortion as health care); Yvonne Lindgren, *The Rhetoric of Choice: Restoring Healthcare to the Abortion Right*, 64 HASTINGS L. J. 385, 387–88 (2013) [hereinafter *Rhetoric of Choice*] (arguing for restoring a view of abortion as a healthcare right).

22. *See, e.g.*, Ruqaiijah Yearby & Seema Mohapatra, *Law, Structural Racism, and the COVID-19 Pandemic*, 7 J. L. & BIOSCIENCES 1, 4 (2020).

23. *See* Konnoth, *supra* note 8, at 1170–71 (summarizing extensive literature on medicalization across disciplines).

issues within biomedicine's jurisdiction.[24] Often, medicalization was also associated with physicians' efforts to expand professional dominance and assert social control.[25] However, that narrower definition of medicalization expanded over time.[26] Peter Conrad, one of the earliest scholars of medicalization, provides this oft-cited definition:

> Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to 'treat' it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession.[27]

Although Conrad's definition is prominent in the medicalization literature, other scholars have criticized conceptualizing medicalization so broadly.[28] As Joseph Davis notes, medicalization "once referred to a specific social process—the expansion of the jurisdiction of the medical profession that followed from the successful redefinition of forms of deviance, natural life processes, and problems of living as illnesses requiring medical intervention."[29] Medicalization, defined in these narrower terms, is an analog to other terms describing the expansion of institutional jurisdiction, such as the phenomenon of criminalization.[30] Davis laments that today, "medicalization refers to any definition or description of a problem in 'medical' terms or its treatment by a 'medical' intervention—no matter who is doing the defining or intervening . . . ."[31] The lack of clarity around the definition of "medicalization" has led scholars studying the same event to disagree as to whether the event constitutes an instance of medicalization or not.[32] In contrast to medicalization, scholars have not as thoroughly

24. Joseph E. Davis, *How Medicalization Lost Its Way*, 43 SOC'Y 51, 51 (2006).

25. *Id.* at 53.

26. *See, e.g.*, *id.* at 51–52; Drew Halfmann, *Recognizing Medicalization and Demedicalization: Discourses, Practices, and Identities,* 16 HEALTH (LONDON) 186, 187 (2012) (reviewing different definitions of medicalization in scholarly literature and providing a typology of medicalization and demedicalization).

27. Peter Conrad, *Medicalization and Social Control*, 18 ANN. REV. SOCIO. 209, 211 (1992); Davis, *supra* note 24, at 53 (noting that Conrad's broad definition of medicalization in 1992 has been influential).

28. *See* Halfmann, *supra* note 26, at 187.

29. *See* Davis, *supra* note 24, at 51.

30. *Id.*

31. *Id.*

32. *See* Halfmann, *supra* note 26, at 187.

analyzed the phenomenon of demedicalization, which scholars simply define as the obverse of medicalization.[33]

Although many scholars assert that medicalization is value neutral, in that it merely describes a social process, most literature on medicalization assumes the process is socially harmful.[34] Scholars in many disciplines, particularly in medical sociology, often view medicalization suspiciously.[35] Critics generally understand medicalization as an effort to exert the hierarchy of the physician/patient relationship and to advance the hegemony of Western biomedicine.[36] In this view, medicalization pathologizes normal human conditions in order for institutions of medicine to assert control over targeted populations—for example in the case of the medicalization of childbirth.[37] Furthermore, medicalization tends to deflect attention away from structural forms of oppression and ascribe social problems to individual failures requiring individual clinical solutions.[38] As one very early scholar critiquing medical expansionism exhorted, "[a]lways it is easier to put up a clinic than to pull down a slum."[39] Thus, traditional forms of medicalization focused on individualized clinical interventions requiring a physician's oversight, as opposed to modern public health approaches that seek systemic solutions to address population level health disparities.

In the early 1960s, French philosopher Michel Foucault's analysis of power dynamics in modern societies included a critique of the "medical gaze," a process of medicalization that lifted biomedical and physician control over patients.[40] In the late 1960s, medical sociologists including Eliot Freidson and Irving Zola continued critiques of medicine's expansionist tendencies, emphasizing how medicalization operates as a means of social control.[41] In the 1980s, Peter Conrad and

33. *See id.* Halfmann argues that medicalization and demedicalization should be understood in more nuanced ways, including that both processes can occur simultaneously and that scholars should "conceptualize medicalization in terms of an increase or decrease rather than a presence or absence." *Id.* at 189.

34. Erik Parens, *On Good and Bad Forms of Medicalization*, 27 BIOETHICS 28, 28–29 (2013).

35. *Id.* at 29.

36. Davis, *supra* note 24, at 56; Halfmann, *supra* note 26, at 190.

37. Davis, *supra* note 24, at 53.

38. *Id.* at 52.

39. *Id.* (quoting BARBARA WOOTTON, SOCIAL SCIENCE & SOCIAL PATHOLOGY 329 (1959)).

40. MICHEL FOUCAULT, THE BIRTH OF A CLINIC: AN ARCHEOLOGY OF MEDICAL PERCEPTION 9 (1963); *see also* Webb & Matthew, *supra* note 4, at 589 (briefly summarizing history of medicalization critiques).

41. Davis, s*upra* note 24, at 51.

Joseph Schneider described and critiqued how "[d]eviant behaviors that were once defined as immoral, sinful, or criminal have been given medical meaning" and taken to be "properly under medical social control."[42]

Much literature on medicalization follows this pattern of critique. In particular, critics argue that medicalization mistakenly converts normal human states into medical problems with negative consequences. The negative consequences include: focusing on human beings as objects of medical interventions rather than subjects with agency, increasing medical costs, and diverting resources away from changing larger social structures that are the root cause of health or other social problems.[43] Those who criticize medicalization argue that it "crowd[s] out attention to structural inequities that characterize the social determinants of poor health" and operates to "create an abusive power structure of control by physicians over patients."[44]

In contrast, some feminist and bioethics scholars have described medicalization as having both "good" and "bad" forms, either by imposing medical professional control over normal occurrences (such as childbirth) or in contrast by encouraging welfare-enhancing reforms.[45] For example, Erik Parens argues that bioethicists should be more explicit in their analysis to "get over the traditional assumption that medicalization is bad *per se*, and try to articulate the difference between good and bad forms of it."[46] In Parens' framing, some forms of medicalization constitute "over-medicalization" (which he argues is bad) while other issues are simply medicalized (which he argues might

42. PETER CONRAD & JOSEPH W. SCHNEIDER, DEVIANCE AND MEDICALIZATION: FROM BADNESS TO SICKNESS 2, 9 (1980); *see also* Catherine Kohler Riessman, *Women and Medicalization: A New Perspective*, 14 SOC. POL'Y 3 (1983) (describing medicalization as referring to both a definitional and a jurisdictional process whereby a social problem is given a medical meaning and jurisdictionally medicine takes over social control typically from religion or law); *see also* PETER CONRAD, THE MEDICALIZATION OF SOCIETY: ON THE TRANSFORMATION OF HUMAN CONDITIONS INTO TREATABLE DISORDERS 4–9 (2007); Nikolas Rose, *Beyond Medicalisation*, 369 LANCET 700, 701 (2007) (arguing that "medicalisation, implying the extension of medical authority beyond a legitimate boundary, is not much help in understanding how, why, or with what consequences these mutations have occurred").

43. *See* Parens, *supra* note 34, at 29–30.

44. Webb & Matthew, *supra* note 4, at 589–90.

45. *See id.* at 589; Parens, *supra* note 34, at 33; Laura Purdy, *Medicalization, Medical Necessity, and Feminist Medicine,* 15 BIOETHICS 248, 249 (2001).

46. Parens, *supra* note 34, at 29. Nikolas Rose argues that medicalization is an inherently ambiguous term: "The term medicalization obscures the differences between placing something under the sign of public health . . . placing something under the authority of doctors . . . and placing something within the field of molecular psychopharmacology . . . ." Rose, *supra* note 42, at 701.

be good).[47] Feminist scholars have also noted that "charges of medicalization can obscure as well as illuminate."[48] For example, many feminists have "lamented the medicalization of everything from childbirth, to menstruation to menopause" out of concern that "by bringing ever more normal features of women's bodies and lives within the purview of medicine, disease mongers diminish women's power to control their own bodies . . . ."[49] Nevertheless, some feminist scholars also emphasize how medical technologies help women gain control over their lives and "promote their own flourishing."[50] For example, fertility control through medical contraceptives "counts as a good form of medicalization" since these technologies foster women's social and economic well-being.[51] Thus, feminist scholars have argued that medicalization is neither inherently oppressive nor liberatory, but holds both promise and peril.[52]

B. Medicalization, Professionalization, and the Early History of Abortion Regulation

Related to scholarship on medicalization, theories about the rise and fall of physicians' professional dominance provide a useful angle on the links between medicalization, law, and abortion rights. The processes of medicalization and demedicalization of abortion in the law has traveled with the trajectory of the rise and fall of physicians' professional dominance in the U.S.[53]

Medicalization theory often depicts institutionalized medicine as seeking to expand its own domain by taking social control away from another domain, such as law or religion.[54] Pre-*Roe* v. *Wade abortion* provides an empirical example of law and medicine not in conflict, but

47. Parens, *supra* note 34, at 29.

48. Purdy, *supra* note 45, at 257.

49. Parens, *supra* note 34, at 33; *see, e.g.*, KHIARA BRIDGES, REPRODUCING RACE: AN ETHNOGRAPHY OF PREGNANCY AS A SITE OF RACIALIZATION 24 (2011) (arguing that medicalization serves as a tool of social control over poor pregnant people).

50. Parens, *supra* note 34, at 33.

51. *See id.*

52. *See, e.g.*, Purdy, *supra* note 45 (noting feminist critiques of medicalization of normal events in women's lives and medicalization as a means of social control, but also arguing that feminists should use medicalization for empowerment); Riessman, *supra* note 42, at 59 (contending that medicalization "is part of the problem and of the solution . . . As women have tried to free themselves from control that biological processes have had over their lives, they simultaneously have strengthened the control of a biomedical view of their experience.").

53. *See generally* Drew Halfmann, *Political Institutions and the Comparative Medicalization of Abortion*, 60 J. HEALTH & SOC. BEHAVIOR 138 (2019).

54. *See* Davis, *supra* note 24, at 52.

instead working in concert to exercise social control particularly over marginalized groups of women. Pre-*Roe v. Wade*, medicalization and criminalization worked as combined forces to assert power in a way that aggrandized both the domains of law and medicine to the detriment of women and pregnant people.[55] Since the early 19th Century, the battle over abortion has been a three-way struggle between medicine, law, and women and pregnant people's interests in reproductive autonomy.[56] In that ongoing struggle for control, pregnant people appear to lose in every era—especially less affluent people and people of color.[57]

Generally speaking, laws regulating abortion care in the U.S. target health care providers for punishment, not patients.[58] As the targets of criminal punishment, physicians have had an especially strong stake in the law's approach to regulating abortion care.[59] Furthermore, debates about abortion served as a means for the medical profession to establish professional sovereignty more widely across society.[60] Historically, physicians' push for professional sovereignty has been a driver of medicalization, especially in the context of women's reproduction.[61] The early history of abortion regulation shows how physicians' efforts at professionalization instigated the medicalization of reproductive health care.[62] Yet, this early history also demonstrates that medicalization and criminalization can operate in complementary rather than contradictory ways, with poor women and women of color caught in the cross hairs.[63]

In the United States, the legal regulation of abortion has shifted dramatically between deference to physicians who offer abortion care,

55. *See generally* Linda Greenhouse & Reva B. Siegel, *Before (and After)* Roe v. Wade*: New Questions About Backlash*, 120 YALE L. J. 2028 (2011).

56. *See* REVA SIEGEL & LINDA GREENHOUSE, BEFORE ROE V. WADE: VOICES THAT SHAPED THE ABORTION DEBATE BEFORE THE SUPREME COURT'S RULING (2010); MARY ZIEGLER, AFTER ROE: THE LOST HISTORY OF THE ABORTION DEBATE (2015) [hereinafter AFTER ROE].

57. Ederlina Co, *Abortion Privilege,* 74 RUTGERS U. L. REV. 1, 16–22, 48–53 (2021).

58. *Targeted Regulation of Abortion Providers*, GUTTMACHER INST. (Aug. 31, 2023) https://www.guttmacher.org/state-policy/explore/targeted-regulation-abortion-providers [https://perma.cc/2R77-K9RF]; *see, e.g.*, 2 Ill. Comp. Stat. Ann. 34/5 (West 2023) (criminalizing a provider's failure to report a provided abortion).

59. *See id.*

60. FREEDMAN, *supra* note 17, at 9–13.

61. *See* Halfmann, *supra* note 26, at 193.

62. *See id.* at 192–93.

63. *See id.* at 200–02; Michele Goodwin, *The Racist History of Abortion and Midwifery Bans*, ACLU (July 1, 2022), https://www.aclu.org/news/racial-justice/the-racist-history-of-abortion-and-midwifery-bans [https://perma.cc/GEP6-RP38].

to a high level of regulation over abortion providers.[64] Legal regulation of abortion has expanded and contracted like a rubber band, from the largely deregulatory environment of the early 19th Century, to extensive criminalization in the mid-19th Century until the mid-20th Century, back to a deregulatory environment after *Roe v. Wade* in 1973, and finally a return to increased regulation of abortion care beginning in the 1980s.[65] As numerous scholars have noted, Justice Alito's recounting of the legal history of abortion in *Dobbs* misses this nuance.[66]

Much of this legal history of abortion is closely tied to the history of the rise and fall of the medical profession in the United States and the corresponding medicalization of reproductive health care.[67] Sociological scholarship on the professionalization of medicine describes how physicians established professional sovereignty and dominance beginning in the 19th Century, and how that dominance eroded over the course of the late 20th Century.[68] Physicians' sought professional sovereignty through the medicalization of phenomena, such as abortion and childbirth, that had historically been governed by other experts.[69] In the early 19th Century, abortion before "quickening" (when the pregnant person first feels fetal movement, usually at about five months) was readily available.[70] During the last half of the 19th Century, formally trained physicians pushed to change the law on abortion.[71] Beginning in the late 1850s, the organized efforts of the recently formed American Medical Association (AMA) resulted in criminal abortion

64. *See* AFTER ROE, *supra* note 56; s*ee also Targeted Regulation of Abortion Providers*, *supra* note 58.

65. *See* AFTER ROE, *supra* note 56; *See* MARY ZIEGLER, ABORTION AND THE LAW IN AMERICA: ROE V. WADE TO THE PRESENT (2020) [hereinafter ABORTION AND THE LAW].

66. *See, e.g.*, Reva B. Siegel, *Memory Games: Dobbs's Originalism As Anti-Democratic Living Constitutionalism—and Some Pathways for Resistance*, 101 TEX. L. REV. 1127 (2023).

67. *See* Halfmann, *supra* note 26, at 192–93.

68. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 79 (1982); John B. McKinlay & Lisa D. Marceau, *The End of the Golden Age of Doctoring*, 32 INT'L J. HEALTH SERVS. 379, 381 (2002); FREEDMAN, *supra* note 17 (providing a short summary on theories of the rise and fall of the medical profession as it relates to abortion regulation).

69. *See* Halfmann, *supra* note 26, at 192–93.

70. *See* FREEDMAN, *supra* note 17, at 10.

71. Halfmann, *supra* note 26, at 192–96 (reviewing early history of abortion regulation); *see also* Shelley A. M. Gavigan, *Women, Law and Patriarchal Relations*, *in* THE SOCIAL DIMENSIONS OF LAW 101, 107 (1986); KRISTIN LUKER, ABORTION AND THE POLITICS OF MOTHERHOOD 14–16 (1984); JAMES MOHR, ABORTION IN AMERICA 147 (1978); LESLIE J. REAGAN, WHEN ABORTION WAS A CRIME: WOMEN, MEDICINE, AND LAW IN THE UNITED STATES, 1867-1973 10–11 (1997).

laws.[72] The AMA's work around abortion was part of an attempt to professionalize physicians and seize control over lucrative work from midwives.[73] In particular, the AMA saw abortion regulation as a way to enhance their own professional authority.[74] The AMA's campaign to criminalize abortion offered numerous benefits to the profession: it positioned "physicians as morally and scientifically informed vis-à-vis pregnant women," "legitimized physicians as moral authorities about female sexuality and reproduction," and "put them on the side of the law, further delegitimizing the competing health practitioners they wished to displace" (such as midwives), and "it strengthened the budding medical profession by increasing the health territory under its purview."[75]

By 1900, almost every state had criminalized abortion at all stages of pregnancy, but most state laws included a therapeutic exception, allowing physicians to perform abortion care to preserve the health of a pregnant woman.[76] Since the physicians could interpret these exceptions broadly to include physical and mental health, criminalization of abortion meant that physicians now exercised discretion and control over whether women could obtain a legal abortion.[77] As one scholar of medicalization and abortion notes, criminalization of abortion "both increased and decreased medicalization" at the same time.[78] Doctors' monopoly over therapeutic abortions increased medicalization, while criminalization expanded law's jurisdiction over midwives and women who self-induced their own abortion.[79]

Thus, ironically, in urging the criminalization of abortion, the AMA achieved greater authority for the medical profession. Criminalization took abortion care out of the hands of women patients and their midwives and into the expertise of physicians along with the law.[80] Since after criminalization women who sought abortion care now needed permission from physicians on special hospital committees that could

72. MOHR, *supra* note 71; *see also* Halfmann, *supra* note 26, at 193.

73. *See* Melissa Murray, *Race-ing* Roe*: Reproductive Justice, Racial Justice, and the Battle for* Roe v. Wade, 134 HARV. L. REV. 2025, 2035 (2021).

74. *Id.*

75. FREEDMAN, *supra* note 17, at 10.

76. Jennifer L. Holland, *Abolishing Abortion: The History of the Pro-Life Movement in America*, ORG. AM. HISTORIANS (Dec. 24, 2023), https://www.oah.org/tah/november-3/abolishing-abortion-the-history-of-the-pro-life-movement-in-america/ [https://perma.cc/E4QL-4UXH].

77. *See id.*

78. Halfmann, *supra* note 26, at 193.

79. *Id.* at 196.

80. Murray, *supra* note 73, at 2035.

authorize "therapeutic" abortion care, physicians also exerted much greater control over *which* women had access to safe and legal abortion care.[81] The only way for a woman to obtain legal abortion care was by persuading a group of physicians on the committee that she needed an abortion for health reasons.[82] In the pre-*Roe* era of criminalization, physician's control over legal abortion care resulted in less affluent and racial minorities disproportionately suffering injuries or death from illegal abortion, since often only wealthier, white women had the resources to obtain permission from hospital committees for legal abortion care.[83] In sum, during this period in history: "Men 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 controlling birth, each acting to preserve life in the social order as they knew it."[84] Thus, physicians used criminalization for their own ends to expand medicine's power.[85]

Racism also played an important role in these power shifts. Historians of medicine have excavated the racist origins of physician control over reproductive healthcare.[86] Midwifery providers were interracial, including white, Native American, and Black women.[87] In fact, in the nineteenth century, half of the women providing reproductive health care through midwifery were Black women.[88] Physicians "pushed women out of the field of reproductive health by lobbying state legislatures to ban midwifery and prohibit abortions. Doing so not only undercut women's reproductive health, but also drove qualified Black women out of medical services."[89] Since the AMA barred women and Black people from membership, the AMA's anti-abortion efforts furthered both racial and gender oppression.[90] Typically,

81. REAGAN, *supra* note 71, at 173 (describing hospital committee abortion care in the pre-*Roe* era).

82. FREEDMAN, *supra* note 17, at 12.

83. *Id.* at 12.

84. *Reasoning From the Body*, *supra* note 15, at 318.

85. *Health Care Rights*, *supra* note 19, at 510–12.

86. *See, e.g.*, DEIDRE COOPER OWENS, MEDICAL BONDAGE: RACE, GENDER, & THE ORIGINS OF AMERICAN GYNECOLOGY (2017).

87. *A Brief History of Midwifery in America*, OREGON HEALTH & SCI. UNIV., https://www.ohsu.edu/womens-health/brief-history-midwifery-america [https://perma.cc/Y3WL-DBY5].

88. Goodwin, *supra* note 63.

89. *Id.*

90. *See id.*; *see also* Deleso A. Alford, *A Call for Medical Students to Learn the Full Story About the "Father of Gynecology,"* HASTINGS CTR. (Oct. 5, 2017), https://www.thehastingscenter.org/call-medical-students-learn-

medicalization is seen as a one-way expansionary move, by moving something into the jurisdiction of medicine and out of the jurisdiction of law.[91] Institutional jurisdiction in medicalization theory is usually understood as mutually exclusive—either medicine has primary social control over the topic or law possesses that control.[92] Contrary to this theorizing about medicalization, the early history of abortion law shows that medicalization and criminalization are not necessarily always in conflict with each other.[93] In the pre-*Roe* era, the legal and medical systems were working together to limit women's autonomy, suggesting a more complicated three-way dynamic at play in the abortion context between law, medicine, and women's reproductive autonomy. Furthermore, this history indicates that the medical profession benefited by working with the legal profession rather than struggling against law's domain.

The early history of the criminalizing abortion care also shows how a phenomenon can be both criminalized and medicalized at the same time in a stratified manner.[94] Physicians worked with the legal profession to both criminalize abortion and coopt abortion care as a vehicle to expand their professional authority, leading to much more restricted access to abortion especially for poor women and women of color.[95] Given this history, feminist skepticism towards medicalizing abortion rights is understandable.

Yet, as physicians altered their view of abortion from one of gender deviant behavior towards understanding abortion as a medical solution to a public health crisis, physicians once again helped to drive changes

full-story-father-gynecology/ [https://perma.cc/7492-D47Z] (on racist history behind obstetrics).

91. *See* Davis, *supra* note 24, at 51.

92. Peter Conrad's well-known analysis of the medicalization of deviance is also a useful theoretical tool to understand the early history of abortion law. CONRAD & SCHNEIDER, *supra* note 42, at 28–37; *see also* Peter Conrad, *The Shifting Engines of Medicalization*, 46 J. HEALTH & SOC. BEHAV. 3, 3–14 (2005). The medicalization of deviance refers to "how medical definitions of deviant behavior are becoming more prevalent in modern industrial societies like our own." CONRAD & SCHNEIDER, *supra* note 42, at 28–29. Conrad is not just concerned with the medicalization of normal biological processes, such as childbirth, but more specifically with the medicalization of deviance ("the transformation of deviance from *badness* to *sickness*") and the turn to manage deviance through the medical profession rather than through law or religion. *Id.* As Conrad explains, over time "the jurisdiction of the medical profession has expanded and encompasses many problems that formerly were not defined as medical entities." *Id.* at 29.

93. *See* REAGAN, *supra* note 71, at 8–10.

94. *See id.* at 10.

95. *See id.* at 10–11.

in the law.[96] What had been considered deviant behavior appropriately subject to criminal punishment unless a physician authorizes care, became an issue of public health to be exclusively managed by physicians.[97] The shift to decriminalizing abortion and instead to primarily medicalize it is most evident in *Roe v. Wade*.[98]

II. THE TRAJECTORY OF MEDICALIZATION AND DEMEDICALIZATION IN ABORTION JURISPRUDENCE

This Part excavates the trajectory of medicalization in abortion jurisprudence and analyzes where it pivots and with what consequences. A look through several landmark abortion cases—from *Roe* to *Casey* to *Dobbs*—reveals how the Court reconceptualized abortion over time from being medicalized to demedicalized with corresponding shifts in who exercises social control over abortion decisions.[99] In the decades since *Roe*, abortion has become increasingly stigmatized and isolated from the rest of women and pregnant people's health care.[100] While feminist critiques of *Roe*'s medical model of abortion had validity, the law has now shifted to the opposite extreme of severing abortion completely from the realm of health care.[101] Today, the law fails to treat abortion as medical care at all.[102] Numerous laws and policies illustrate the

96. *See id.* at 218–20.

97. *See id.* at 221–22.

98. *See id.* at 244.

99. This Part focuses on the legal opinions' construction of abortion as medical or not and the corresponding legal consequences of those framings, rather than looking upstream to explain how the Court came to medicalize or demedicalize abortion. *See, e.g.*, ABORTION AND THE LAW, *supra* note 65; *Health Care Rights*, *supra* note 19 (noting that multiple legal scholars have analyzed the claims-making of different groups that occurred before, during, and after *Roe v. Wade,* that helped to shape whether and how abortion is medicalized in the law).

100. *See* Lori Freedman et al., *Obstacles to the Integration of Abortion Into Obstetrics and Gynecology Practice*, 42 PERSPS. ON SEXUAL & REPROD. HEALTH 146, 146 (2010) ("Since legalization, abortion services have increasingly become consolidated into the socially insulated settings of specialized abortion clinics.").

101. Lisa C. Ikemoto, *Abortion, Contraception and the ACA: The Realignment of Women's Health*, 55 HOW. L. J. 731, 762–64 (2012).

102. *See* Rachel Rebouché & Karen Rothenberg, *Mixed Messages: The Intersection of Prenatal Genetic Testing and Abortion*, 55 HOW. L. J. 983, 1006 (2012) (noting that the ACA typifies this view, covering prenatal screening and testing as essential healthcare but excluding and segregating abortion coverage); *Rhetoric of Choice*, *supra* note 21, at 389–90 ("Thus case law, legislation, and policy in the area of abortion are all coalescing around the same idea that abortion is a right of choice but is not healthcare.").

isolation of abortion from the rest of women's healthcare, which has contributed to its stigmatization.[103] For example, excluding abortion from healthcare coverage, as the Affordable Care Act (ACA) does, "underscores the perception that abortion services, unlike [prenatal] testing services, have *no relation* to protecting women's physical or mental health."[104] The ACA has also spawned new state laws that prevent private insurers from offering abortion coverage on state exchanges.[105] The Hyde Amendment similarly prohibits federal Medicaid funding for abortion care for poor women, except where the pregnancy resulted from rape, incest, or will endanger the woman's life.[106] Abortion is the only medical care exempted from federal Medicaid funding.[107] In addition, a series of other federal laws allow healthcare providers and entities to refuse to perform or assist with abortion care, to provide or arrange training for such care, or to refer patients to abortion care.[108] In sum, "[a]s a matter of national health policy, abortion services have been severed and isolated from women's health."[109] This demedicalization of abortion has corresponded with decreased access to abortion care.

103. *See* Carole Joffe & Willie J. Parker, *Race, Reproductive Politics and Reproductive Health Care in the Contemporary United States*, 86 CONTRACEPTION 1, 2 (2012) (noting that isolation of abortion from healthcare contributes to its stigmatization and to conspiracy theories of racial eugenics).

104. Rebouché & Rothenberg, *supra* note 102, at 1007; Ikemoto, *supra* note 101, at 755 ("As a matter of federal health law and policy, abortion and the women who choose it barely exist.").

105. Ikemoto, *supra* note 101, at 761.

106. Consolidated Appropriations Act, 2010, Pub. L. No. 111-117, §§ 507–08, 123 Stat. 3280 (2009) (The Hyde Amendment was first passed in 1976 as the Departments of Labor and Health, Education, and Welfare Appropriations Act, Pub. L. No. 94-439, § 209, 90 Stat. 1434 (1976), and it has been reauthorized by each Congress since then, although the exact scope and wording of the exceptions have shifted over time).

107. Ikemoto, *supra* note 101, at 760; *see also* NAT'L NETWORK OF ABORTION FUNDS, *Understanding The Hyde Amendment: An FAQ*, (Sept. 30, 2016), https://abortionfunds.org/understanding-the-hyde-amendment-an-faq/#:~:text=NNAF%20Is%20Working%20to%20Repeal,legislation%20like%20the%20EACH%20Act%20. [https://perma.cc/GB7U-AG2W] (explaining the Hyde Amendment's effect on Medicaid coverage for abortion).

108. Ikemoto, *supra* note 101, at 759 (describing a variety of federal laws and policies that allow for refusals by institutions and providers, including the Church Amendments and the Weldon Amendment); *see also* Dov Fox, *Medical Disobedience*, 136 HARV. L. REV. 1030, 1039–50 (2022).

109. Ikemoto, *supra* note 101, at 762–63 (noting that this narrowing of the scope of women's health will have devastating consequences because federal health policy omits a procedure that an estimated three in ten American women will have by age forty-five).

Many legal feminists have critiqued *Roe v. Wade* as overly medicalizing abortion care and centering the physician's decision-making power over women. However, in practice *Roe* served to provide strong protection for women's decision-making autonomy, although affluent women benefitted more from *Roe*'s privacy rationale. In contrast, as abortion became demedicalized in legal discourse and rhetorically shifted decision-making power from physicians to women, women began to experience lesser decision-making authority and more restricted access to abortion care.[110]

This Part argues that, in *Roe* and its progeny, medicalization helped to protect abortion rights by rhetorically sheltering women's abortion decision-making within the trusted authority of physicians. In *Casey,* as the Court demedicalized and resituated abortion as a moral decision that must be made by the woman herself, women simultaneously received more legal oversight and fewer legal rights to make abortion decisions autonomously. Thus, the demedicalization of abortion in legal discourse corresponds with a transfer of power away from both physicians *and* women and into the hands of legal professionals, particularly legislators and judges. While these rhetorical shifts of course reflected the more conservative composition of the Supreme Court, these shifts also illustrate the potential benefits of medicalized framings of abortion now that the case for abortion rights must be made to voters and policymakers in the post-*Dobbs* policy environment.

A. Medicalization in Roe v. Wade

In the landmark 1973 ruling, *Roe v. Wade*, the Supreme Court held that state bans on access to abortion care violated a woman's constitutional rights under the Due Process Clause of the Fourteenth Amendment.[111] The Court grounded its decision in a line of "privacy" cases, which recognized the right of the individual to make decisions with respect to "marriage, procreation, contraception, family relationships, and child rearing and education."[112] The Court concluded that these rights of privacy in family life encompassed the right of a woman to decide whether to carry her pregnancy to term. In the

110 *See, e.g.*, *Rhetoric of Choice*, *supra* note 21, at 388 (arguing that the Supreme Court's abortion jurisprudence increasingly identified abortion as a right of choice uncoupled from meaningful access to the healthcare needed to exercise that right); D. Hunter, *Justice Blackmun, Abortion, and the Myth of Medical Independence*, 72 BROOK. L. REV. 147, 179 (2006); Linda Greenhouse, *Democracy and the Courts: The Case of Abortion*, 61 HASTINGS L. J. 1333, 1336 (2010) (describing rhetorical shifts in abortion jurisprudence from *Roe* to *Casey*).

111. Roe v. Wade, 410 U.S. 113, 130–31 (1973).

112. *Id.* at 152–53.

decades following *Roe,* the Court's reasoning, rhetoric, and rules on the constitutional right to abortion shifted dramatically.

Roe provided extensive protection for women's constitutional right to abortion.[113] The opinion declared that the right to abortion is a "fundamental right," a legal term of art meaning that states could restrict access to abortion only where there is a compelling state interest.[114] The Court established a strict trimester-based framework for state regulation of abortion, holding that government only has a compelling interest in regulating abortion beginning in the second-trimester.[115] Thus, states could enact almost no restrictions on abortion during the first-trimester; could enact restrictions necessary to protect maternal health in the second-trimester; and could ban abortion entirely in the third trimester but must make exceptions to protect maternal life and health.[116]

Despite this broad legal protection for the abortion right, *Roe's* rhetoric unfortunately did not evince much respect for women's decision-making capacity.[117] Instead, the Court characterized the abortion decision as belonging primarily to the physician rather than the patient.[118] One oft-heard criticism of *Roe* is that it overemphasized abortion as a medical decision and the physician's role in that decision.[119] Feminist scholars have amply and compellingly critiqued *Roe*'s medicalization of abortion decision-making as undermining women's agency and reinforcing gender inequalities.[120]

Many feminists criticized *Roe* for empowering physicians rather than women.[121] For example, in establishing abortion as a fundamental

113. *Id.*

114. *Id.* at 155.

115. *Id.* at 163.

116. *Id.* at 163–65. Note that the Court defined "health" for the health exception requirement very broadly in this era. *See* Doe v. Bolton, 410 U.S. 179 (1973). *Doe v. Bolton* also adopted a medicalized framing of abortion, repeatedly comparing abortion to other surgeries and emphasizing deference to physicians' medical judgment on a range of issues including emotional and psychological health. *See id.*; *Health Care Rights*, *supra* note 19, at 508–09.

117. *See Reasoning From the Body*, *supra* note 15.

118. *Id.*

119. *Id.*

120. *Health Care Rights*, *supra* note 19 (describing feminist critiques); *Reasoning From the Body*, *supra* note 15; Serena Mayeri, *Undue-ing Roe: Constitutional Conflict and Political Polarization in* Planned Parenthood v. Casey *in* REPRODUCTIVE RIGHTS AND JUSTICE STORES 150 (Melissa Murray, Katherine Shaw & Reva B. Siegel eds., 2019).

121. *See Health Care Rights*, *supra* note 19; *see also Reasoning From the Body*, *supra* note 15.

constitutional right, *Roe* stated that the "decision vindicates the right of the physician to administer medical treatment according to his professional judgment."[122] The Court's rhetoric repeatedly placed less emphasis on the woman's interest in the decision and greater emphasis on the physician's involvement.[123] The Court stressed that abortion law should respect the *physician*'s medical judgment in making the decision to terminate a pregnancy: "[T]he attending physician, in consultation with his patient, is free to determine, without regulation by the State, that, in *his* medical judgment, the patient's pregnancy should be terminated."[124] The Court described the abortion decision as "in all its aspects [] inherently, and primarily, a *medical decision*, and basic responsibility for it must rest with the *physician*."[125]

Regardless of these feminist critiques, under the constitutional rules established in *Roe v. Wade*, the law generally treated women as entitled to autonomy in their abortion decision-making similar to other patients.[126] Despite *Roe*'s paternalistic rhetoric, *de facto* women retained ultimate decision-making authority over abortion and *Roe* provided strong protection against legal prohibitions of women's abortion decisions (although it failed to protect against denial of insurance coverage).[127]

In *Roe*, medicalization served to shelter women's autonomy over their abortion decision-making from legal encroachment, since rhetorically the Court situated the decision comfortably within the trusted authority of physicians.[128] As the medical sociologist Lori

122. Roe v. Wade, 410 U.S. 113, 165–66 (1973).

123. *Id.* at 153 ("All these factors [discussed above] the woman and her responsible physician necessarily will consider in consultation.").

124. *Id.* at 163, 164 (emphasis added) (holding that until the end of the first trimester "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician.").

125. *Id.* at 166 (emphasis added). *Roe* also relied on rationales about the effects of carrying unwanted pregnancies to term that were framed as being public health issues. *Id.*

126. *See Rhetoric of Choice*, *supra* note 21.

127. *Id.* at 388–89 (reviewing feminist criticisms of *Roe*'s medical model and arguing that "paradoxically, because the medical model situated abortion in the context of healthcare, the Court was more willing to protect access to abortions services and articulated the abortion right as the decisional right to *obtain* abortion-related healthcare.").

128. *See id.* at 396–404 (analyzing cases under the *Roe* medicalized framework and arguing that "it was because the Court characterized abortion as healthcare that it was able to reject attempts to replace the judgment of healthcare providers with the political agenda of the legislature and protect the right of providers to deliver abortion services free of legislative agendas"). Lindgren argues that the healthcare framing of abortion operated to link the right to abortion with access to healthcare, rather

Freedman has noted, "Ironically, although *Roe* legally located abortion rights under the authority of the physician, in practice, legalization meant that physicians would largely relinquish their role in the decision-making process around abortion, and the moral authority would become that of the pregnant woman herself."[129]

While the *Roe* opinion medicalized abortion rhetorically, its impact was more complicated. *Roe* both medicalized and demedicalized abortion at different levels of analysis.[130] While *Roe* clearly adopted medical discourses at a conceptual level, the decision itself demedicalized abortion care at the institutional and individual levels by reducing medical gatekeeping for early abortion care and allowing abortion care "on demand."[131] At the same time, *Roe* maintained the therapeutic exception for third trimester abortion care and expanded doctors' discretion in exercising this exception in *Doe v. Bolton*.[132] Medicalization and demedicalization could be parsed out more finely throughout the Supreme Court's abortion jurisprudence, with instances of both occurring simultaneously.[133] Yet, focusing on the Court's conceptualization of abortion as largely medicalized or demedicalized illuminates how different framings of abortion correspond with different legal regimes on abortion—and in particular that the Court has only granted broad legal rights to access abortion care when the decision is framed as belonging to medical experts.

Although *Roe*'s medicalized framing led to very limited legal oversight of women's abortion decisions, it failed to protect access to abortion care for poor women and women of color. Litigation over the

than merely being a right of "choice" even if abortion care remained inaccessible in reality. *Id.*

129. FREEDMAN, *supra* note 17, at 13.

130. *See* Halfmann, *supra* note 26, at 196.

131. *Id.* at 192.

132. *Id.* at 190–92, 201 (explaining typology of medicalization at macro, meso, and micro levels of analysis and through discourses, practices, and actors, and noting that lack of clarity on which aspect of medicalization is being analyzed leads scholars to examine the same events but disagree on whether the events constitute medicalization or demedicalization); *see also* CAROLE JOFFE, THE REGULATION OF SEXUALITY: EXPERIENCES OF FAMILY PLANNING WORKERS (1986); CAROLE JOFFE, DOCTORS OF CONSCIENCE: THE STRUGGLE TO PROVIDE ABORTION BEFORE AND AFTER ROE V. WADE (1995); Carole Joffe et al., *Uneasy Allies: Pro-Choice Physicians, Feminist Health Activists and the Struggle for Abortion Rights*, 26 SOCIO. HEALTH & ILLNESS 775 (2004) (arguing that the Court medicalized abortion in its justification for abortion rights, but after *Roe* freestanding clinics dedicated to abortion care demedicalized abortion by separating abortion from mainstream medicine and challenging norms of professional medicine) [hereinafter *Uneasy Allies*].

133. Halfmann, *supra* note 26, at 197–98.

Hyde Amendment highlighted the limits of *Roe*'s privacy framework in this regard.

B. Race, Class, Gender, and Demedicalization in Maher v. Roe and Harris v. McRae

Roe's reliance on the doctrine of "privacy" left low-income women and women of color without much protection against encroachments on abortion rights.[134] In *Maher v. Roe* and *Harris v. McRae,* the Court upheld limits on public health insurance coverage for abortion care for low-income women.[135] *Maher* upheld a state's limits on public insurance coverage for abortions that were deemed not medically necessary.[136] *Harris v. McRae* upheld the Hyde Amendment, which bars federal health insurance coverage for "medically necessary" abortions with very narrow exceptions.[137] Both cases cemented abortion as a right which the government could not significantly regulate but need not support, despite the disparate impact of unequal insurance coverage for abortion care on low income people and people of color.

Maher upheld a Connecticut regulation denying coverage for abortion care unless a doctor deemed the abortion "medically necessary."[138] The Court held that the law did not violate the Equal Protection Clause or the right of privacy under the Due Process Clause.[139] *Maher* brushed aside evidence before the Court on the disparate impact of the law on indigent women and women of color.[140] The Court declared:

> The Connecticut regulation places no obstacles -- absolute or otherwise -- in the pregnant women's path to an abortion. An indigent woman who desires an abortion suffers no disadvantage as a consequence of [Connecticut's law] . . . she continues as before to be dependent on private sources for the service she desires.[141]

134. Jeanie Gersen, *Why the Privacy Wars Rage On*, NEW YORKER, (June 20, 2022), https://www.newyorker.com/magazine/2022/06/27/why-the-privacy-wars-rage-on-amy-gajda-seek-and-hide-brian-hochman-the-listeners [https://perma.cc/FLT3-Z8ER].

135. Maher v. Roe, 432 U.S. 464, 480 (1977); Harris v. McRae, 448 U.S. 297, 322 (1977).

136. *Maher*, 432 U.S. at 466.

137. *Harris*, 448 U.S. at 322.

138. *Maher*, 432 U.S. at 465.

139. *Id.* at 479–80.

140. Ederlina Co, Maher v. Roe, *432 U.S. 464 (1977)*, *commentary in* FEMINIST JUDGMENTS: REPRODUCTIVE JUSTICE REWRITTEN (Kimberly M. Mutcherson ed., 2020).

141. *Maher*, 432 U.S. at 474.

Similarly, in *Harris,* the Court asserted that the government was not responsible for the indigence that might impede a woman's access to abortion care; therefore, the Hyde Amendment did not infringe any constitutional rights.[142]

In both *Maher* and *Harris,* in contrast to *Roe*, the Court refused to frame abortion as needed healthcare. The Court framed abortion as simply a "right of choice" for the woman decoupled from access to healthcare.[143] Through this demedicalized lens, the Court positioned the government's exclusion of abortion from public health insurance as a permissible exercise in resource allocation to encourage childbirth, even though childbirth is significantly more expensive than abortion.[144] Furthermore, in both cases, the Court ignored that denying public health insurance coverage for abortion would disparately impact poor women and women of color.[145]

The reasoning in *Maher* and *Harris* continues to have impacts today. The Affordable Care Act similarly siloes abortion from healthcare and permits both public and private insurance to exclude coverage for abortion—further demedicalizing abortion in the law.[146]

C. Demedicalization in Planned Parenthood v. Casey

As the composition of the Supreme Court shifted to the right, the Court began signaling a more relaxed standard for judicial scrutiny of abortion restrictions, which came to fruition in *Planned Parenthood v. Casey.*[147] *Casey* dramatically changed the landscape of abortion law and set forth the basic test for abortion regulation that is still the law today.[148] The *Casey* joint opinion rejected both the trimester framework and the compelling state interest test set forth in *Roe*, instead declaring that the state had an interest from the outset of pregnancy in protecting

142. *Harris*, 448 U.S. at 310; AFTER *ROE*, *supra* note 56, at 122 (discussing *Harris v. McRae*).

143. *Rhetoric of Choice*, *supra* note 21, at 396–98.

144. *Id.* at 397.

145. Khiara Bridges, *Elision and Erasure: Race, Class, and Gender in* Harris v. McRae *in* REPRODUCTIVE RIGHTS AND JUSTICE STORIES (Melissa Murray, Katherine Shaw & Reva B. Siegel eds., 2019) (explaining "the majority opinion in Harris v. McRae [which] makes absolutely no mention of race . . . .it makes no mention of gender, and it makes little mention of class—wholly effacing the fact that poor women of color bear the brunt of the Hyde Amendment.").

146. Alina Salganicoff et al., *Coverage for Abortion Services and the ACA*, KFF WOMEN'S HEALTH POL'Y (Sept. 19, 2014), https://www.kff.org/womens-health-policy/issue-brief/coverage-for-abortion-services-and-the-aca/ [https://perma.cc/83FE-V234].

147. Planned Parenthood v. Casey, 505 U.S. 833, 871 (1992).

148. S*ee id.* at 833.

maternal health and the potential life of the fetus.[149] Rather than restrict the state's ability to regulate abortion in the first two trimesters, *Casey* drew the line at viability, holding that pre-viability abortion restrictions are constitutional unless they amount to an "undue burden" on a woman's right to access abortion.[150] Post-viability, the rule remained the same as in *Roe*—the government is free to ban abortion entirely with exceptions to protect the health and life of the woman.[151] By creating the viability line, the Court still medicalized abortion in the sense that viability is still largely left to physicians to determine.[152] However, while viability is a medical decision, otherwise the doctor is largely out of the picture in *Casey.*[153]

Casey defined the term "undue burden" as a government regulation that has the "purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus."[154] Under this new and notoriously vague test, *Casey* upheld all but one of a number of restrictions on abortion. The Court struck down only the spousal notification provision in the challenged statute.[155] Many of the other restrictions *Casey* upheld were in fact reenactments of similar statutory provisions that the Supreme Court had previously struck down under the rules established in *Roe.*[156]

Despite significantly reducing constitutional protection for abortion, *Casey* claimed to preserve the "core" of *Roe.*[157] It also offered a restatement of the rationale for protecting a constitutional right to abortion.[158] *Casey* employed a different reasoning, one that still rested in the Due Process Clause, but also stressed the importance of gender equality and bodily autonomy in protecting access to abortion.[159] Although *Casey* did not ground the abortion right in the Equal

149. *Id.* at 874.

150. *Id.* at 873.

151. *Id.* at 877–78.

152. *Id.* at 846.

153. *Id.* at 838.

154. *Id.* at 877.

155. *Id.* at 898.

156. *See id.* at 887 (showing that upholding biased so-called "informed consent" to abortion regulations and twenty-four hour waiting periods based on the idea that women could not be trusted to make these decisions themselves as an example); *see* Maya Manian, *The Irrational Woman*, 16 DUKE J. GENDER LAW & POL'Y 223, 226 (critiquing the Court's departure in abortion jurisprudence from normal standards of informed consent law in health care) [hereinafter *The Irrational Woman*].

157. *Casey*, 505 U.S. at 993 (Rehnquist, J., dissenting).

158. *Id.* at 874.

159. *Id.* at 912 (Stevens, J., concurring).

Protection Clause, the opinion made repeated references to the impact of reproductive rights on women and the effect of abortion restrictions on women's ability to achieve equality in society:

> The mother who carries a child to full term is subject to anxieties, to physical constraints, to pain that only she must bear. That these sacrifices have from the beginning of the human race been endured by woman with a pride that ennobles her in the eyes of others and gives to the infant a bond of love cannot alone be grounds for the State to insist she make the sacrifice. Her suffering is too intimate and personal for the State to insist, without more, upon its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture. The destiny of the woman must be shaped to a large extent on her own conception of her spiritual imperatives and her place in society.[160]

The Court went on to famously state that "[t]he ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives."[161] Numerous scholars have noted the shift in rhetoric from *Roe*'s emphasis on the physician's prerogative in abortion decision-making to *Casey's* emphasis on women's autonomy in abortion decision-making.

Yet, ironically, by rhetorically shifting the locus of abortion decision-making authority from physicians to women, the Court also justified placing greater legal restrictions on abortion rights.[162] For example, *Casey* permitted states to mandate information biased against abortion under the guise of abortion-specific "informed consent" legislation.[163] *Casey* concluded that "the giving of truthful, nonmisleading information about the nature of the procedure, the attendant health risks and those of childbirth" did not amount to an undue burden.[164] This rationale for upholding biased "informed consent" laws contradicts the underlying purposes of the doctrine of informed consent.[165] *Casey* claimed to be supporting women's fully informed, autonomous decisions, but then allowed the government to use the "informed consent" process to pressure women to choose childbirth over abortion.

Not only did *Casey* permit information biased against abortion that would pressure patients' decisions under the misnomer of an "informed

160. *Id.* at 852.

161. *Id.* at 856.

162. *Id.* at 881.

163. *Id.*

164. *Id.* at 882.

165. *Id.* at 936 (Blackmun, J., dissenting).

consent" law, but also much of the Court's rationale displayed little deference to women's equal capacity to make sound medical decisions. For example, in upholding the constitutionality of the biased "informed consent" provision (along with abortion-specific waiting periods), *Casey* stated: "Though the woman has a right to choose to terminate or continue her pregnancy before viability, it does not at all follow that the State is prohibited from taking steps to ensure that this choice is thoughtful and informed."[166] Therefore, "[m]easures aimed at ensuring that a woman's choice contemplates the consequences for the fetus do not necessarily interfere with the right recognized in *Roe.*"[167] The *Casey* opinion assumed that women lacked the judgment to make "mature and informed" abortion decisions on their own, without pressure from the State, as other patients do with respect to other important medical decisions.[168] Statutes singling out abortion for state-mandated information enforced by criminal sanction imply that women patients cannot be trusted to elicit information from their physicians and sue in malpractice if necessary, as is the norm. As Justice Stevens pointed out in his separate opinion in *Casey*, the joint opinion "rests either on outmoded and unacceptable assumptions about the decision-making capacity of women."[169]

Thus, as abortion became rhetorically demedicalized in the law and resituated as a moral decision that must be made by the woman herself, women simultaneously received more legal oversight and fewer legal rights to make abortion decisions autonomously.[170] *Casey* deployed rhetorical flourish to grant the appearance of autonomy to women, but created legal doctrine circumscribing women's decision-making authority. Feminists who criticized *Roe* argued that demedicalization might shift reproductive health care decisions into the hands of women and out of the hands of (male) physicians.[171] Instead, authority over abortion shifted professions—from physicians to lawyers.

The rhetorical shifts evident in Supreme Court case law on abortion reflect how demedicalization of abortion did not fundamentally alter stratified power relations in society.[172] *Roe* granted women extensive autonomy over abortion on the ground, but at the cost of framing

166. *Id.* at 872.

167. *Id.* at 873.

168. *Id.* at 883.

169. *Id.* at 918 (Stevens, J., dissenting).

170. *Id.* at 886 (explaining that *Casey* also upheld abortion-specific waiting periods for the same reasons used to justify biased informed consent laws. Under the *Casey* test, courts have also upheld mandatory ultrasounds and forced information from the ultrasounds.).

171. MICHELE GOODWIN, POLICING THE WOMB 63–64 (Cambridge Univ. Press 2020).

172. *Id.* at 69.

abortion decisions as primarily the (white male) physician's prerogative.[173] *Casey* made a significant rhetorical shift to emphasizing that abortion decisions belong to the woman, because such decisions are central to women's equal citizenship in society.[174] Yet, *Casey*'s holdings failed to deliver on the promise of its rhetoric and in fact used the new locus of decision-making power in women as opposed to physicians as a reason to restrict their autonomy through legal control.[175]

D. Deprofessionalization in Gonzales v. Carhart

While feminists heavily criticized *Roe* for medicalizing the abortion decision and empowering doctors rather than women, post-*Casey,* the Supreme Court moved to the opposite extreme and hardly seemed to consider abortion as medical care at all. The Supreme Court's decision in *Gonzales v. Carhart* bears a striking contrast to *Roe* in this regard.[176] The abortion regulation at issue in *Gonzales v. Carhart* purports to ban a method of second trimester abortion, medically termed "intact D&E," but called "partial-birth" abortion by its opponents.[177] The Court upheld the federal "partial-birth" abortion ban in *Carhart,* and in the process described the abortion decision as purely political in nature and one that is made as a matter of "convenience."[178] The Court ignored extensive medical evidence on the health reasons for employing the banned procedure, leaving it to legislatures and courts, rather than physicians and their patients, to determine how best to protect women's health.[179]

Historically, physicians played a large part in reconceptualizing abortion as a medical issue that required medical management. *Gonzales v. Carhart* shifts dramatically away from *Roe* in this regard. In particular, the Court altered its views of the professional autonomy that should be granted to physicians in the abortion context.[180] In *Gonzales v. Carhart,* the Court began its explanation of how the ban on intact D&E ("partial-birth" abortion) can "protect" women with the declaration: "Respect for human life finds an *ultimate* expression in the bond of love the mother has for her child."[181] The *Carhart* Court gave no explanation for why the mother-child bond is the ultimate bond, as

173. *Id.* at 50–53.

174. *Id.* at 70.

175. *Id.* at 70–71.

176. Gonzales v. Carhart, 550 U.S. 124, 124 (2007).

177. *Id.* at 124–125.

178. *Id.* at 186–187 (Ginsburg, J., dissenting).

179. *The Irrational Woman*, *supra* note 156, at 224.

180. *Carhart*, 550 U.S. at 169.

181. *Id.* at 159 (emphasis added).

opposed to father-child or parental bonds, especially for a woman with an unwanted pregnancy.[182] Rather, the Court simply declared that the Act recognizes the supposedly "self-evident" reality of women's nature and role as mothers.[183] The Court's statement not only echoes archaic notions of women's proper roles, it also contradicts *Casey*'s reasoning that the government cannot impose "its own vision of the woman's role, however dominant that vision has been in the course of our history and our culture."[184] *Casey* also spoke of the "bond of love" between a woman and her child, but specifically noted that "[this] bond of love cannot alone be grounds for the State to insist she make the sacrifice" of her bodily integrity and right to equal citizenship.[185] Following its statement about women's "ultimate" role as mothers, the *Carhart* Court declared: "While we find no reliable data to measure the phenomenon, it seems unexceptionable to conclude some women come to regret their choice to abort the infant life they once created and sustained."[186] As the Court acknowledged, it had no data to support its claim that women "regret" their abortions.[187] In fact, studies on the psychological impact of abortion show that women generally do not regret decisions to terminate a pregnancy.[188] Relying on this unsupported claim of women's regret, the *Carhart* Court expressed concern that because the decision "[is] so fraught with emotional consequence," 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."[189] Here the Court explicitly expressed distrust of the medical profession in its role of policing women's abortion decisions. The Court went on to recognize that the law of informed consent generally does not require disclosure of every detail of a particular medical procedure and that "[a]ny number of patients facing imminent surgical procedures would prefer not to hear all the details, lest the usual anxiety preceding invasive medical procedures become the more intense."[190] However, it was "precisely this lack of information concerning the way in which the fetus will be killed that is of legitimate concern to the State."[191] The Court concluded:

182. *Id.*

183. *Id.*

184. Planned Parenthood v. Casey, 505 U.S. 833, 852 (1992).

185. *Id.* at 852.

186. *Carhart*, 550 U.S. at 159.

187. *Id.*

188. *Id.* at 184, n.7 (Ginsburg, J., dissenting) (citing studies repudiating the claim that women suffer psychological harm from abortion).

189. *Id.* at 159.

190. *Id.*

191. *Id.*

> The State has an interest in ensuring so grave a choice is well informed. It is self-evident that a mother who comes to regret her choice to abort must struggle with grief more anguished and sorrow more profound when she learns, only after the event,what she once did not know: that she allowed a doctor to pierce the skull and vacuum the fast-developing brain of her unborn child, a child assuming the human form.[192]

The obvious (although controversial) solution to a problem of lack of information would be for government to mandate more information, as *Casey* permits. The Court's concern for informed decision-making hardly seems genuine when its solution denies decision-making altogether.

Not only does the decision evince no respect for women's decision-making capacity, it also expresses deep skepticism towards the medical authority of physicians, in stark contrast to *Roe.* In *Carhart,* even questions about the need for a health exception—a seemingly quintessential medical question—was left to legislatures and judges rather than medical experts.[193] If the underlying question is *who decides* when an abortion procedure is medically necessary, *Carhart* reaches the opposite decision as *Roe.*

In her dissent in *Gonzales v. Carhart*, Justice Ginsberg emphasized that the majority's reasoning "reflects ancient notions about women's place in the family and under the Constitution—ideas that have long since been discredited."[194] In this regard, Ginsburg remarked on the peculiarities of the Court's rhetoric throughout the opinion: "[T]he opinion refers to obstetrician-gynecologists and surgeons who perform abortions not by the titles of their medical specialties, but by the pejorative label 'abortion doctor' . . . . A fetus is described as an 'unborn child' and as a 'baby'; second-trimester, pre-viability abortions are referred to as 'late-term'; and the reasoned medical judgments of highly trained doctors are dismissed as 'preferences' motivated by 'mere convenience.'"[195] These rhetorical moves by the *Carhart* Court display how medical professionals (or at least "abortion doctors") lose their authority over abortion care as abortion is reframed as a moral issue instead of a medical issue. In fact, the Court also coopts the public

192. *Id.* at 159–60.

193. *Id.* at 168; B. Jessie Hill, *What is the Meaning of Health? Constitutional Implications of Defining "Medical Necessity" and "Essential Health Benefits" Under the Affordable Care Act*, 38 AM. J. L. & MED. 445, 455 (2012) [hereinafter *What is the Meaning*] (discussing Carhart's approach to medical necessity and the health exception in the abortion context).

194. *Carhart*, 550 U.S. at 185 (Ginsburg, J., dissenting).

195. *Id.* at 186, 187; *see also* Sonia M. Suter, *The "Repugnance" Lens of* Gonzales v. Carhart *and Other Theories of Reproductive Rights: Evaluating Advanced Reproductive Technologies*, 76 GEO. WASH. L. REV. 1514, 1569–83 (2008).

health frame and uses it to justify legal regulation of abortion to "protect" women's mental health (to protect women from regret) since doctors can no longer be trusted in that role.[196]

The rise and fall of the medical profession from the "golden age of medicine" correlates with the rise and fall of the Court's medicalization of abortion, although there is not a causal link between the two.[197] *Carhart* reflects the physician's loss of what some consider the essential element of a profession: legitimate control over their work.[198] *Roe* represented the apex of legitimate autonomy granted to physicians over abortion care.[199] In contrast, the *Carhart* Court no longer imputes a "collectivity orientation" to physicians—at least for those that provide abortion care—and therefore concludes that granting physicians' autonomy over their work is not warranted.[200]

E. Corrupted Medicalization in Whole Woman's Health v. Hellerstedt and June Medical Services v. Russo

As abortion opponents shifted tactics in enacting abortion restrictions, the Court's abortion decisions further complicate the narrative of medicalization in abortion law. The Court's decisions in *Whole Woman's Health v. Hellerstedt* and *June Medical Services v. Russo* illustrate both the benefits and risks of medicalizing abortion. On the one hand, both cases address state legislation that uses "over-medicalization" to justify abortion restrictions. On the other hand, the Court also adopted medicalized framings in its analysis by relying heavily upon medical expertise to strike down those same abortion restrictions.

Over-medicalization is a "bad" form of medicalization from a feminist perspective. Feminists argue that it adopts medicalized framings to justify medically unnecessary restrictions on reproductive

196. *Carhart*, 550 U.S. at 159, 160; *see infra* Part II Section E (highlighting that this line of argument in *Carhart* also illustrates the problem of overmedicalization—how medicalization can also be used by anti-abortion forces).

197. *See, e.g.*, STARR, *supra* note 68; McKinlay & Marceau, *supra* note 68, at 379.

198. ELIOT L. FREIDSON, PROFESSION OF MEDICINE 82 (1970) (noting that countering arguments made by other scholars of the professions that the actual content of training matters, instead emphasizing that "the only truly important and uniform criterion for distinguishing professions from other occupations is the fact of autonomy—a position of legitimate control over work.").

199. *Id.* at 54.

200. *See id.* at 77–82 (arguing that assumptions about the nature of professions are actually a part of the political process of professionalization, i.e., notions of the medical profession as having a "collectivity orientation" are imputed to the medical profession through a lobbying campaign designed to win support for the profession's autonomy).

healthcare.[201] The legal regulation of abortion at issue in *Whole Women's Health* and *June Medical* were both medically unnecessary, but were justified on the ground that these restrictions protected women's health.[202] These types of "TRAP" laws exemplify the over-medicalization or corrupted medicalization of abortion.[203] Over-medicalization occurs when legislators enact laws aimed to reduce access to abortion, but defend these laws as necessary to protect women's health.[204] Corrupted medicalization occurs when medical practice is corrupted by law, for example in medically unnecessary restrictions on medication abortion and mandatory ultrasound laws.[205]

Whole Woman's Health v. Hellerstedt strengthened constitutional protection of abortion rights, although *June Medical* quickly undermined the decision.[206] In 2020, in *June Medical Services,* the Supreme Court struck down a Louisiana law that would have shuttered all but one abortion clinic in the state.[207] The Fifth Circuit Court of Appeals had upheld the Louisiana law requiring abortion providers to have admitting privileges at local hospitals.[208] Four years earlier in *Whole Woman's. Health,* the Supreme Court struck down a Texas law with precisely the same requirement because the Court recognized that admitting privileges laws serve no health benefits yet impose substantial obstacles to accessing abortion care.[209] Unfortunately, the *June Medical* decision came at a steep cost: Chief Justice Roberts wrote a separate opinion concurring in the judgment that weakened the legal standard for protecting abortion access and set forth a road map for how states could continue to undermine abortion rights going forward.[210]

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201. *See supra* Part I Section A (discussing notions of "good" and "bad" forms of medicalization).

202. Cathren Cohen, *"Beyond Rational Belief": Evaluating Health-Justified Abortion Restrictions After Whole Woman's Health*, 42 N.Y.U. L. REV. 173, 178–79 (2018).

203. Lois Shepherd & Hilary D. Turner, *The Over-Medicalization and Corrupted Medicalization of Abortion and Its Effect on Women Living in Poverty,* 46 J. L. MED. & ETHICS 672, 672 (2018); *see also* Ruth Colker, *Overmedicalization?*, 46 HARV. J. L. & GENDER 205, 249–262 (2023).

204. Shepherd & Turner, *supra* note 203, at 672.

205. *Id.* at 673.

206. Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 591 (2016); June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103 (2020).

207. *June Med. Servs. L.L.C.*, 140 S. Ct. at 2115.

208. *Whole Woman's Health*, 579 U.S. at 583.

209. *See* Maya Manian, *Eviscerating Access to Abortion Care Under* Roe v. Wade, GENDER POL'Y REP. (Mar. 3, 2020), https://genderpolicyreport.umn.edu/eviscerating-access-to-abortion-care-under-roe-v-wade/ [https://perma.cc/VDA5-6K4R].

210. *See* Maya Manian, *Winning by Losing: Chief Justice Roberts's Strategy to Eviscerate Reproductive Rights and Justice*, HARV. L. & POL'Y REV.

Women's health and the medicalized framing of abortion was at the center of the analysis of *Whole Woman's Health,* because the government itself had argued that its abortion restrictions served to protect women's health.[211] The Court relied heavily on medical and scientific expertise—especially epidemiological data—to debunk the state's assertion that the restrictions at issue operated to protect women's health.[212] *Whole Woman's Health* adopted a more medicalized approach to abortion rights that in practice helped to preserve women's access to abortion care.[213] *June Medical Services* largely reiterates the *Whole Woman's Health* analysis, although Chief Justice Roberts wrote a separate opinion concurring in the judgment that opened the door to future restrictions.[214]

While the healthcare framing of abortion in *Whole Women's Health* and *June Medical* protected access to care in the end, notably the controlling opinions in both cases make little to no mention of the social justice implications of access to abortion care. In *Whole Woman's Health,* Justice Ginsburg wrote separately to highlight the importance of access to abortion care for women's liberty and equality.[215] In the *June Medical* opinion, no woman's voice is heard at all—only male Justices authored all of the plurality, concurring, and dissenting opinions.[216] The opinions make almost no mention of race inequality in access to abortion care, although amici took pains to point out the health disparities that flow from medically unnecessary abortion restrictions.[217]

Medicalization in these cases presented both risks and benefits. Initially, the state coopted medicalized framings to enact abortion restrictions in the first place, claiming without evidence that the laws protected public health. Yet, the Court's heavy reliance on medical expertise and public health research provided justification for striking down these legal restrictions and protecting access to abortion care.[218] As in *Roe,* deference to medical expertise appears to be less threatening

(Aug. 10, 2020), https://journals.law.harvard.edu/lpr/2020/08/10/winning-by-losing-chief-justice-robertss-strategy-to-eviscerate-reproductive-rights-and-justice/ [https://perma.cc/6AHH-VJ4F].

211. *Whole Woman's Health*, 579 U.S. at 583.

212. *Id.* at 611.

213. *Id.*

214. *See* Manian, *supra* note 210.

215. *Whole Woman's Health,* 579 U.S. at 627–28 (Ginsberg, J., concurring).

216. June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2103 (2020).

217. *See e.g.*, Brief of Amici Curiae Reproductive Justice Scholars Supporting Petitioners-Cross-Respondents at 17, June Med. Servs. v. Russo, 140 S. Ct. 2103 (2020) (No. 18-1323, 18-1460).

218. *Whole Woman's Health,* 579 U.S. at 616.

to the gendered social order and permits the Court to reject abortion restrictions. On the other hand, the Court's medicalized rhetoric elided concerns about gender equality, as well as health disparities along lines of race.[219] As the composition of the Court shifted further to the right, any concern for public health in the context of abortion regulations disappeared entirely from the Court's reasoning.

F. Erasure of Medicalization in Dobbs v. Jackson Women's Health Organization

In stark contrast to *Whole Women's Health* and *June Medical,* the *Dobbs* decision makes no mention of women's health or public health at all—instead focusing primarily on concern for fetal life.[220] *Dobbs* evinces a complete erasure of medicalization in the abortion context, despite an increasing amount of public health data available on the health harms resulting from being denied a wanted abortion.[221]

In 2018, Mississippi passed a law banning abortion after fifteen weeks of pregnancy with very limited exceptions.[222] Federal courts struck down the Mississippi abortion ban, basing their decision on fifty years of consistent precedent asserting that abortion prior to viability is constitutionally protected.[223] After federal courts struck down the fifteen-week abortion ban, Mississippi asked the Supreme Court to intervene—opening up a serious challenge to the right to abortion before viability.[224]

Dobbs outright overturns *Roe v. Wade* and *Planned Parenthood v. Casey's* protection of the abortion right, which rested on a long line of precedents holding that the "liberty" written into the Fourteenth Amendment's Due Process Clause prevents the government from interfering in private medical and familial decisions.[225] The sole rationale for the majority's holding is that unenumerated rights that have long been protected by the Due Process Clause will no longer be protected unless they are "deeply rooted" in the Nation's history.[226] By

219. *See* S. Marie Harvey et al., *The Dobbs Decision – Exacerbating U.S. Health Inequity*, 388 NEW ENG. J. MED. 1444 (2023).

220. Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228 (2022).

221. *See infra* Part III (describing Turnaway Study data on the health harms of being denied abortion care).

222. Jackson Women's Health Org. v. Dobbs, 945 F.3d 265, 268–69 (5th Cir. 2019).

223. *Id.*

224. *See Dobbs*, 142 S. Ct. at 2242.

225. *Id.*

226. *Id.*

"deeply rooted," the Court now asks only whether the right was *already* protected by law in the Nineteenth Century.[227]

Based on this claim that constitutional rights must have existed two centuries ago to be protected today, Justice Alito spends much of the opinion cherry-picking the legal history of abortion in the 1800s rather than consider the impact of reversing *Roe* on women's health and equality today.[228] As the joint dissent by Justices Breyer, Kagan and Sotomayor emphasizes, in the past: "[T]his Court has rejected the majority's pinched view of how to read our Constitution . . . .The Constitution does not freeze for all time the original view of what [the 14th Amendment] rights guarantee, or how they apply."[229]

In addition to liberty under the Due Process Clause, the Court also briefly discussed whether the Equal Protection Clause guarantees reproductive rights.[230] Although many scholars and advocates have developed a strong case for Equal Protection as a firmer constitutional footing for protecting reproductive rights and justice, Justice Alito dismissed these carefully developed arguments in a mere paragraph.[231]

Thus, the Court jettisoned 50 years of legal precedent on abortion and—for the first time in its history—clawed back an individual right that has been relied on for half a century.[232] The majority opinion ends by setting forth the new doctrinal test for abortion rights, the rational basis test, which is the lowest level of review known in constitutional law and one that means abortion restrictions will almost always be upheld:

> A law regulating abortion, like other health and welfare laws, is entitled to a "strong presumption of validity." . . . It must be sustained if there is a rational basis on which the legislature could have thought that it would serve legitimate state interests.[233]

The Court then listed a series of rationales for abortion bans, including "preservation of prenatal life at all stages of development" and a long list of other grounds that have been used in the past as pretexts for restricting or banning abortion care.[234] Applying the rational basis test likely means that abortion bans at any stage of pregnancy and possibly

227. *Id.* at 2242–43.

228. *Id.* at 2248–55*; see* Siegel, supra note 66 (critiquing *Dobbs* selective analysis of history).

229. *Dobbs*, 142 S. Ct. at 2325–26 (Breyer, J., dissenting).

230. *Id.* at 2245–46.

231. *See id.*

232. *Id.* at 2347–48 (Breyer, J., dissenting).

233. *Id.* at 2284.

234. *Id.*

without any exceptions will be upheld.[235] The Court in fact upheld the Mississippi fifteen-week abortion ban which has no exception for rape and incest, and a medical "emergency" exception that leaves much unclear about how doctors can protect women and pregnant people's health.[236]

In fact, since the *Dobbs* decision was published patients have been unable to receive other pregnancy-related care in states with abortion bans in effect.[237] Even if an abortion ban has a "medical emergency" health exception, emergency health exceptions are not a silver bullet to protect women's health against the impact of abortion bans.[238] Health care providers have no way to know what precisely counts as a medical emergency in the eyes of local law enforcement—for example, for a pregnant patient with cancer, does abortion care count as an emergency if death is not immediate?[239] The *Dobbs* majority opinion addresses none of these concerns about women and pregnant people's health, and instead expresses a thorough rejection of understanding abortion as a public health concern.

* * *

Abortion provides a fascinating case study of a phenomenon going, "from *badness* to *sickness*" and back to badness again.[240] Scholars have noted that: "Abortion rights supporters were often ambivalent about both medicalization and demedicalization. They saw the benefits and costs to both but these were difficult to assess and changed over time and across different contexts."[241] In the pre-*Roe* era, physicians worked with the law to establish professional sovereignty by bringing abortion within both medical and legal jurisdiction.[242] In the *Roe* era, at the height of physicians' professional dominance in the early 1970s, the medicalization of abortion helped women gain autonomy over abortion

235. Nicole Huberfeld, *Returning Regulation to the States and Predictable Harms to Health*, SCOTUSBLOG, (June 30, 2022, 9:28 AM), https://www.scotusblog.com/2022/06/returning-regulation-to-the-states-and-predictable-harms-to-health/ [https://perma.cc/7JGY-RQM4].

236. *Dobbs*, 142 S. Ct. at 2317–18 (Breyer, J., dissenting).

237. *See, e.g.*, Greer Donley & Kimberly Chernoby, *How to Save Women's Lives After Roe,* ATLANTIC, https://www.theatlantic.com/ideas/archive/2022/06/roe-v-wade-overturn-medically-necessary-abortion/661255/ [https://perma.cc/F66M-LHEP].

238. *Id.*

239. *See generally* Greer Donley & Caroline Kelly, *Abortion Disorientation*, 74 DUKE L. J. (forthcoming 2025).

240. CONRAD & SCHNEIDER, *supra* note 42, at 9.

241. Halfmann, *supra* note 26, at 202 (recognizing medicalization).

242. *Id.* at 196.

decisions in the real world, although rhetorically the Court situated the decisional right with physicians.[243] As abortion became demedicalized in legal discourse and resituated as a woman's moral decision, power shifted hands once again, this time away from both physicians and women, and into the hands of lawmakers and judges.[244]

In sum, in both medicalized and demedicalized framings of abortion rights, the Supreme Court's abortion jurisprudence does not allow women to exercise decisional autonomy without supervision by either medicine or law. Under conditions of patriarchy, racism, and capitalism, neither medicalized nor demedicalized rights alone have been sufficient to protect the reproductive autonomy of the most vulnerable groups of pregnant people. Yet, medicalized framings of abortion appear to correlate with fewer legal restrictions *because* women's abortion decision-making is rhetorically under the supervision of medical expertise. Given the reversal of *Roe,* the need for creative new framings to persuade the public to preserve access to abortion is apparent.[245] The health justice framework offers a strategy to capture the rhetorical benefits of medicalized framings of abortion rights, while also maintaining focus on concerns about race, class, and gender inequality in access to abortion care.

III. HEALTH JUSTICE, THE NEW MEDICALIZATION AND ABORTION AS A MEDICAL CIVIL RIGHT

The waxing and waning of medicalization in abortion jurisprudence illustrates how medicalized framings of abortion carry both promise and peril. Although recognizing the risks associated with medicalization, this Part argues that medicalization of abortion could be leveraged by reproductive rights and justice advocates to advance more equitable access to reproductive health care. Rather than return to *Roe*'s paternalistic model of abortion that portrayed women as passive receivers of care determined by their physicians, this Part contends that the health justice framework offers a new form of medicalization, one that would situate abortion in legal and policy discourses in ways that address the downsides of past forms of medicalization while still leveraging its potential benefits.

This Part extends other legal scholars' work urging a health justice approach to civil rights to the abortion context. Legal scholars arguing in favor of medicalizing civil rights more generally highlight the benefits

243. *Id.* at 198–99.

244. It is also notable that this shift occurred over a time period when more women became physicians, especially in the specialized field of obstetrics and gynecology, while lawmakers and judges continue to remain a largely white and male professional work force.

245. *See* David S. Cohen et al., *Rethinking Strategy After Dobbs*, 75 STAN. L. REV. 1, 7 (2022).

of a health justice framing for traditional civil rights issues. In response, a number of scholars have also criticized the notion of medicalizing civil rights, generating a lively debate. None of this literature has specifically addressed abortion rights. Below, Section A addresses the potential benefits of medicalizing civil rights in legal discourses. Section B discusses the hazards of medicalizing civil rights. Section C argues that the health justice framework offers a path forward for medicalizing abortion rights in ways that could harness the upsides of medicalization while also centering social justice concerns with equity.

A. The Benefits of Medicalizing Civil Rights

As described in Part I, the bulk of scholarly literature criticizes medicalization as a process that inscribes social hierarchies through the physician-patient relationship. Yet, others see promise for new forms of medicalization that will lead to greater social justice. Recently, several legal scholars have argued that medicalization could be deployed in ways that might advance civil rights.[246] Legal scholars advocating for medicalized civil rights argue that there are significant advantages to medicalizing civil rights issues such as race discrimination and housing inequity, particularly by using the health justice framework, although none of this work has addressed reproductive rights directly.

Scholars arguing in favor of medicalizing civil rights using the health justice framework view public health research on the social determinants of health (SDOH) as the tool that can bring together civil rights and public health professionals, and build a bridge for professionals from these arenas to partner with social justice movements. The social determinants of health include both structural and intermediate determinants that mediate the levels at which populations are exposed to health risks and are able to tolerate those risks.[247] Structural determinants of health include "discrimination, poverty, and other forms of subordination, as well as the political and legal systems in which subordination is embedded;" structural determinants of health also impact the intermediary determinants of

246. Webb & Matthew, *supra* note 4, at 588 (summarizing the history of scholarly debates on medicalization and arguing in favor of the medicalization of poverty to address the social determinants of health); *see also* Konnoth, *supra* note 8, at 1249.

247. *See* Rachel Rebouchè & Scott Burris, *The Social Determinants of Health*, *in* OXFORD HANDBOOK OF U.S. HEALTH LAW 1097–112, 1101 (I. Glenn Cohen et al., eds., 2017); Seema Mohapatra & Lindsay F. Wiley, *Feminist Perspectives in Health Law*, 47 J. L. MED. & ETHICS 103, 109 (2019); Paula Braveman et al., *The Social Determinants of Health: Coming of Age*, 32 ANN. REV. PUB. HEALTH 381, 382 (2011); Bruce G. Link & Jo Phelan, *Social Conditions as Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80, 80 (1995).

health.[248] Intermediary determinants include "material and environmental circumstances, such as health care, housing, and employment conditions."[249] Public health research on the SDOH has established that social and environmental factors such as poverty, poor housing, and food deserts contribute to health disparities more than access to health care alone.[250] Studies show that differences in social factors account for 40% of health outcomes and another 30% of health outcomes relate to health behaviors influenced by social context.[251]

Legal scholars proposing a medicalized civil rights framework identify a number of potential benefits to medicalizing civil rights through the health justice framework and using its emphasis on SDOH health disparities research. First, medicalizing civil rights could help bring together resources from the otherwise disconnected fields of public health and civil rights law to aim for structural changes that address systemic discrimination.[252] Second, a health justice approach to policymaking could lead to more robust protections for disadvantaged groups than solely relying on civil rights law's increasingly narrow protections in the federal courts.[253] Third, these scholars argue that the medicalized framework offered by the health justice approach might be potentially less divisive for advancing civil rights in some contexts—although of course public health frameworks can also be politicized as we have seen during the COVID-19 pandemic.[254]

248. Emily A. Benfer et al., *Health Justice Strategies to Combat the Pandemic: Eliminating Discrimination, Poverty, and Health Disparities During and After COVID-19*, 19 YALE J. HEALTH POL'Y L. & ETHICS 122, 126–27 (2020).

249. *Id.* at 127.

250. Samantha Artiga & Elizabeth Hinton, *Beyond Health Care: The Role of Social Determinants in Promoting Health and Health Equity*, KFF (May 10, 2018), https://www.kff.org/racial-equity-and-health-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/ [https://perma.cc/RT7D-DK6V].

251. Webb & Matthew, *supra* note 4, at 591; Yearby & Mohapatra, *supra* note 22, at 2 ("Racial and ethnic minorities are disproportionately impacted during pandemics, not due to any biological difference between races, but rather as a result of social factors.").

252. *See, e.g.*, Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 808 (2020) [hereinafter *Civil Rights of Health*] ("Central to [x] justice movements is the recognition that universalist-individualist approaches to disparities [in access to resources and exposure to harm] are inevitably limited and inadequate.").

253. *See id.*

254. *See id; see also* Katie Watson, *The Ethics of Access: Reframing the Need for Abortion Care as a Health Disparity*, 22 AM. J. BIOETHICS 22, 27 (2022) (arguing that bioethicists should frame the need for abortion care in the language of health disparities).

First, medicalizing civil rights through the health justice approach could bring together the knowledge and resources of public health experts, civil rights lawyers, and social justice advocates. In particular, drawing from public health literature on the social determinants of health provides a solid evidentiary basis for advocating for legal reforms that address structural inequities in a way that neither field alone has accomplished. The social determinants of health framework rests on public health research that has identified discrimination and poverty as a root cause of poor health outcomes and health disparities at the population level.[255] Researchers have now extensively documented "that health outcomes are highly dependent on an individual's social background and environmental context."[256] Literature on the social determinants of health reveals "how interpersonal, institutional, and structural discrimination decreases the length and quality of people's lives across populations and geographies."[257] Public health data shows that health disparities flow from discrimination at micro, meso, and macro levels—from individual implicit and explicit bias (micro), institutional discrimination (meso), and structural discrimination (macro).[258]

Yet, since public health and civil rights advocacy have largely remained disconnected, neither has been able to address discrimination at all three levels. Conservative forces have narrowed civil rights law to focus largely on explicit (intentional) interpersonal racism, ignoring

255. Yearby, *supra* note 6, at 643.

256. *See supra* Part I (reviewing public health literature on the social determinants of health and health disparities and arguing that anti-subordination law and policy is a health intervention); *Civil Rights of Health*, *supra* note 252, at 767; Rachel Rebouché, *The Public Health Turn in Reproductive Rights*, 78 WASH. & LEE L. R. 1355, 1407 (2021) [hereinafter *Public Health Turn*].

257. Angela P. Harris & Aysha Pamukcu, *Fostering the Civil Rights of Health*, *in* COVID-19 POLICY PLAYBOOK: LEGAL RECOMMENDATIONS FOR A SAFER, MORE EQUITABLE FUTURE 252, 253 (Scott Burris et al. eds., 2021) [hereinafter *Fostering*]; ELIZABETH TOBIN-TYLER & JOEL B. TEITELBAUM, ESSENTIALS OF HEALTH JUSTICE: A PRIMER xii (2018) (noting that social determinants of health research shows how "the conditions in which people live, work, and play have an enormous impact on . . . health totally irrespective of whether a person ever sees the inside of a doctor's office").

258. *Fostering*, *supra* note 257, at 253; *see also* Yearby & Mohapatra, *supra* note 22, at 3, 4 ("Institutional racism operates through 'neutral' organizational practices and policies that limit racial and ethnic minorities equal access to opportunity. Interpersonal racism operates through individual interactions, where an individual's conscious and/or unconscious prejudice limits racial and ethnic minorities' access to resources. Structural racism operates at a societal level and refers to the way laws are written or enforced, which advantages the majority, and disadvantages racial and ethnic minorities in access to opportunities and resources.").

institutional and structural forms of discrimination.[259] Public health interventions focusing on population health often ignore racial health disparities within the population or shift focus to individual behavioral changes rather than targeting the social determinants of health-impacting behaviors at systemic levels.[260]

Thus, scholars like Angela Harris and Aysha Pamukcu argue for an approach they term the "civil rights of health" to address inequities along lines of race, gender, sexuality, and class through a health justice framing.[261] They propose a strategy that "involves partnerships among civil rights advocates, community advocates, and public health advocates to use litigation, administrative action, planning, and policymaking to connect the fight against health disparities with the fight against subordination."[262] Harris and Pamukcu aim to link public health and civil rights advocacy with social justice movements to leverage the strengths of each of these domains.[263] They argue that civil rights law needs to draw on public health's social determinants of health literature to address discrimination at the structural level, public health needs to embrace the values of anti-discrimination law as a public health priority, and both must work with the leadership of frontline communities to ensure anti-racist values drive policy.[264] They explain the importance of intertwining these three key elements into a health justice approach to civil rights:

> Understanding health as a matter of justice, and civil rights law as a health intervention, has the potential to strengthen public health advocacy. Conversely, understanding social injustice as a health issue as well as a moral issue has the potential to reinvigorate civil rights advocacy. But given the history of law-and-public health initiatives that have reflected and even reinforced subordination, social movements are an essential advocacy partner and watchdog.[265]

In a similar vein, Cameron Webb and Dayna Bowen Matthew argue for the "medicalization of poverty."[266] These scholars also take a health justice approach to medicalization that focuses on epidemiological understandings of population health, as opposed to a brand of

259. *Fostering*, supra note 257, at 253.

260. *Id.*

261. *Id.* at 252; *see also Civil Rights of Health*, *supra* note 252, at 783.

262. *Civil Rights of Health*, *supra* note 252, at 813–14.

263. *Id.* at 831.

264. *Fostering*, *supra* note 257, at 254; *see also Civil Rights of Health*, *supra* note 252, at 762–66, 805.

265. *Civil Rights of Health*, *supra* note 252, at 758.

266. Webb & Matthew, *supra* note 4, at 588.

medicalization that focuses on physician control over patients.[267] The authors argue that, "Instead of medicalizing people (e.g. pregnant women) or conditions (pregnancy) or even the social position or views of stakeholders which can stymie effective treatment (e.g. HIV prevention or teenage pregnancy), we think the preferred conceptual framework is medicalization of the risk factors that contribute to diseases."[268] Using housing as an example, Webb and Matthew argue for a "framework that medicalizes the condition of poverty, and the cluster of risk factors incident to poverty."[269] In particular, Webb and Matthew argue that medicalizing fair housing rights by understanding substandard housing as a SDOH and health risk factor can address the fundamental causes of diseases and health disparities.[270]

Second, an additional benefit to medicalizing civil rights through a health justice approach that focuses on the SDOH could be potentially more robust protections for accessing civil rights than the increasingly anemic protections offered through civil rights laws. Historically, antidiscrimination law has largely protected "negative" rights—rights which immunize protected activity from governmental infringement—although scholars have argued that the constitution and other legislation should also protect "positive" rights by compelling government to support access to protected activity, such as access to health care for abortion.[271] The health justice framework provides a mode of reasoning for demanding greater resources from policymakers to combat discrimination.[272] Legal scholars arguing in favor of medicalized civil rights contend that a health care framing of civil rights issues could have more purchase with the public when seeking economic redistribution.[273]

267. *Id.* at 590; *see also* Dayna Bowen Matthew, *Health and Housing: Altruistic Medicalization of America's Affordability Crisis*, 81 L. & CONTEMP. PROBS. 161, 162 (2018) (arguing for a public health approach to housing inequity as a "scientific approach to promote and protect population health").

268. Webb & Matthew, *supra* note 4, at 590, 591.

269. *Id.* at 591.

270. *Id.*

271. *See* Susan Frelich Appleton, *Beyond the Limits of Reproductive Choice*, 81 COLUM. L. REV. 721, 734–37 (1981) (explaining the constitutional debate between "negative" rights—which only immunize protected activity from governmental interference—versus "positive" rights—which compel affirmative government support for being able to engage in the protected activity); Maya Manian, *Commentary on* Dandridge v. Williams, *in* FEMINIST JUDGEMENTS: REWRITTEN FAMILY LAW OPINIONS 68 (Rachel Rebouchè ed., 2020).

272. Konnoth, *supra* note 8, at 1202.

273. For example, building on the work of Harris and Pamukcu and others, Craig Konnoth argues in favor of medical civil rights more broadly. Konnoth describes a larger phenomenon of the medicalization of civil

For example, Harris and Pamukcu argue that civil rights advocates should frame racism as a public health crisis, an approach that gained some traction during the coronavirus pandemic.[274] Harris and Pamukcu propose that medicalized framings of racism as a public health concern could then lead to novel legal and policy solutions that address structural forms of discrimination through demands for shifting economic resources at the community level.[275] For example, the authors argue that the Movement for Black Lives (M4BL) protests against police brutality have sparked conversations that illustrate how the combined forces of public health expertise on the SDOH, civil rights advocacy, and anti-discrimination social movements could lead to more transformative structural changes.[276] The M4BL call to defund the police has sparked discussions about the underfunding of key social determinants of health, such as education and social safety net programs.[277] By "treating community violence as a public health problem rather than a criminal justice problem," public health and civil rights advocates could work together with frontline community activists to address racial disparities at the structural and institutional levels by pushing to redistribute resources (for example, shifting funding from the criminal justice system to education, health, and social welfare programs).[278]

Third, legal scholars advocating for medicalizing civil rights emphasize the potential for health care framings to be a pragmatically useful strategy especially given a federal judiciary that has become increasingly hostile to civil rights laws. Thus, legal scholars assert that, "While it is important to keep the Janus faced nature of medical civil rights in mind, at both the individual and aggregate level, medical civil rights might be the best of a set of limited alternatives available to vulnerable individuals," especially in a politically fraught climate around civil rights claims.[279] Similarly, scholars argue that a medicalized, health justice framework for civil rights "may . . . produce less political friction and divisiveness than civil rights campaigns in other areas such as employment and education," since health is "not a

rights across substantive areas of law, from antidiscrimination law to disability law to housing law. Konnoth argues that medical rights-seeking could help subordinated groups obtain more than negative rights, but also seek positive rights through legislative and administrative bodies. *See* Konnoth, *supra* note 8, at 1172–88.

274. *Fostering*, *supra* note 257, at 253; Benfer et al., *supra* note 248, at 130; Alan R. Weil, *Racism and Health*, 41 HEALTH AFFS. 157, 157 (2022).

275. *Fostering*, *supra* note 257, at 253.

276. *Id.* at 254.

277. *Id.*

278. *Id.*

279. Konnoth, *supra* note 8, at 1244–45.

zero-sum game" (good health for one group does not necessarily result in poorer health for another group) and health is a public good not just an individual good.[280] Of course, health care framings can also be highly politicized as witnessed during the COVID-19 pandemic and as illustrated in the abortion context in cases like *Whole Woman's Health* and *June Medical*. Yet, given the increasingly conservative makeup of the federal courts and the inability of antidiscrimination law to deliver on the large-scale goals of the civil rights movement, a health justice approach to civil rights potentially offers a new language for advocating for positive rights and resources for marginalized groups in policymaking venues beyond the federal courts.

In sum, legal scholars in favor of medicalizing civil rights using the health justice framework argue that building a "sustained partnership between public health, civil rights legal advocacy, and anti-discrimination social movements" could provide an effective means to address discrimination at all levels—interpersonal, institutional, and structural.[281] Unlike past forms of medicalization, the health justice approach to civil rights focuses on the social determinants of health and health equity, rather than focusing on physician controlled clinical interventions. Still, medicalizing civil rights is certainly not a silver bullet, and legal scholars are debating whether the risks are worth the potential benefits.

B. The Risks of Medicalizing Civil Rights

Despite potential benefits to framing various kinds of civil rights as a matter of public health and health justice, legal scholars arguing for medicalizing civil rights also acknowledge potential risks to their proposals. Critics worry that medicalizing civil rights could do more harm than good, particularly for marginalized groups.

Legal scholars debating medicalized civil rights frameworks have noted several perils of medicalization in this context. First, given a context of subordination along lines of race, class, sex, and disability among others, civil rights advocates worry that medicalization can be a means to stigmatize vulnerable groups and could be coopted in ways that lead to further violations of civil rights rather than amelioration.[282] In the past, public health forces have aligned with state power to both stigmatize marginalized populations and give scientific legitimacy to civil rights abuses.[283] For example, racialized panics around "crack

280. *Civil Rights of Health*, *supra* note 252, at 792.

281. *Fostering*, *supra* note 257, at 253.

282. Konnoth, *supra* note 8, at 1245 (noting that medicalization can impose stigma and social control over vulnerable groups).

283. Rabia Belt & Doron Dorfman, *Reweighing Medical Civil Rights*, 72 STAN. L. REV. 176, 187–88 (2020) (noting how medicalization has often led to stigmatization of disabled individuals and transgender people, and arguing that although "the current landscape of antidiscrimination law looks dire,

babies" and the history of eugenics and forced sterilization throughout the twentieth century illustrate the potential dangers of medicalization.[284] Public health research does not always take account of how its own methods and practices reproduce subordination.[285] Furthermore, public health experts historically have not clearly articulated their values from a perspective of social justice.[286]

Moreover, critics of medicalizing civil rights argue that medicalization could narrow anti-discrimination concerns "by focusing only on discrimination that manifests in medically meaningful harms."[287] The health justice approach and its focus on social determinants of health research highlight the physical manifestations of the harm of race, sex, or class discrimination. However, critics point out that discrimination is harmful not only due its negative health impacts, but "discrimination is problematic for reasons that reach well beyond the measurable, physical ways it manifests, and medicalization may subtly encourage us not to see racism or sexism as harmful when they fail to manifest in physical ways."[288] While civil rights law is admittedly doing less and less to address discrimination in structural and more transformative ways, critics of medicalized civil rights worry that "medicalization may by definition be forever incapable of doing so because of its granular and belated way of understanding harms and may affirm some of the deepest failings in civil rights law's doctrinal development."[289]

Finally, medicalization has in the past led to expanded social control by medical experts who themselves have no democratic legitimacy. Some worry that medicalizing civil rights "means taking the expertise and decision-making capacity away from patients . . . and handing it over to other experts to make decisions for them."[290]

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there are ways to move forward without resorting to older models of justice."); *see also* Doron Dorfman, *Disability as Metaphor in American Law*, 170 U. PA. L. REV. 1757, 1805 (2022).

284. *Civil Rights of Health*, *supra* note 252, at 803–04; *see also* Aziza Ahmed, *Floating Lungs: Forensic Science in Self-Induced Abortion Prosecutions*, 100 B.U. L. REV. 1111 (2020) (discussing "crack baby" panic and risks of relying on scientific expertise to protect rights more generally).

285. *Civil Rights of Health*, *supra* note 252, at 796.

286. *See, e.g.*, Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J. L. & PUB. POL'Y 47, 62 (2014).

287. Allison K. Hoffman, *How Medicalization of Civil Rights Could Disappoint*, 72 STAN L. REV. 165, 166 (2020) (noting that although medical rights-seeking could be useful from "a short-term, utilitarian perspective," nevertheless "medicalization may not provide a clear civil rights cure in the long run" and elaborating on its potential risks).

288. *Id.* at 169.

289. *Id.*

290. Belt & Dorfman, *supra* note 283, at 184.

Furthermore, medicalizing civil rights issues could potentially "sap[] medical institutions of *their* legitimacy, and invite[] cooptation by other institutions."[291] The COVID-19 pandemic has made clear both the breadth and depth of social inequities and their resulting health disparities, and has also demonstrated how a polarized political environment can delegitimize public health expertise on basic public health policies such as mask and vaccine mandates.[292] Thus, even if medicalizing civil rights produces short term benefits, these benefits "might diminish as medicalization becomes a new situs for civil rights contests."[293] Furthermore, framing civil rights issues (and abortion in particular) in the language of health disparities that is the focus of SDOH research also presents the risk of furthering stigma along lines of race and class.[294]

C. Health Justice, The New Medicalization, and Abortion as a Medical Civil Right

All of the potential benefits of medicalizing civil rights discussed above apply in the abortion context—as do the potential risks. This section argues that the framework of health justice could help to link together the benefits of both medicalized and demedicalized framings of abortion rights in a way that advances equitable access to care. Health justice is an emerging framework that builds from other social justice movements, including reproductive justice. Yet, health justice and reproductive justice frameworks have not been put directly into conversation with one another.[295] This section argues that health justice is a complementary framework to reproductive justice and both

291. *See* Aziza Ahmed, *A Critique of Expertise for Health Law*, 50 J. L. MED. & ETHICS 682 (2022); Konnoth, *supra* note 8, at 1202 (summarizing potential problems with medicalizing individual rights claims).

292. *See, e.g.*, Shaun Ossei-Owusu, *Coronavirus and the Politics of Disposability*, BOS. REV. (Apr. 8, 2020), https://bostonreview.net/articles/shaun-ossei-owusu-coronavirus-and-politics-disposability/ [https://perma.cc/7HAK-UHWQ] (describing how COVID-19 disproportionately harms marginalized groups).

293. Hoffman, *supra* note 287, at 165; *see also* Aziza Ahmed, *Medical Evidence and Expertise in Abortion Jurisprudence*, 41 AM. J. L. & MED. 85, 86–87 (2015) (critiquing use of medical expertise in abortion litigation).

294. *See* Watson, *supra* note 254, at 25–26 (discussing potential disadvantages of using health disparities frame to support the need for abortion care including risks of racialized abortion stigma and fueling false claims about abortion providers being racially predatory).

295. *See Public Health Turn*, *supra* note 256, at 1430 (describing the rise of public health research in abortion litigation and noting that health justice could work in tandem with reproductive justice but the two frameworks "are not always in conversation with one another"); *see also* Watson, *supra* note 254, at 23 (noting that the health disparity framework differs from the reproductive justice framework and arguing that both have compelling strengths).

frameworks could be deployed more effectively together to advance equitable access to abortion care.

The reproductive justice movement arose in reaction to the movement for reproductive rights, which narrowly focused on a negative right to contraception and abortion (*i.e.,* the right to have government not interfere with contraception and abortion but no right to positive government support to access that care).[296] The reproductive justice framework emphasizes that low income people and women of color lack the same ability to exercise rights to contraception or abortion as affluent white women, and that marginalized pregnant people often lack the ability to choose to give birth or raise their children in healthy environments.[297] Thus, one crucial aspect of the reproductive justice framework is its focus on identifying power systems that prevent all people from equally enjoying sexual and reproductive autonomy in deciding whether to avoid pregnancy, to give birth, or to parent their children.[298] The health justice approach to abortion builds upon the insights of the reproductive justice framework in a way that explicitly links abortion with healthcare and health disparities. The argument is not that advocates should jettison reproductive justice, but rather that health justice's medicalized framing of abortion rights could be more productive in post-*Dobbs* political and legal arenas that are not as welcoming to autonomy-framed arguments. In other words, medicalizing abortion rights through a health justice lens is a pragmatic reframing, not a normative imperative.[299]

For a variety of complex reasons, abortion has been siloed from mainstream medicine and isolated into specialized clinics that provide the vast majority of abortion care in the United States.[300] Laws and healthcare policies in the U.S. reflect what scholars have termed "abortion exceptionalism," which refers to the ways in which "abortion

296. *See e.g.*, Joan C. Crisler, *Introduction: A Global Approach to Reproductive Justice—Psychological and Legal Aspects and Implications*, 20 WM. & MARY J. WOMEN & L. 1, 4 (2013) (noting that reproductive justice emphasizes a principle of positive rights which includes the right to government support to access the means to exercise autonomy); Rachel Rebouché, *The Limits of Reproductive Rights in Improving Women's Health*, 63 ALA. L. REV. 1, 3 (2011).

297. *See e.g.*, ROSS & SOLINGER, *supra* note 12, at 9, 55–56.

298. *Id.* at 9, 17.

299. *See* Watson, *supra* note 254, at 27–28 (arguing that although the reproductive justice framework is more intellectually compelling, pragmatically it makes sense to engage "in an academic version of code switching," which requires advocates to become fluent in the "languages and imperatives of both health disparity and RJ justifications for removing barriers to abortion care and switch between them depending on who we are talking to").

300. *See Uneasy Allies*, *supra* note 132, at 782; *see also* Freedman et al., *supra* note 100, at 146.

is treated uniquely compared to other medical procedures that are comparable to abortion in complexity and safety."[301] Legal scholars have argued that reviving medicalized framings of abortion could bolster efforts to resist legal restrictions on abortion and ensure more equitable access to abortion care.[302] In part, the healthcare framing of abortion may be less politically inflammatory than one overtly emphasizing women's sexual liberty.[303]

The health justice approach leverages the benefits of medicalized framings of abortion—as shown above in Part II where medicalization in abortion jurisprudence is less threatening to the patriarchal legal order—while also bridging the gap between rights-based discourses and the traditional focus of public health on population health but not social justice. In other words, the health justice framework offers a way to highlight traditional civil rights concerns with liberty and equality but sheltered in a medicalized framing emphasizing the health care aspects of abortion. In this regard, health justice is better understood as a new form of medicalization, one that adopts medicalized framings but with a critically different emphasis than medicalization of the past.[304] While

301. DAVID COHEN & CAROLE JOFFE, OBSTACLE COURSE: THE EVERYDAY STRUGGLE TO GET AN ABORTION IN AMERICA 8 (2020).

302. Professor Jessie Hill has argued that "the health care framework may assist in garnering a broader base of support for abortion rights, since health care is a non-gender-specific need, and one that affects nearly everyone at some point." B. Jessie Hill, *Abortion as Health Care*, 10 Amer. J. Bioethics 48, 48–49 (2010) [hereinafter *Abortion as Health Care*]. Furthermore, Hill argues that "the health care framework sufficiently conveys the weightiness of the abortion decision" while still protecting autonomous decision-making, similar to other weighty health care decisions such as organ donations. *Id.* at 49 (noting that many other health care decisions "may be morally fraught; they are not always undertaken for 'therapeutic' reasons in a strict sense; and they may have profound effects on other people in the immediate and long term"). *See also Lessons from Personhood, supra* note 21, at 76, 116, 119 (urging a resurrection of the healthcare framing of abortion rights and citing other scholars arguing for reconnection between abortion and medical care); *Health Care Rights, supra* note 19, at 543, 549; *Rhetoric of Choice, supra* note 21, at 397; Yvonne Lindgren, *From Rights to Dignity: Drawing Lessons From Aid in Dying and Reproductive Rights*, 5 UTAH L. REV. 779, 780 (2016) [hereinafter *From Rights to Dignity*] (arguing that situating the constitutional right to abortion in a healthcare framing that takes into account social, political, and economic inequality would better protect equitable access to care).

303. *See* SIEGLE & GREENHOUSE, *supra* note 56, at viii–ix, 276 (documenting debates before *Roe v. Wade*); *see also* Susan Reid, *Sex, Drugs, and American Jurisprudence: The Medicalization of Pleasure*, 37 VT. L. REV. 47, 84 (2012) (arguing that medicalization of individual interests in contraception, abortion, and "obscene devices" cases helped to facilitate decriminalization by shifting focus away from pleasure).

304. As described in Part I, scholars continue to debate the definition of medicalization and whether a particular approach should be described as

traditionally the concept of medicalization focused on physician's professional dominance, more expansive understandings of medicalization today include other actors and institutions as participating in the process of medicalization.[305] As noted above, the health justice framework relies heavily on public health research on the SDOH.[306] SDOH are the social and economic conditions that shape an individual's ability to achieve their full health potential.[307] While scholars may debate whether health justice is a form of medicalization depending on how that concept is defined, this Article contends that the health justice approach to civil rights is a form of medicalization, although it places public health experts in the driver's seat as opposed to physicians.[308]

A number of legal scholars have explained the meaning of health justice in the legal context. Health justice is a "jurisprudential and legislative framework" for eradicating population level health disparities caused by political subordination.[309] In particular, it is "an emerging framework for eradicating unjust health disparities . . . caused by discrimination, poverty, and other forms of subordination."[310] The framework focuses on health equity:

> [H]ealth justice requires that all persons have the same chance to be free from hazards that jeopardize health, fully participate in society, and access opportunity. Health justice addresses the social determinants of health that result in poor health for individuals and consequential negative outcomes for society at large.[311]

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medicalized, demedicalized, or both can be a matter for contention. *See e.g.*, Konnoth, *supra* note 8, at 1249–62 (discussing scholars' ongoing debates around defining the concept of medicalization).

305. *See e.g.*, Joan Busfield, *The Concept of Medicalisation Reassessed*, 39 SOCIO. HEALTH & ILLNESS 759, 763 (2017); Tiago Correia, *Revisiting Medicalization: A Critique of the Assumptions of What Counts as Medical Knowledge*, 2 FRONTIERS SOC. 1, 2–3(2017).

306. Yearby, *supra* note 6, at 641.

307. *See id.*

308. *Civil Rights of Health*, *supra* note 252, at 765.

309. Emily A. Benfer, *Health Justice: A Framework (and Call to Action) for the Elimination of Health Inequity and Social Injustice,* 65 AM. U. L. REV. 275, 277–78.

310. Benfer et al., *supra* note 248, at 128 (summarizing literature on health justice as a framework for using law to reduce health disparities).

311. Benfer, *supra* note 309, at 278; *see also* DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RACIAL INEQUALITY IN AMERICAN HEALTH CARE (2015) [hereinafter JUST MEDICINE]; Dayna Bowen Matthew, *Toward a Structural Theory of Implicit Racial and Ethnic Bias in Health Care,* 25 HEALTH MATRIX 61, 62 (2015) (discussing health justice approaches).

More generally, legal scholars propose health justice as a framework for reorienting health law to a social justice focus.[312] Legal scholars emphasize that "health justice requires a regulatory and jurisprudential approach that consistently and reliably considers the health ramifications of judicial and legislative decision making." [313] Thus, knowledge of the social determinants of health should inform legal decision making, including designing laws to prevent health inequity and address the socioeconomic inequalities that lead to health disparities.[314]

As discussed above in Part III.A, legal scholars advocating for medicalizing civil rights as a new framework for civil rights advocacy rely on the health justice approach. [315] In Harris and Pamukcu's conceptualization of medicalized civil rights, the health justice framework helps to intertwine public health expertise on the social determinants of health, civil rights legal principles on equality and liberty, and social movement focus on challenging racist power structures and obtaining equitable redistribution of economic resources.[316] Harris and Pamukcu describe the health justice framework as treating "public health, law, and social movement advocacy as

312. *See* Wiley, *supra* note 286, at 47, 104 (identifying social justice movements as a rich resource for reframing health disparities research and policy). Lindsay Wiley suggests that "health justice offers an alternative to the market competition and patient rights paradigms that currently dominate health law scholarship, advocacy, and reform." *Id.* at 47.

313. *See* Benfer, *supra* note 309, at 337.

314. *See* Wiley, *supra* note 286, at 104 (identifying social justice movements as a rich resource for reframing health disparities research and policy).

315. *Civil Rights of Health*, *supra* note 252, at 806; *Fostering*, *supra* note 257, at 254; TOBIN-TYLER & TEITELBAUM, *supra* note 257, at xvi. Health justice, like reproductive and environmental justice movements, center the voices of marginalized communities. Health justice posits that social movement and community leaders should both work with and challenge abuses of power by experts from the legal and health professional communities. *See Civil Rights of Health*, *supra* note 252, at 765–66.

316. Harris and Pamukcu also emphasize intersectionality theory, which "aligns with the public health recognition of the multiple, overlapping pathways through which health disparities emerge, as well as with the civil rights recognition that historical and current forms of discrimination, from the interpersonal to the structural, shape the choices that people make and the life chances they experience." *Civil Rights of Health*, *supra* note 252, at 810. "Embracing social movements as equal partners in the civil rights of health initiative acknowledges the internal limitations of public health and law. Moreover, allowing marginalized groups an equal voice empowers them against the possibility of abusive alliances of public health and law." *Id.* at 806. Harris and Pamukcu argue that health justice is a framework that "combines knowledge of the social determinants of health with a commitment to legal principles of equal justice" and "vigorous engagement and leadership of frontline communities . . . " *Id.* at 807.

collaborative and potentially counteracting forces, creating a system of checks and balances against abuses of power."[317] This system of checks and balances is essential for addressing the criticisms of medicalizing civil rights, especially that deference to medical expertise reinscribes hierarchy and oppression of marginalized groups.

In this vein, a health justice approach to abortion rights would similarly link public health data on the impact of legal restrictions on abortion on the health and well-being of pregnant people with concerns about gender, race, and class inequality. Furthermore, the health justice framework focuses not only on abstract rights, but on the need for marginalized communities to obtain economic resources for more equitable access to the full spectrum of reproductive care. A health justice framework for abortion should rely on public health research on the social determinants of health to seek structural changes that address the underlying root causes of disparities in unplanned pregnancy and access to abortion care. The tripartite system of checks and balances identified by Harris and Pamukcu is key to differentiating health justice from the medicalization of the past. While public health expertise is essential to the health justice framework, that expertise should be subject to input and critique by reproductive justice advocates. Thus, the people targeted, the experts relied upon, and the goals sought to be achieved all significantly differ between the medicalization of the past and the new medicalization approach of health justice, as the chart below illustrates:

	Traditional Medicalization	**The New Medicalization**
Framework:	Clinical Framework	Health Justice Framework
Whom Targeted:	Individual Patient	Populations
Who Decides:	Expertise of Physicians	Expertise of Public Health Professionals
Goal:	Treat Medical Conditions	Address Health Disparities by Focusing on Social Determinants of Health

There are at least three ways in which a health justice approach to abortion could build upon and reframe reproductive justice commitments. First, a health justice approach to abortion should emphasize how abortion restrictions impact pregnant people's health in a broad sense. Second, in addition to emphasizing how restricting abortion access harms women's physical and mental health, the health justice approach to abortion centers concerns about race and class inequality, similarly to reproductive justice, but by focusing on data about reproductive *health* disparities. Third, framing abortion restrictions as threats to public health and to health equity could also help to build broader coalitions for advocacy in state courts,

317. *Id.* at 765.

legislatures, and policy-making bodies, especially in a post-COVID and post-*Dobbs* world. These three advantages of the health justice framework for abortion are discussed in more detail below.

First, a health justice approach to abortion should highlight the negative impacts of abortion restrictions on pregnant people's health in a broad sense. As Rachel Rebouchè has explained, lawyers and the courts have in recent years explicitly drawn on public health research on abortion and "emphasize[d] abortion's role in the health ecosystem."[318] Rebouchè spotlights how public health research has "advanced nuanced understandings of abortion laws' health effects . . . " and locates this public health data as an essential element of a growing movement for expanding access to abortion care.[319] This "public health turn" in policymaking and litigation around abortion connects abortion to health outcomes and health disparities more broadly.[320] A health justice approach to abortion should emphasize this growing body of research on how being denied abortion care harms women's physical and mental health and the well-being of their families.

For example, we now have good data on the harms suffered by women unable to access abortion care from the Turnaway Study, a nation-wide study conducted by researchers at UCSF.[321] The Turnaway Study followed people who were seeking abortion care either just under or just over the time limits of thirty abortion facilities across the country.[322] Some women were just in time to get an abortion and some were turned away and later gave birth.[323] The Turnaway Study provided evidence about the harms that result when pregnant people are denied wanted abortion care.[324] Study participants who were denied an abortion experienced long lasting physical health harm from carrying the pregnancy to term, including two women in the study who were denied abortion care and died following childbirth.[325] The Turnaway Study also found that women denied abortions were less likely than those who received them to achieve other aspirational plans, including

318. *Public Health Turn*, *supra* note 256, at 1364.

319. *See id.* at 1395.

320. *See id.*

321. DIANA GREENE FOSTER, THE TURNAWAY STUDY: TEN YEARS, A THOUSAND WOMEN, AND THE CONSEQUENCES OF HAVING – OR BEING DENIED – AN ABORTION 15–16 (2021); *Public Health Turn*, *supra* note 256, at 1401–02 (summarizing use of public health data on abortion in legal advocacy).

322. FOSTER, *supra* note 321, at 16.

323. *Id.*

324. *Id.* at 21–22.

325. Lauren J. Ralph et al., *Self-reported Physical Health of Women Who Did and Did Not Terminate Pregnancy After Seeking Abortion Services: A Cohort Study*, 171 ANNALS INTERNAL MED. 238, 245 (2019).

providing for their existing children and having children later under better circumstances.[326]

Second, in addition to emphasizing how restricting abortion access harms women's physical and mental health, the health justice approach to abortion centers concerns about race and class inequality. In this respect, health justice takes a similar intersectional understanding of oppression as the reproductive justice framework, but places more emphasis on public health evidence of health disparities and their consequences.[327] Thus, the health justice approach differs in its sources of knowledge and modes of reasoning from reproductive justice arguments, in that health justice relies heavily on public health data on health disparities to push forward concerns about subordination at the intersection of race, class, and gender. In general, the health justice framework aims to provide "a mechanism for systems-level transformation of governmental responses to health disparities to achieve health equity."[328]

For example, in the COVID-19 context, public health evidence has exposed how racial minorities have been disproportionately impacted by the pandemic.[329] This research has shown that the unequal rates of infection, hospitalization, and death are "not due to any biological differences between races, but rather as a result of social factors," including "historical and current practices of racism that cause disparities in exposure, susceptibility, and treatment."[330] Similarly, public health literature on reproductive health care shows how the systemic impacts of poverty and race discrimination shape the risk of unintended pregnancy, the need for abortion care, and hurdles to

326. Ushma D. Upadhyay et al., *The Effect of Abortion on Having and Achieving Aspirational One-Year Plans*, 15 BMC WOMEN'S HEALTH 1, 6 (2015); Diana Greene Foster et al., *Effects of Carrying an Unwanted Pregnancy to Term on Women's Existing Children*, 205 J. PEDIATRICS 183, 186–87 (2018); Ushma D Upadhyay et al., *Intended Pregnancy After Receiving vs. Being Denied a Wanted Abortion*, 99 CONTRACEPTION 42, 46 (2018); *see generally The Turnaway Study*, ANSIRH, https://www.ansirh.org/research/ongoing/turnaway-study [https://perma.cc/4WD8-LN55].

327. *See, e.g.*, Loretta Ross, *Reproductive Justice as Intersectional Feminist Activism*, 19 SOULS 286 (2017).

328. Benfer et. al, *supra* note 248, at 137.

329. *See* Don Bambino Geno Tai et al., *Disproportionate Impact of COVID-19 on Racial and Ethnic Minority Groups in the United States: A 2021 Update*, 9 J. RACIAL & ETHNIC HEALTH DISPARITIES 2334, 2335 (2022).

330. Yearby & Mohapatra, *supra* note 22, at 2–3; *see also* Emily A. Benfer & Lindsay F. Wiley, *Health Justice Strategies to Combat COVID-19: Protecting Vulnerable Communities During A Pandemic,* HEALTH AFFS. (Mar. 19, 2020), https://www.healthaffairs.org/content/forefront/health-justice-strategies-combat-covid-19-protecting-vulnerable-communities-during [https://perma.cc/G2XV-JLY7].

accessing that care across different populations.[331] Empirical data shows that seventy-five percent of people who have abortions live at or near the federal poverty line, and more than half are people of color.[332] A majority of abortion patients in the U.S. are already parents and studies report that one of the primary reasons given for terminating a pregnancy are related to the costs of child rearing.[333] Of course, abortion is not the solution to poverty—the reproductive justice framework properly emphasizes the need for social welfare programs to support the right to give birth and to parent one's children as well.[334] Yet, the Turnaway Study reveals how lack of access to abortion care worsens the health and economic circumstances of already struggling pregnant people and their families.[335] Empirical evidence confirms that lack of access to abortion perpetuates existing inequalities along lines of gender, race, and class.[336] Poverty both "drives rates of unintended pregnancies and then circumscribes women's responses to those pregnancies," resulting in the medicalization of women's poverty.[337] Poverty increases the likelihood of an unplanned pregnancy and the need for but inability to access abortion care, which results in worsening poverty from having children after being denied a wanted abortion.[338]

A health justice approach to abortion should highlight how the SDOH impact who needs access to abortion care and the links between abortion, contraception, pregnancy care, and maternal and fetal

331. *See, e.g.*, Madeline Y. Sutton et al., *Racial and Ethnic Disparities in Reproductive Health Services and Outcomes, 2020*, 137 OBSTETRICS & GYNECOLOGY 225 (2021); Christine Dehlendorf et al., *Disparities in Family Planning*, 202 AM. J. OF OBSTETRICS & GYNECOLOGY 214 (2010).

332. *Induced Abortion in the United States*, GUTTMACHER INST. (Sept. 2019), https://www.guttmacher.org/fact-sheet/induced-abortion-united-states [https://perma.cc/YH6H-G92B].

333. *See, e.g.*, Lawrence B. Finer et al., *Reasons U.S. Women Have Abortions*, 37 PERSPS. ON SEXUAL REPROD. HEALTH 110 (2005); M. Antonia Biggs et al., *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC WOMEN'S HEALTH 29 (2013); KATRINA KIMPORT, NO REAL CHOICE: HOW CULTURE AND POLITICS MATTER FOR REPRODUCTIVE AUTONOMY 2–3 (2021).

334. *See, e.g.*, *Reproductive Justice*, SISTERSONG, https://www.sistersong.net/reproductive-justice [https://perma.cc/33EC-6VY5]; MICHELLE OBERMAN, HER BODY OUR LAWS: ON THE FRONTLINES OF THE ABORTION WAR, FROM EL SALVADOR TO OKLAHOMA, 97–98 (2018); Michelle Oberman, *Motherhood, Abortion, and the Medicalization of Women's Poverty*, 46 J. L. MED. ETHICS 665, 668 (2018) [hereinafter *Motherhood*] (describing observations of women at crisis pregnancy centers).

335. *See The Turnaway Study*, *supra* note 326.

336. Murray, *supra* note 73, at 2045–46; B. Jessie Hill, *The Geography of Abortion Rights* 109 GEO. L. J.1081, 1098 (2021).

337. *Motherhood*, *supra* note 334, at 665.

338. *See id.* at 665–70.

morbidity and mortality. Researchers believe that the correlation between poverty and unintended pregnancy is likely a result of lack of access to the most effective (and more expensive) forms of contraception.[339] As has been increasingly reported in recent years, the United States is facing a maternal mortality crisis and data shows that this crisis is borne disproportionately by Black women.[340] People's needs for and access to contraception, abortion, and pregnancy-related care are linked,[341] and race and class health disparities are apparent across the spectrum of reproductive health care.[342] The U.S. maternal mortality crisis may very well worsen if abortion access is further cut back since studies show that legal restrictions on abortion and rates of maternal mortality are related.[343] A health justice approach to abortion should link together the data on health disparities and negative public health impacts of the maternal mortality crisis and its relationship to denials of abortion care. This medicalized framing in terms of public health could have more resonance with voters who in many states are now deciding the fate of abortion rights.

Third, framing abortion restrictions as threats to public health and to health equity could also help to build broader coalitions for advocacy in state courts, legislatures, and policy-making bodies, especially in a post-COVID world where public health is at the forefront of public concern. The health justice approach to abortion would focus less on constitutional rights on the books and more on political action to improve access to healthcare on the ground. Like the reproductive justice framework, the health justice framework seeks not just negative rights against government encroachment on abortion, but access to resources to make reproductive rights meaningful for the least well-off.[344] Given the Supreme Court's retrenchment on abortion rights,

339. *See e.g.*, *Unintended Pregnancy in the United States*, GUTTMACHER INST. (Jan. 2019), https://www.guttmacher.org/fact-sheet/unintended-pregnancy-united-states [https://perma.cc/N2LZ-W4JG]; Jeffrey F. Peipert et al., *Preventing Unintended Pregnancies by Providing No-Cost Contraception*, 120 OBSTETRICS & GYNECOLOGY 1291 (2012).

340. Sema Sgaier & Jordan Downey, *What We See in the Shameful Trends on U.S. Maternal Health*, NY TIMES (Nov. 17, 2021) https://www.nytimes.com/interactive/2021/11/17/opinion/maternal-pregnancy-health.html [https://perma.cc/3GK8-DBZW].

341. Joerg Dreweke, *New Clarity for the U.S. Abortion Debate: A Steep Drop in Unintended Pregnancy Is Driving Recent Abortion Declines*, GUTTMACHER INST. (Mar. 18, 2016), https://www.guttmacher.org/gpr/2016/03/new-clarity-us-abortion-debate-steep-drop-unintended-pregnancy-driving-recent-abortion [https://perma.cc/KX99-UYSZ].

342. Sutton et al., *supra* note 331, at 226.

343. Dovile Vilda et al., *State Abortion Policies and Maternal Death in the United States, 2015-2018*, 111 AM. J. PUB. HEALTH 1696, 1701 (2021).

344. Jessie Hill also argues that advocates might frame legal arguments for abortion rights as part of a "right to health." *Abortion as Health Care,*

reproductive rights and justice advocates have recognized that "the next generation of abortion policy may have less to do with courts and more to do with political action that advances innovative practices and technologies in the pursuit of abortion access."[345] Using public health knowledge about the SDOH to surface concerns about reproductive health disparities in access to abortion care could help advocates craft more robust protections that serve the interests of more than just the affluent.[346]

Recent examples of legal battles around abortion provide support for the argument that focusing on the health harms of abortion restrictions can persuade members of the public to oppose further legal limits. For example, the movement since the early 2000s to establish fertilized eggs as legal persons (the movement for "personhood" legislation) failed to succeed, even in states extremely hostile to abortion, because opponents of personhood legislation successfully framed the issue as a threat to women's health more broadly.[347] Abortion rights advocates fought personhood laws by successfully reconnecting abortion to pregnancy care, contraception, fertility, and women's health in general.[348] Recently, during the COVID-19 pandemic, a number of states sought to use executive orders to ban abortion under the guise of serving public health goals by limiting non-essential healthcare.[349] Jessie Hill suggests that "abortion restrictions adopted during the pandemic contain[] useful lessons about the rhetorical framing of abortion even during non-pandemic times."[350] Hill argues for a "robust understanding of abortion as medically necessary" and a "rhetorical integration of abortion into health care" in order to draw on

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supra note 302, at 49. The right to health, at least in international human rights advocacy, includes both a right to be free from unwarranted governmental intrusions into health care decision-making and a right to affirmative access to health care. *See id.*; *see also Health Care Rights*, *supra* note 19, at 504–05. As Rachel Rebouché has argued, this shift "from rights to resources" has already begun through partnerships between lawyers, advocacy groups, and public health researchers. *Public Health Turn*, *supra* note 256, at 1395, 1416.

345. *Public Health Turn*, *supra* note 256, at 1410.

346. *See* Watson, *supra* note 254, at 27.

347. *Lessons From Personhood*, *supra* note 21, at 99.

348. *Id.* at 87–93.

349. B. Jessie Hill, *Essentially Elective: The Law and Ideology of Restricting Abortion During the COVID-19 Pandemic*, 106 VA. L. REV. 99 (2020) [hereinafter *Essentially Elective*]; Rachel Rebouché, *Abortion Opportunism*, 7 J. L. & BIOSCIENCES 1 (2020) [hereinafter *Abortion Opportunism*]; Greer Donley et al., *The Legal and Medical Necessity of Abortion Care Amid the COVID-19 Pandemic*, 7 J. L. & BIOSCIENCES 1 (2020) (describing articles on COVID-19 abortion bans).

350. *Essentially Elective*, *supra* note 349, at 111.

the political power of the broader health care community, especially in a post-*Dobbs* world.[351] Legal scholars have shown how locating abortion exclusively as a right of "choice" uncoupled from healthcare access has resulted in the segregation of abortion from other healthcare laws and policies, and has diminished access to abortion care especially for marginalized populations.[352]

More recently, after the *Dobbs* decision instigated numerous total abortion bans, lawsuits have been filed challenging those bans as violating patients' rights to obtain urgent abortion care when a pregnancy threatens their life or health.[353] For example, in Texas, a group of women and physicians filed a lawsuit pursing claims for protection of health and life under the Texas state constitution.[354] The complaint alleges the women were unable to obtain obstetric care due

351. *See id.* at 100, 122 (describing state limits on abortion care during the pandemic based on the claim that abortion is not essential health care and arguing that "for long-term protection of abortion rights, abortion must be reframed as a medically necessary and appropriate treatment, and it must be rhetorically re-incorporated into health care more generally"). By relying on the underlying ambiguity of terms such as "essential health care" and "medical necessity," state officials claimed that abortion care could be stopped pursuant to executive orders banning non-urgent or "elective" medical treatments. Jessie Hill argues that "the longstanding ambivalence about the place of abortion within health care" was leveraged to further "abortion exceptionalism." *See id.* at 100. Although clinicians only demanded to be treated like other health care providers during the pandemic, opponents of abortion claimed abortion providers sought special treatment for an "elective" procedure. Describing abortion care as an "elective" procedure is problematic for a number of reasons. *See* Katie Watson, *Why We Should Stop Using the Term "Elective Abortion",* 20 AMA J. ETHICS 1175 (2018); *What is the Meaning*, *supra* note 193, at 446–47 (discussing in depth the political and legal disputes surrounding how to define what counts as health care and ambiguity in terms such as health, essential health care, and medical necessity).

352. *Rhetoric of Choice*, *supra* note 21, at 420. ("Abortion must be reconstituted as a right that includes both the choice of the pregnant woman and healthcare. The challenge is to bring together these two strands, healthcare and decisional autonomy, in a way that keeps women as medical consumers central to the court's analysis."). *See also From Rights to Dignity*, *supra* note 302.

353. Selena Simmons-Duffin, *Patients and Doctors in 3 States Announce Lawsuits Over Delayed and Denied Abortions*, NPR (Sept. 12, 2023), https://www.npr.org/2023/09/12/1199068710/patients-and-doctors-in-3-states-announce-lawsuits-over-delayed-and-denied-abort#:~:text=Books-,Patients%20and%20doctors%20in%203%20states%20announce%20lawsuits%20over%20delayed,laws%20interfered%20with%20patients'%20care [https://perma.cc/B9G5-6932].

354. Plaintiffs' Original Petition For Declaratory Judgment And Application For Permanent Injunction, Zurawski v. Texas, D-1-GN-23-000968 (Dist. Ct. Travis Cnty., Mar. 6, 2023); Simmons-Duffin, *supra* note 353.

to Texas' anti-abortion laws, including care for miscarriages, pregnancy-induced health complications, and severe fetal abnormalities, and collects similar stories of denials of care in states with abortion bans from across the country.[355] These lawsuits emphasize the dramatic medical impacts of abortion bans on pregnant people's access to urgently needed abortion care and have achieved some success.[356] Given that the post-*Dobbs* health consequences of abortion bans have been starkly disturbing and well-reported, the health justice framework could especially resonate with the public.[357]

In addition, as described above in Part II, after *Roe,* Supreme Court abortion jurisprudence that adopts medicalized modes of reasoning correlates with decreased legal restrictions on access to abortion care, likely because healthcare framings are less threatening to gendered social hierarchies. This history also indicates that there are pragmatic benefits to emphasizing the connection between abortion and healthcare, as legal scholars arguing for medicalizing civil rights in the context of poverty and housing have argued.[358] However, when the Supreme Court adopts a medicalized framework around abortion, it tends to place less emphasis on the social justice issues at stake in access to reproductive healthcare. For example, the abortion rights victories in *Whole Woman's Health* and *June Medical Services* hardly mention how access to care impacts race and gender equality although those concerns were raised in amicus briefs by reproductive justice advocates.[359] The Court's medicalized framings in these cases failed to put forward any articulation of the importance of access to reproductive healthcare as a matter of social justice. The health justice framework

355. *See* Plaintiffs' Original Petition For Declaratory Judgment And Application For Permanent Injunction, Zurawski v. Texas, D-1-GN-23-000968 (Dist. Ct. Travis Cnty., Mar. 6, 2023).

356. The Biden Administration filed several lawsuits challenging abortion bans as violating EMTALA, because the bans hindered physicians' ability to provide emergency abortion care to protect patient health. *See* United States v. Idaho, 623 F. Supp. 1096, 1101 (D. Idaho Aug. 24, 2022); Texas v. Becerra, 623 F. Supp. 696, 703–04 (N.D. Tex. 2022). EMTALA requires hospitals with emergency departments that receive federal funding to provide emergency stabilizing care, which may include abortion care if necessary to stabilize a pregnant patient's health. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUM. SERVS., QSO-22-22-HOSPITALS, REINFORCEMENT OF EMTALA OBLIGATIONS SPECIFIC TO PATIENTS WHO ARE PREGNANT OR ARE EXPERIENCING PREGNANCY LOSS (2022).

357. *See, e.g.,* Maya Manian, *The Ripple Effects of Dobbs on Health Care Beyond Wanted Abortion*, 76 SMU L. REV. 77 (2023).

358. *See What is the Meaning*, *supra* note 193, at 454–55 (analyzing *Gonzales v. Carhart*'s reasoning on health exception).

359. Whole Woman's Health v. Hellerstedt, 579 U.S. 582, 624–27 (2016); June Med. Servs. L.L.C. v. Russo, 140 S. Ct. 2103, 2133 (2020).

bridges this gap by leveraging the benefits of medicalized framings while also stressing reproductive justice concerns with race, class, and gender equity in access to the full spectrum of reproductive healthcare.

A few examples can illustrate how a health justice framework overlaps with, yet also reframes, reproductive rights and justice concerns in medicalized ways. The payoff of the health justice framework lies mainly in offering advocates additional modes of reasoning about the inequitable harms of abortion restrictions that could be more persuasive to public audiences who are less receptive to arguments explicitly emphasizing sexual and reproductive liberty and autonomy. The sections below analyze how the health justice framework could be deployed in debates about parental consent requirements for minors' abortion care and self-managed abortion. The final section discusses potential risks of using the health justice framework in the abortion context.

(i) Parental Consent to Abortion for Minors

Debates over laws requiring parental involvement with adolescent abortion decisions provide a concrete example of how the health justice framework could advance more equitable access to abortion care. In states with parental notice or consent mandates, which are the vast majority of states, teenage girls facing an unplanned pregnancy must obtain permission from a parent or alternatively from a judge to receive abortion care.[360] Decades of studies on the efficacy of parental involvement requirements and the judicial bypass process demonstrate that these laws harm more than they help adolescent girls.[361]

Yet, even in jurisdictions sympathetic to abortion rights, the notion of parental involvement with abortion for adolescents remains quite popular.[362] For example, when a parental involvement law was proposed through California's ballot initiative process, abortion rights advocates worried that the public might favor such legislation even though Californians are generally friendly to abortion rights.[363] Rather than

360. *Parental Involvement in Minors' Abortions*, GUTTMACHER INST., https://www.guttmacher.org/state-policy/explore/parental-involvement-minors-abortions [https://perma.cc/8ULV-4SYF].

361. *See, e.g.*, Maya Manian, *Functional Parenthood and Dysfunctional Abortion Policy: Reforming Parental Involvement Legislation*, 50 FAM. CT. REV. 241 (2012) [hereinafter *Functional Parenthood*]; Carol Sanger, *Decisional Dignity: Teenage Abortion, Bypass Hearings, and the Misuse of Law*, 18 COLUM. J. GENDER & L. 409 (2009); Carol Sanger, *Regulating Teenage Abortion in the United States: Politics and Policy*, 18 INT'L J. L. POL'Y & FAM. 305 (2004).

362. *See Functional Parenthood*, *supra* note 361, at 242 (noting that 37 states have parental involvement legislation for abortion, including otherwise prochoice states such as Massachusetts).

363. *See* Maya Manian, *Proposition 4: Constitutional Amendments for Sale*, REWIRE NEWS GROUP (Nov. 3, 2008, 2:10 PM), https://rewirenews

frame arguments against the parental involvement law as a matter of reproductive autonomy, abortion rights groups emphasized that the law would threaten adolescent health. In particular, advocates argued that most teens do involve parents in abortion decisions; however, the most vulnerable groups of minors who cannot safely inform their parents about a pregnancy would have delayed access to abortion care and suffer greater health risks.[364] In other words, a health justice approach to parental involvement laws would rely on public health research on health disparities to emphasize the health harms of delaying access to abortion care particularly for marginalized minors. This approach to parental involvement laws illustrates how a health justice framework offers potential benefits in political and legal arenas in which reproductive autonomy arguments may not have persuasive force, such as for adolescents, while also incorporating concerns about equity in access to health care. Health justice is a powerful framework especially when speaking to voters, a necessity in the post-*Dobbs* world. Abstract notions about rights worked for a time when courts protected abortion rights. Now that access to abortion depends upon the public and policymakers, health justice offers a pragmatic strategy that has the potential to be persuasive to a broad swath of voters by adopting a medicalized rhetorical framing that rests on public health data while also incorporating concerns about equality along lines of gender, race, and class.[365]

(ii) Self-Managed Abortion

A health justice approach to abortion could also advance access to self-managed abortion (SMA). SMA differs from telehealth abortion, which involves the use of traditional health care systems to deliver abortion care remotely.[366] The remote delivery of medication abortion

group.com/article/2008/11/03/proposition-4-constitutional-amendments-sale/ [https://perma.cc/PD8W-YBA7].

364. Carole Joffe & Eleanor Day, *California's Prop 4 Jeopardizes the Doctor-Patient Relationship*, REWIRE NEWS GROUP (Nov. 2, 2008, 3:49 PM), https://rewirenewsgroup.com/article/2008/11/02/californias-prop-4-jeopardizes-doctorpatient-relationship/ [https://perma.cc/8W8R-72M5]; *see also Functional Parenthood*, *supra* note 361. Minors in detention, or in foster homes or group homes, are often have no way of contacting parents who may be deported, imprisoned, or whose whereabouts are unknown and be least able to access the judicial bypass system. *See id.* at 250.

365. Although public health data can of course also be politicized and contested. *See infra* Part III Section C(iii).

366. Telehealth abortion has become more readily available, in part due to the expansion of telemedicine generally during the coronavirus pandemic. In 2021, the FDA authorized expanded access to abortion pills through telemedicine alone, but this significant legal change will have little impact in jurisdictions hostile to abortion rights and may be restricted nationwide depending on the outcome of a legal challenge in Texas. *See* Alliance for

(abortion through pills rather than a procedure) has expanded the reach of abortion care earlier in pregnancy.[367] In a post-*Dobbs* world, more pregnant people turn to SMA in states where legal restrictions or a lack of resources hinders access to abortion care through the formal medical system.[368]

SMA presents the most likely path towards increased access to abortion for the most vulnerable populations of pregnant people after *Dobbs.* Still, it is important to note that those in need of later abortion care or with medical contraindications will be less able to take advantage of SMA.[369] Reproductive rights advocates might emphasize pregnant people's autonomy interests in SMA, particularly for people of color given the long history of race discrimination in formal systems of medicine.[370] Adding a health justice approach to SMA would place greater emphasis on public health research on the safety and efficacy of SMA and how SMA can address health disparities and reduce the health harms that flow from being denied abortion care. Although reproductive rights and justice arguments remain important, the health justice framing based on public health data could have more force in

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Hippocratic Med. v. U.S. Food and Drug Admin., 78 F.4th 210 (5th Cir. 2023), *cert. granted sub nom.* Danco Lab'y v. Alliance for Hippocratic Med., 2023 WL 8605744 (U.S. Dec. 13, 2023) (No. 23-236); *see also* Greer Donley, *Medication Abortion Exceptionalism*, 107 CORNELL L. REV. 627 (2022) (discussing FDA regulation of medication abortion). In contrast to telehealth abortion, SMA occurs without clinician oversight. *See Public Health Turn*, *supra* note 256, at 1425–28 (describing SMA). An individual can self-manage abortion without a clinician's supervision by obtaining access to a two-drug regimen or a one-drug protocol—although these means may violate a variety of federal and state laws that could subject the person to criminal punishment, which is particularly concerning for people of color who have been disproportionately criminalized for pregnancy outcomes. *See* Ahmed, *supra* note 284; MICHELE GOODWIN, POLICING THE WOMB (2020).

367. *See, e.g.*, Yvonne Lindgren, *When Patients are Their Own Doctors:* Roe v. Wade *in an Era of Self-Managed Care*, 107 CORNELL L. REV. 151, 188–200 [hereinafter *When Patients*] (explaining medication abortion regiments); *Abortion Opportunism*, *supra* note 349, at 8 (discussing telehealth abortion).

368. *See, e.g.*, *When Patients*, *supra* note 367, at 157–58 (summarizing research on SMA and noting increased use of SMA in states with severe restrictions on abortion such as Texas).

369. Greer Donley & Jill Wieber Lens, *Second Trimester Abortion Dangertalk*, 62 BOS. COLL. L. REV. 2145, 2153–54 (2021).

370. *See, e.g.,* JUST MEDICINE, *supra* note 311, at 84; HARRIET A. WASHINGTON, MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT *passim* (2006); Ruha Benjamin, *Assessing Risk, Automating Racism*, 366 SCIENCE 421 (2019) (arguing that the problem is not that racial minority patients lack trust in the healthcare system, but that the healthcare system and medical industry lacks trustworthiness).

persuading policymakers focused on public health to decriminalize SMA.[371] Arguably, SMA represents a move to demedicalization since it eliminates health care providers from abortion care.[372] Yet, the health justice approach to abortion illustrates how public health research can reframe SMA as an issue of health equity.

Even though SMA operates largely outside the healthcare system and might not be considered health care at all under traditional physician-patient focused forms of medicalization, the health justice framework can and should be applied to support SMA. As Yvonne Lindgren explains, "self-managed abortion falls outside of the narrow framing of the medical gatekeeper model of the abortion right" but tracks "larger trends in self-managed care, including direct-to-consumer blood testing, fecal testing, DNA testing, self-managed gender-affirming hormone therapy, and assisted reproductive technology such as ova and sperm shopping."[373] Lindgren argues for framing the abortion right as one of a right to care for one's health through direct-to-consumer access to abortion care via the online pharmaceutical marketplace.[374] This argument in favor of SMA aligns with proponents of direct-to-consumer medicine in other contexts, who argue that "the new model [of self-managed care] increases patient autonomy while also reducing costs to both individuals and the healthcare system as a whole."[375] In this understanding of the healthcare system, self-managed care of all kinds is healthcare but operates outside the traditional physician-controlled medical orthodoxy.[376]

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371. *See generally* Laura Huss et al., *Self-Care, Criminalized: August 2022 Preliminary Findings*, IF WHEN HOW: LAWYERING FOR REPROD. JUST. (2022), https://www.ifwhenhow.org/wp-content/uploads/2023/06/22_08_SMA-Criminalization-Research-Preliminary-Release-Findings-Brief_FINAL.pdf [https://perma.cc/UA8A-AJHZ].

372. *See* Jessie Hill, *De-Medicalizing Abortion Rights*, 22 AM. J. BIOETHICS 57 (2022).

373. *When Patients*, *supra* note 367, at 158–59; *see also* Yvonne Lindgren, *The Doctor Requirement: Griswold, Privacy and At-Home Reproductive Care*, 32 CONST. COMMENT. 341, 341 (2017) [hereinafter *The Doctor*].

374. *When Patients*, *supra* note 367, at 159; *see also The Doctor*, *supra* note 373, at 343 (arguing that privacy law provides a strong constitutional basis for protection at-home abortion).

375. *See When Patients,* supra note 367, at 197.

376. *See id.* at 196 (arguing that self-managed abortion fits into larger trends in healthcare from patients as passive recipients of doctors' orders to patients as informed consumers who can direct their own healthcare); *see also* Lewis A. Grossman, *FDA and the Rise of the Empowered Consumer*, 66 ADMIN. L. REV. 627, 638 (2014) (describing the trend towards patient as active and engaged consumers in the context of FDA policy); LEWIS GROSSMAN, CHOOSE YOUR MEDICINE: FREEDOM OF THERAPEUTIC CHOICE IN AMERICA 144–61 (2021) (explaining the rise of patients' rights and

In applying the health justice framework, legal scholars have offered three overarching principles to help guide policymakers and to eliminate health disparities in different policy contexts (such as housing and employment), but scholars have not considered the application of health justice principles in the abortion context. The health justice framework's three key principles are: (i) to ensure that policy-making addresses the structural and intermediary determinants of health; (ii) to require policies that seek individual behavior changes to also offer social support to foster those changes; and (3) that policy-making bodies must empower marginalized communities through inclusion in decision-making.[377] These three principles are particularly useful for considering how the health justice framework can support SMA in a post-*Dobbs* world.

The literature on health disparities in access to abortion care provides support for those who argue in favor of SMA more broadly, even in jurisdictions where abortion remains legal but inaccessible for some pregnant people. Self-managed care serves the interests of health justice by expanding access to abortion care for those who lack the funds for clinical care or have good reasons not to trust the formal health care system, in particular people who are low-income, undocumented immigrants, and people of color. Applying the first principle of health justice to SMA, legal and policy responses that address structural determinants of health in this context would include further FDA expansion of access to medication abortion.[378]

This could include eventually allowing medication abortion pills over-the-counter to make SMA more readily accessible,[379] and

women's health movements in the 1970s and their resistance to physician dominated medicine).

377. *See, e.g.*, Benfer et al., *supra* note 248, at 137–39 (explaining three overarching principles of the health justice framework). For example, in the context of housing as a social determinant of health, structural changes include legal reforms that would prevent evictions and homelessness and policies encouraging long-term investment in affordable housing; social supports for required behavior changes include utility shut-off moratoriums during stay-at-home orders so that tenants have access to clean water and heat while at home; and empowerment of marginalized communities occurs by including people who live in low-income housing in policy decisions such as through supporting tenant unions. *See id.* (providing examples applying the health justice framework and its three key principles to healthcare, housing, and employment contexts). *See also* Yearby, *supra* note 6, at 642.

378. *See generally* Lewis A. Grossman, *Freedom Not to See a Doctor: The Path Toward Over-The-Counter Abortion Pills*, 2023 WIS. L. REV. 1041 (2023).

379. *See, e.g.*, *When Patients*, *supra* note 367, at 218–19; *Support Self-Managed Abortion*, PLAN C, https://www.plancpills.org/support-abortion [https://perma.cc/KZ8R-6Q4C]; *see* Lisa H. Harris & Daniel Grossman, *Complications of Unsafe and Self-Managed Abortion*, 382 NEW ENG. J.

decriminalizing SMA especially since low-income pregnant people and people of color are far more likely to face criminal charges for pregnancy outcomes.[380] Law is a structural determinant of health since it "mediates the social, economic, and physical structures" that determine access to resources.[381] Changing laws limiting SMA would be a crucial first step towards structural changes that could vastly expand abortion access

Despite evidence that SMA can be accomplished safely, if policymakers nevertheless wish to generally encourage pregnant people to obtain abortion care or post-abortion care through the formal medical system as a harm minimization policy, the second principle of health justice requires that government provide legal protection, financial support, and social supports to encourage behavior changes such as increasing healthcare-seeking behavior. For example, federal and state governments should cover abortion care in public and private health insurance even for residents traveling from out-of-state, permit clinicians to provide abortion care for out-of-state patients via telemedicine, fund greater access to the technology required for telemedicine for low-income communities, and integrate abortion care in a wider variety of clinical settings with a wider variety of providers (not just physicians) so that patients can avoid the violence and harassment targeted at abortion clinics. For those people who seek to self-manage abortion, laws and hospital policies should ensure that patients who need follow-up care can obtain post-abortion healthcare at hospitals and clinics without punishment. Otherwise, fear of legal repercussions deters healthcare-seeking behaviors, particularly for vulnerable populations such as undocumented immigrants. Some of these supports would also expand access to healthcare through telemedicine more generally and help to integrate abortion into mainstream medicine, both efforts that could help build broader coalitions for advocacy than approaches that treat abortion care as exceptionalized.

The third principle of health justice mandates that marginalized communities serve as leaders in the development of laws and policies

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MED. 1029 (2020); Daniel Grossman et al., *A Research Agenda for Moving Early Medical Pregnancy Termination Over the Counter*, 124 BJOG 1646, 1649 (2017) (explaining data on safety and efficacy of SMA and arguing for over-the-counter availability of medication abortion pills); Daniel Grossman, *The Victory for Over-the-Counter Birth Control Pills Is Just the Beginning*, NY TIMES (July 19, 2023), https://www.nytimes.com/2023/07/19/opinion/birth-control-pills-opill-over-the-counter.html [https://perma.cc/APD5-NXMD].

380. Greer Donley & Jill Wieber Lens, *Abortion, Pregnancy Loss, & Subjective Fetal Personhood*, 75 VAND. L. REV. 1649, 1664, 1702 (2022) (linking SMA with other forms of pregnancy loss such as miscarriage and stillbirth and noting potential criminalization of pregnant people for pregnancy outcomes in a post-*Dobbs* world).

381. *Public Health Turn*, *supra* note 256, at 1408.

on reproductive healthcare to ensure that concerns particular to those communities are accounted for and addressed. In the past, the failure of mainstream reproductive rights advocates to include women of color in decision-making led to intra-feminist conflict and policies that ignored the reproductive harms suffered disproportionately by marginalized groups.[382] In the abortion context, people most at risk of unplanned pregnancies should be at the forefront of developing interventions promoting the safety, efficacy, and accessibility of SMA.

As described above, public health research shows that the majority of abortion patients are low-income and, due to a history of systemic racism, are disproportionately women of color. Pregnant people living in rural areas and jurisdictions that are "abortion deserts" also lack access to abortion care through formal medical systems.[383] These groups should not only be included in decision-making around best practices for SMA, but also given resources to encourage their participation such as compensation for their work.[384] In these ways, the health justice framework and its guiding principles can be used to normalize and expand access to SMA, despite no formal health care providers being involved in the practice.

(iii) Risks of a Health Justice Approach to Abortion

Despite potential benefits of framing abortion access as a matter of health justice, relying upon the health justice framework to advance abortion rights also presents the potential downsides described by critics of medicalized civil rights more generally. First, medicalized frameworks can be coopted by anti-civil rights forces though stigmatization and over-medicalization, as seen in the passage of abortion restrictions that claim to protect women's health.[385] Scientific

382. For example, the failure of mainstream reproductive rights advocates to consult with or include women of color on sterilization policy led to intra-feminist conflict around informed consent to sterilization and a failure of reproductive rights groups to address sterilization abuse of low income women and women of color. *See* Maya Manian, *The Story of* Madrigal v. Quilligan, *in* REPRODUCTIVE RIGHTS AND JUSTICE STORIES (2019). *See generally* DOROTHY E. ROBERTS, KILLING THE BLACK BODY (1997*)*.

383. *See, e.g.*, Lisa R. Pruitt et al., *Legal Deserts: A Multi-State Perspective on Rural Access to Justice*, 13 HARV. L. & POL'Y REV. 15, 18–19 (2018); Lisa R. Pruitt, *Gender, Geography & Rural Justice*, 23 BERKELEY J. GENDER L. & JUST. 338, 359 (2008); Lisa R. Pruitt & Marta R. Vanegas, *Urbanormativity, Spatial Privilege, and Judicial Blind Spots in Abortion Law*, 30 BERKELEY J. GENDER L. & JUST. 76, 77, 107 (2015).

384. Benfer et al., *supra* note 248, at 162 (stating the third prong of health justice requires marginalized groups to be "consulted as interventions are developed and given autonomy over decision-making that will affect their lives" and given "compensation, training, childcare, and transportation, to enable participation" in policy-making bodies).

385. *See supra* Part II.

expertise—including public health expertise—is highly contested as we have seen both in litigation around abortion and during the COVID-19 pandemic.[386]

Second, the health justice framework focuses on medically recognized harms of being denied access to abortion care since it relies heavily upon evidence from public health research. Data from the Turn Away Study and litigation on the impacts of abortion bans on access to medically-indicated abortion care bolster the claim that there are in fact health harms from abortion bans.[387] Yet, abortion restrictions are harmful beyond their impact on physical and mental health and beyond patients who have a medically-indicated need for abortion care. Abortion bans threaten women and pregnant people's economic and political equality, especially for people who are low income and people of color.[388]

Third, in the abortion context, the health justice framework's deference to the expertise of public health professionals elides underlying concerns about sexual and reproductive autonomy and could diminish pregnant people's own voices as valuable sources of knowledge for reproductive health policy. In other reproductive health contexts such as childbirth, medical evidence has been used to deny pregnant patients autonomy in decision-making.[389] While framing abortion as a health justice issue could offer pragmatic, short term benefits in a post-*Dobbs* and post-COVID world where health is at the forefront of public concern, civil rights advocates will need to pay attention to what might be lost if abortion and other civil rights are medicalized through a health justice lens.[390]

386. *See, e.g.*, Ahmed, *supra* note 291, at 683. *Cf.* Alejandra Caraballo, *The Anti-Transgender Medical Expert Industry*, 50 J. L. MED. & ETHICS 687, 687–89 (2022) (describing challenges with sorting out validity of expert evidence in civil rights litigation).

387. *See supra* Part III.

388. Sheelah Kolhatkar, *The Devastating Economic Impacts of an Abortion Ban*, NEW YORKER (May 11, 2022) https://www.newyorker.com/business/currency/the-devastating-economic-impacts-of-an-abortion-ban [https://perma.cc/E8RZ-L5JG].

389. *See, e.g.*, Elizabeth Kukura, *Contested Care: The Limitations of Evidence-Based Maternity Care Reform*, 31 BERKELEY J. GENDER L. & JUST. 241 (2016); Jamie R. Abrams, *The Illusion of Autonomy in Women's Medical Decision-Making*, 42 FLA. ST. UNIV. L. REV. 17 (2014); *see also* Ahmed, *supra* note 291.

390. *See also* Watson, *supra* note 254, at 25 (discussing risks of health disparities framing of abortion including stigmatizing low-income people and people of color).

CONCLUSION

Medicalization in abortion regulation has been neither entirely good nor bad. Rather, medicalization in abortion law has impacted access to abortion care in varied ways depending on who is doing the medicalizing, for what purposes, and for whom access is increased or decreased. [391] While medicalization may not promote women's autonomy in all realms of reproductive health care (for example, in childbirth), this Article's analysis of abortion jurisprudence shows how medicalized framings of abortion could help to persuade the public and policymakers to preserve abortion rights by wrapping claims for reproductive autonomy in the language of public health and health equity.

The health justice framework offers a new way of medicalizing abortion that still relies on medical expertise, but is not a return to physician control over patients as framed in *Roe v. Wade*.[392] By focusing on the social determinants of health, the health justice framework brings traditional civil rights concerns about race, gender, and class equality to the fore while also leveraging public health's medicalized discourse to persuade voters to support abortion rights. The health justice framework brings to bear on public contestation over abortion both medicalized and demedicalized framings that—while bearing its own risks and costs—may be strategically useful in a post-*Dobbs* world. Given the Supreme Court's retrenchment on abortion rights and the likelihood that more states will move to ban or further restrict access to abortion, the health justice framework offers a new mode of reasoning about abortion that may have more traction in venues outside the federal courts.

In addition to having more political resonance in arenas less amenable to explicitly feminist arguments about women's sexual and reproductive autonomy, the health justice framework could help reintegrate abortion care into mainstream medicine and into legal understandings of abortion as essential healthcare. Furthermore, the health justice framework could help abortion rights advocates build coalitions with other social movement groups, especially in a post-COVID world in which race and class health disparities are at the forefront of concerns for many advocacy groups. Even though the federal courts no longer protect abortion rights, a health justice approach to abortion is a framework that could be utilized by executive branch officials, federal and state legislatures, and community

391. Webb & Matthew, *supra* note 4, at 588 (noting that "the value and the impact of medicalization depend entirely on what is being medicalized, and for whom.").

392. Roe v. Wade, 410 U.S. 113, 165–66 (1973).

organizations striving for more equitable access to the full spectrum of reproductive healthcare.[393]

393. *See, e.g.*, David S. Cohen et al., *Joe Biden Can't Save* Roe v. Wade *Alone. But He Can Do This*, NY TIMES (Dec. 30, 2021), https://www.nytimes.com/2021/12/30/opinion/abortion-pills-biden.html [https://perma.cc/KYK8-B6H4] (arguing that more creative avenues for protecting access to abortion care are needed given the current composition of the U.S. Supreme Court, including legislative and executive actions such as using federal lands for abortion clinics in hostile states, asserting the power over the U.S. postal system to thwart state limitations on mailing abortion pills, and "encouraging the adoption of so-called interstate licensure compacts, which would allow providers in good standing to prescribe medication, including abortion medication, across at least some state borders.").